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DEPT. OF HEALTH AND HUMAN SERVICES

Certified Nurse Midwives
Credentialing Review Meeting #2
Public Meeting
Minutes

This is a draft. Minutes have not been approved by the Technical Review Committee.

Thursday, October 29th, 2026, 9:00am

MEMBERS: Mark Malesker, PharmMD, FCCP, FCCM, FASHP, BCPS; Tami Dolphens, PA-C; Kevin Low, DDS; Judy Neville, CPhT, CSPT; Brandon Holt, BSRT [R] (CT) (ARRT); Stacy Waldron, PhD; Jacob Sikes
STAFF: Emma Davis, Emma Soukup

1. **Call to Order and Roll Call**
   Jacob Sikes, Technical Review Committee Chair, called the second meeting of the certified nurse midwives credentialing review process to order at approximately 9:00am on October 29th, 2026, virtually over teams. Copies of the agenda, the previous meeting's minutes, and the applicant group's handout materials were mailed electronically to committee members prior to the meeting and posted on the Health and Human Services website. The following members were present: Mark Malesker, PharmMD, FCCP, FCCM, FASHP, BCPH; Tami Dolphens, PA-C; Judy Neville, CPhT, CSPT; Brandon Holt, BSRT [R] (CT) (ARRT); Stacy Waldron, PhD; Jacob Sikes. There was one committee member who was in attendance but joined the meeting approximately 50 minutes after it began, Kevin Low, DDS. Quorum met.
   Staff and others in attendance: Emma Davis, Emma Soukup, Marley Sandberg
   A copy of the Open Meetings Act was available online.

2. **Adoption of the Agenda and Approval of Minutes**
   - Waldron made a motion to approve the agenda, seconded by Holt; voting yes: 6 (Malesker, Dolphens, Neville, Holt, Waldron, Sikes); voting no: 0; not voting: 1 (Low). Motion carried.
   - Malesker made a motion to approve the minutes from the previous meeting, seconded by Waldron; voting yes: 6 (Malesker, Dolphens, Neville, Holt, Waldron, Sikes); voting no: 0; not voting: 1 (Low). Motion carried.

3. **Applicant group follow-up information** presented by Elizabeth Mollard, PhD, CNM, WHNP, IBCLC on behalf of Nebraska Certified Nurse-Midwives (the applicant group)
   - Mollard explained that this meeting is primarily dedicated to answering the TRC's remaining questions and reminded the group that the applicant group proposal has been formulated in collaboration with 14 different organizations in the healthcare community.
   - Mollard reminded the group that nurse-midwives are already licensed in Nebraska and have been since 1984. Their license is one of the four types of Advanced Practice Registered Nurse (APRN) licenses. APRNs, including nurse-midwives have advanced graduate degrees.
   - The applicant group is seeking two statutory changes: They want no physician supervision agreement after a transition to practice agreement. They also want no location restriction, so CNMs can attend home births.
     - Mollard clarified that the applicant group is not seeking to do anything new clinically. Everything under the scope change proposed is already in CNM practice.
   - Mollard explained how nurse-midwives would collaborate with physicians under the new proposal. They would consult physicians, co-manage patients with elevated risk, and refer and transfer patients to physicians when appropriate.

