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DEPT. OF HEALTH AND HUMAN SERVICES

Certified Nurse Midwives
Credentialing Review Meeting #3
Public Meeting
Minutes

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

Tuesday, November 10th, 2026, 9:00am

MEMBERS: Mark Malesker, PharmMD, FCCP, FCCM, FASHP, BCPH; 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, Marley Sandberg

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1. **Call to Order and Roll Call**
   The third meeting of the certified nurse midwives credentialing review process was called to order at 9:00 AM on Tuesday, November 10th. The following members were present: Mark Malesker, PharmMD, FCCP, FCCM, FASHP, BCPH; Tami Dolphens, PA-C; Kevin Low, DDS; Judy Neville, CPhT, CSPT; Brandon Holt, BSRT [R] (CT) (ARRT); Stacy Waldron, PhD; Jacob Sikes. Quorum met.
   Staff and others in attendance: Emma Davis, Emma Soukup, Marley Sandberg
   A copy of the Open Meetings Act was available in the meeting room.

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2. **Approval of agenda and last meeting's minutes**
   Sikes asked for a motion to approve the agenda. Malesker made the motion; Dolphens seconded the motion. All members present voted in favor. Agenda approved. Sikes asked for a motion to approve the minutes from the previous meeting. Waldron made the motion; Malesker seconded the motion. All members present voted in favor. Minutes approved.

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3. **Clarification of CNM amendments – Tami Dolphens**
   Dolphens spoke with Mollard, the spokesperson for the applicant group, about her concerns regarding the proposed statutory language after the previous meeting. She presented her concerns, notes from their discussion, and her proposed changes to the statutory language to the TRC at the public hearing. Her powerpoint presentation can be found below:

Conversation Summary

11/4/2026

CLARIFICATION OF CNM AMENDMENTS

PRIMARY COMPONENTS OF THE PRACTICE MODERNIZATION APPLICATION

1. Full Practice Authority
    - Removal of the physician collaboration requirement
2. Removal of the language that restricts CNMs from attending home births

REQUEST FOR CLARIFICATION

1. Amendments to the overall scope of practice for CNM
    - New Section titled “Gynecologic & Episodic Care”; numbers 4,5,6
2. Transition-to-Practice agreement
    - Clarification on Transition-to-Practice termination, and
    - The ability of a CNM with <2000hrs to continue to provide care for up to 90 days without securing supervision

CONCERNS FOR SCOPE OF PRACTICE LANGUAGE

- Current Role & Personal Experience:
  - This Technical Review Committee
  - A Fellow Healthcare Provider –Physician Assistant x 20+ years
  - PA Educator x 10 years
  - Former member (x 10yrs)and chairperson of PA Licensing Committee - Sub-Committee of NE Board of Medicine & Surgery
    - Handling licensing issues, Public Complaints, & Disciplinary Action

AMENDED SECTION 38-606

Provides Definition of “Gynecologic & Episodic Care”

SUMMARY OF AMENDMENT

- The Amended Section 38-606 provides a definition of “Gynecologic & Episodic Care”. Specifically addressing, but not limited to:
  4) Assessment and treatment of minor, self-limiting conditions, such as urinary tract infections, mild upper respiratory infections, and simple skin infections;
  5) Provision of pharmacologic treatment in accordance with established clinical guidelines; and
  6) Screening, counseling, and referral for conditions that require ongoing primary or specialty care.
- **This language may be interpreted in such a way that allows CNM to treat patients outside of scope of prenatal, intrapartum, and post-partum care.**

JUSTIFICATION FOR CONCERN

- Eliminating the “list of approved conditions” allows the CNM to use their primary care skills to treat conditions specific to patients under their care.
- CNMs may work in a clinical setting specific to breast health, urogynecology, or gynecologic oncology.
  - It is difficult to create a complete list of conditions a CNM may encounter due to clinical setting .
- It is not uncommon for primary care providers to feel pressured by friends/family and in underserved areas to provide episodic care outside of their scope
  - Identifying a specific setting and timeline, can protect CNMs from abuse/inappropriate use
  - A clear statute offers a method to protect the licensed provider from practicing outside of their scope and potential malpractice and other liability

REFERRAL PROVISION

Addition to Section 38-611

§38-611. Certified nurse midwife; authorized activities
(as amended in application)

A certified nurse midwife may~~, under the provisions of a practice agreement, (1) attend cases of normal childbirth, (2)~~ provide prenatal care, intrapartum care, ~~and~~ postpartum care, immediate newborn care, and gynecologic and episodic care consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board.~~ (3) provide normal obstetrical and gynecological services for women, and (4) provide care for the newborn immediately following birth. The conditions under which a certified nurse midwife is required to refer cases to a collaborating licensed practitioner shall be specified in the practice agreement.~~

JUSTIFICATION FOR CONCERN

- Removes several items from the “authorized activities”
  - CNM group worked to create an extensive list of practice scope, by further defining:
    - Gynecologic and Episodic Care (discussed previously)
    - Prenatal care, Intrapartum care, post-partum care, and immediate newborn care
    - Prescribing Authority
    - Planned Out-of-Hospital Birth
- As written, this amendment removes **the “identified conditions required for referral”,** which would have previously been identified in a collaborative agreement

IS REFERRAL ALREADY ADDRESSED?

- Currently addressed as part of Gynecologic & Episodic Care
  - Screening, Counseling, and Referral

- It is my opinion that a clearly identified Referral Provision should be included as part of the Authorized Activities (or Scope of Practice (38-611))
  - Demonstrates Professional Acknowledgement that this licensed group understands and recognizes their limitations,
  - Would also elevate a referral made a CNM to a hospital facility or other specialty to be treated in the same manner as other specialties and/or licensed providers.

TRANSITION-TO-PRACTICE AGREEMENT

New Section

NEW SECTION: TRANSITION-TO-PRACTICE AUTHORITY

(1)(a) A certified nurse midwife who has completed fewer than two thousand hours of active clinical practice shall enter into a transition-to-practice agreement with a qualified supervising provider. A transition-to-practice agreement shall provide for the delivery of health care through a collaborative practice and shall meet the requirements of this section.

(b) After completing two thousand hours under a transition-to-practice agreement, a certified nurse midwife may apply to the board for authorization to practice independently. Upon authorization, the certified nurse midwife shall be granted full independent practice authority and shall no longer be required to participate in a transition-to-practice agreement.

(2) Upon entering or terminating a transition-to-practice agreement, a certified nurse midwife shall report such information to the department on