    - She explained that in certain situations, the physician supervision agreement can prevent collaboration, limiting CNMs' ability to consult several other health professionals.
- Mollard explained that the proposal is very in-depth because it was written by collaborating with other healthcare groups who asked for a specific scope of practice to be written into law, because by national standards, this is a restrictive proposal, and because the wider healthcare community also asked for a regulatory framework for births outside the hospital.
- Mollard then explained that generally birth is safe. She wanted to clarify that healthcare providers need to consider worse-case scenarios and that's why she needed to discuss safety and risk. But she did not mean to make birth sound scary because statistically, it is safe, both at the hospital and at home. She also presented data that shows that the pre- and post-natal stages are higher risk to mothers than birth. She also stated that birth defects are the leading cause of infant death, followed by being born pre-term, then followed by maternal complications. She stated that good prenatal care and monitoring the mother protects the baby most from these complications.
- Next, Mollard addressed the question of what nurse-midwives bring to a home birth. She provided a sample checklist that is available on the DHHS website. She explained that to perform a home birth, midwives bring many different supplies including, but not limited to, medications and IV fluids to stop heavy bleeding after birth, oxygen, masks, resuscitation equipment, advanced life support equipment, IV antibiotics for GBS, mediations for emergencies, routine vitamin K, antibiotic eye ointment, Hepatitis B vaccine, sterile supplies and numbing medicine for laceration repairs, and a transfer plan including hospital and EMS contacts, records, and a handoff form ready before labor. She also explained that people who seem like they need more than standard care are not candidates for home birth.
- Mollard then spoke about the demographics nurse-midwives serve. According to the CDC, CNMs attend more Medicaid births, but otherwise CNMs serve populations at similar rates to non-CNM birthing service providers. CNMs are currently serving a smaller percentage of the rural/non-metro population, but Mollard stated that this is largely due to the restrictions on where nurse-midwives are allowed to practice.
- Mollard presented a map that showed where nurse-midwives live in relation to maternal care deserts. CNMs are largely concentrated in metro areas, but there are also many in rural areas. Currently, CNMs provide care to about 28% of Nebraska's land area. With full practice authority, CNMs could reach up to 47% of Nebraska's land area.
- Mollard presented a statistic that 19.7% of CNMs in Nebraska are also licensed nurse practitioners. The same clinician can practice independently as an NP, but not as a nurse-midwife.
- Neville asked how CNMs acquire products for conducting home births and how they maintain product quality, such as keeping medications refrigerated and in-date, if they are not connected to a physician. Mollard responded that CNMs have prescriptive authority, so they would use their NPI number to purchase these products directly from a supplier. She said that some products are refrigerated, so certain protocols and standards would have to be followed. Most midwives who would attend home births would have a clinic where the medications would stay and where inspections could be performed by the state. Neville asked for clarification, are these things nurse-midwives already do? Mollard clarified that yes, these are all things nurse-midwives already do and the applicant group's proposal would not add any new responsibilities.
- Neville asked a question about the map that shows where nurse-midwives live. She asked if every circle without a number represented only one CNM. Mollard said most do, but not necessarily, because there are three practicing CNMs in Scottsbluff, for example.
- Neville also asked a question about the demographics graph. She asked what the column labeled "All Nebraska births" means because the column doesn't add up to 100%. Mollard explained that each row shows the percentage of births in Nebraska were covered by Medicaid and what percentage of births attended by a CNM were covered by Medicaid. So, some demographics overlap. (Ex. If you were age 25-35, on Medicaid, and in a rural area, you would be counted in all three of those rows.)

- Neville also asked about the steps that would be taken to contact a nurse-midwife and plan a home birth. Mollard explained that step one would be using google or yellow pages to find care, just like normal. The person would need to come into the clinic for a pregnancy confirmation visit. Then, risk status would be assessed. She explained that the person would receive standard prenatal care and that throughout the process, candidacy for home birth would be reassessed. If a patient developed risk factors outside of the CNM's scope, candidacy for home birth would be revoked. It can be revoked at any time during the pregnancy. Neville asked if insurance would pay for home birth and would that be a route to find a midwife for care. Mollard explained that it depends, some insurances cover home birth such as Tricare and many private insurances. It also depends on which insurance the midwife decides to accept.
- Waldron brought up individuals who are not certified to do home births, who might be advertising themselves as having the same skills as CNMs, but who haven't gone to school and don't have the qualifications and licenses that CNMs do. She said she had the sense that the applicant group was thinking far ahead, past the proposed legislation, to what the rules and regulations might be, to protect the public from these individuals. She asked Mollard to expand on what she hopes to see as far as these protections go. Mollard responded that there are stipulations in the proposed law regarding which pregnancies can be considered for home birth, ex. no preeclampsia, the baby must be head down, no multiples, no pre-term births. She said that the proposal also requires a transfer plan as well as other safety measures. The proposal also allows rules and regulations to be written in addition to the text of the proposed law. She said that because there are no regulated and licensed providers for home births in Nebraska, there's currently a black market. This will bring homebirth into a regulatory framework and allow the public safe options. She said all these regulations are written to ensure the standard of care.
- Waldron asked about the 20% of nurse-midwives who are dual-licensed as nurse practitioners. She wondered if these midwives could attend births under their nurse practitioner license in a way that the other 80% cannot. Mollard clarified that nurse practitioner licensure does not independently authorize attendance at births. Nurse-midwives who also hold nurse practitioner licensure may provide care within the scope of both licenses, but their authority to attend births derives from their nurse-midwifery licensure. Holding both licenses does not circumvent Nebraska's prohibition on CNM-attended home births. Waldron then asked for clarification. Only family practice physicians, OBGYN, and nurse-midwives can attend births. Dolphens added that when it is a part of their practice, certain physician assistants (PAs) can attend births.
- Dolphens asked a question about the proposed removal of the provision prohibiting nurse-midwives from attending home births. She asked if that provision was removed, could nurse-midwives attend home births without any other change to the scope of practice. Mollard responded yes. Dolphens explained that she was asking if the scope of practice would need to be changed because there are other additions to statute in the proposal. She wondered if those were necessary to allow CNMs to perform home births. Mollard explained that no, the additions are not technically necessary to allow CNMs to perform home births; the applicant group's original proposal did not contain them, in fact. They are included because the applicant group and the other health professionals they collaborated with in writing the proposed statute changes felt they should include regulation for homebirth and specific practice regulation when striking out the home birth prohibition and physician collaborative agreement requirement.
- Dolphens then asked a question about the map that showed the expansion of CNM reach from 28% to 47% of Nebraska's land area. She asked if this was depicting expansion of home birth care or expansion of in-clinic or primary care that would be allowed by full practice authority. Mollard explained that the map depicts maternal care access, not specifically home birth. She predicts only one or two midwives will attend home births. She explained that the expansion of access map just shows where access could increase if CNMs were no longer required to find a physician or pay a physician for a collaborative agreement.
- Dolphens also brought up this statistic from earlier in the presentation: nearly 20% of CNMs also have a nurse practitioner license. She wanted to clarify if the reason NPs can't deliver babies is because of the

focus of their training and if the reason CNMs do not provide full-scope primary care is also because of the focus of their training. Mollard stated that in some states, CNMs are allowed to provide full-scope primary care, but that the primary care component is much less. CNMs do provide primary care, but Mollard said she wouldn't call herself a primary care provider on the basis of her CNM title. She stated, though, that the education programs are supposed to prepare CNMs in that regard. But you wouldn't see a CNM working at an urgent care, for example.

- Malesker asked if episiotomies are a normal part of the scope of what may happen at a home birth. Mollard responded that CNMs don't typically tend to do episiotomies as standard practice, for example she has done two in her entire career. However, they are trained how to do them and would have all the requisite equipment to perform one and repair one in case of an emergency.
- Sikes asked what percentage of nurse-midwives are actively practicing in Nebraska. Mollard responded that the last she checked, 117 were licensed, 87 were practicing in the state, and about 47 to 50 of those practicing were providing birth care.
- Mollard then presented information regarding CNM education. A handout was provided to those present and is publicly available online. She explained the educational pathway to become a certified nurse-midwife. Somebody would need to complete prerequisite coursework, be admitted to nursing school, complete a bachelor of science in nursing, including supervised clinical rotations, pass the NCLEX-RN (an exam), practice as an RN before graduate school, be admitted to graduate school, complete the APRN core curriculum (including the 3 Ps: advanced pathophysiology, advanced pharmacology, advanced, physical assessment), complete the CNM-specific specialty courses (prenatal, labor and birth, postpartum, newborn, gynecology, primary care), do clinicals, and pass the board exam: AMCB. Mollard explained that by the time a CNM graduates with a graduate degree, they have completed 6 to 8 years of formal education plus however many years they spent as an RN. Some have more if they complete a doctorate.
- Mollard also presented a sample of APRN-CNM curriculum. She showed that most of the classes in the specialty courses are focused on the things midwives will need to know to provide birth care, intrapartum care, gynecological care, women's primary care, etc. She also explained there are two levels of accreditation for nurse-midwife education. She noted that, on average, CNMs have 17,000 hours of bedside RN experience from their education. She also showed a chart that showed how much more education and training CNMs have compared to other groups that may refer to themselves as midwives.
- That concluded the applicant group's presentation and Mollard opened the floor to more questions.

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4. **Technical Review Committee questions**
    - Neville asked if the midwives currently practicing have completed the same education that Mollard presented and when those standards were put into place. Mollard responded that every midwife currently practicing has a master's degree at least. She said that in the past, it was just a certification and at one point, those individuals could have been grandfathered in. However, now the standard Mollard described are set forth in Nebraska statute.
    - Neville asked what type of master's degree CNMs have. Mollard responded that every APRN specialty has a master's of science in nursing. This includes CNMs. Some CNMs also have a doctor of nursing practice.
    - Dolphens asked how an RN in Nebraska might become a CNM using a distance learning program. She wondered what it would look like, how long it would take, and where they would complete their clinical hours. Mollard responded that she went to the University of Colorado while living in Nebraska. Most of their didactic content was online with intensives on campus to learn clinical skills, do simulations, etc. Then, the students had precepted clinical hours with people approved by the program of study. The university creates a contract with the clinical site and is ultimately responsible for making sure their students receive the appropriate clinical education. The university also pays for malpractice insurance for the student doing their clinicals and has close contact with the individual precepting the student. Mollard was able to do the majority of her clinical hours at Nebraska Medicine but was also able to

travel to Colorado to do intensives and several weeks at a time with the practice group at the university. The standard is ultimately ensured by the university and is part of their accreditation standard.

- Dolphens followed up by asking how long that process typically would take for someone working as an RN who was going to continue working as a nurse throughout school. She also asked if majority of people stop work and do school full-time. Mollard noted that it's been a trend for more students to work through school now than before the pandemic. She told Dolphens that the absolute bare minimum to complete the masters is two years with clinical, but that is challenging, and someone doing that would not be able to work at the same time. She guessed that a person working part-time could complete the didactic coursework in three years and said that was probably about average. She said that CNMs often do their clinicals differently than PAs. She noted that there is a popular program that does all the clinicals after the didactic, but there are also programs where students take their didactic coursework about one subject and then do related clinicals before moving on to the next subject.
- Sikes asked if there were people who do not have the same level of education that Mollard presented that could go out and practice as CNMs. Mollard said no, the bare minimum is six years of post-secondary education (includes bachelor's degree). Sikes asked for clarification that all 117 nurse-midwives in Nebraska have that level of education. They do, Mollard responded. She noted that it is good to be able to educate the public on the high level of education and rigorous coursework that nurse-midwives complete in order to work in their profession.
- Sikes asked if the TRC had any more questions. They did not. He asked for comments from interested parties.

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5. Comments from interested parties

- Amy Reynoldson from Nebraska Medical Association revisited Dolphen's question regarding the proposed changes to statute. She asked Mollard if the final statute changes only struck the location prohibition and the requirement for a physician's agreement, and did not add the applicant group's proposed language, how the trajectory of the 407 would change and would all of her goals to maintain patient safety be accomplished. Mollard responded that all of the additions describe good clinical practice. These additions don't technically need to be in statute, but their addition does not cause harm, it provides a basis for protecting the public if there ever arises a need. Putting good clinical practice into statute will help maintain safety for the public in the future. Mollard said this will be good for the people of Nebraska, but also good for the profession as well.
- Reynoldson stated that the NMA is in agreement with Mollard's comments and would likely change their position and no longer support the application if the TRC only recommended the removals of statutory language without the proposed additions. She noted how much thought and deliberation was put in to drafting the statutory language to set certified nurse-midwives up for success. She said that the NMA feels the application brought forth does an excellent job of both setting nurse-midwives up for success and protecting patients from potential harm.
- Reynoldson also made a comment about the extensive training CNMs go through. She wanted the TRC to understand that people that practice in health systems have a credentialing body that gives them privileges. Those privileges come by way of those credentialing bodies ensuring that the standard of care is safe, appropriate, and followed. Education and licensing are a huge piece of that. She said that many experts have weighed in and agreed that the proposal would not impede the credentialing of CNMs. They have looked for, and not found, any new barriers to credentialing that would come from the new language proposed to be added to statute. Mollard added that the applicant group has been in collaboration with these other health organizations and wishes to maintain those relationships long after statutory changes have passed in order to provide patients with the best quality of care possible.
- Dolphens stated that she appreciated Reynoldson's clarification and the process the applicant group and their collaborators have gone through to ensure patient safety. She mentioned that the area that concerned her was the amount of additions into the scope of practice, specifically in the episodic care and transitions to practice where she feels the language describes primary care. She believed nurse-midwife training to be too specialized for primary care provision. She took issue not with the entire

addition to statute, but rather specific line items. Mollard clarified that certified nurse-midwives are classified, at a federal level, by the Centers for Medicare and Medicaid Services (CMS) as primary care providers. The original draft of line that Dolphens took issue with read "to provide primary care" in line with the classification of nurse-midwives. After collaborating with other groups, the applicant group revised the statute. It does not include providing broad-scope primary care and rather describes the care nurse-midwives are currently providing. Changing the drafted statute to limit nurse-midwives any more would narrow the scope of care they are allowed to practice. Mollard also reiterated that nothing in the proposal allows nurse midwives to do anything they are not already doing. The only difference is the location and supervision changes.

- Reynoldson reminded the TRC that they are allowed to propose changes to the legislation proposal and encouraged them to do so since they have far more knowledge on the subject than state senators do.
- Reynoldson also said that the statutory language has been worked on for about 15 months to reach its current state. She mentioned the different types of providers that were consulted and their qualifications. She said the proposed language reflects nurse-midwives' true current practice authority in their current role. Logistically, on paper, things would change, but from a practical standpoint, the patients won't see a difference at all. The only difference will be the home birth piece. The NMA strongly feels the proposal belongs as a whole package.
- Waldron asked for clarification about why the NMA would not support the lone statute removals. Reynoldson had mentioned part of the reason would be liability concerns, which caused some confusion. Reynoldson responded to Waldron, saying that if the definitions of low-risk pregnancy and postpartum care were not added to statute, those definitions would not exist in the statute governing CNMs. Without these and other definitions in statute, patient safety couldn't be ensured as well. NMA feels it should be clear what nurse-midwives can and cannot do. Having the scope language so specific helps physicians to feel comfortable signing collaborative agreements if one was to resurface in the process.
- Dolphens asked if she understood Reynoldson correctly. She said she was hearing that NMA is comfortable removing the physician supervision agreement as long as the CNMs' scope is spelled out in statute. Reynoldson confirmed that was correct.
- Dolphens mentioned that the scope language is clear to a health provider, but not necessarily to lay people in her opinion. She asked about the process for providing suggestions. Sandberg (DHHS, legal) told Dolphens she was allowed to speak directly to Mollard about her suggestions if she wanted to.
- Sikes asked if there were any other questions or comments. He complimented Mollard's presentation and asked the TRC if there were any additional information requests for her.
- Sikes asked for public comments. There were none.

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6. Adjournment and next steps

- Neville asked what the next meeting will look like. Davis said that as long as the TRC is comfortable with it, the next meeting will be the public hearing. Anyone is allowed to come share their thoughts, in favor of the application, against it, and neutral opinions.
- Sikes asked the TRC if they were ready for the public hearing. They were ready, meaning they had no more questions for the applicant group.
- Dolphens asked if the TRC votes on the application as a whole or on individual criteria. Davis responded that the TRC votes on all the individual criteria and then votes on the application as a whole.
- Sikes asked if TRC members could reach out to ask Mollard questions if they wanted. Sandberg told them that it was fine to do so, but at the next meeting, they should share any information with the group.
- Sikes adjourned the meeting.
- Next meeting: Tuesday, November 10th, 9:00am – 11:00am in the Goldenrod room.

Note: *If you would like any attachments mentioned in these minutes, or have other questions, please contact Emma.Soukup@nebraska.gov.*

Updated: November 3, 2026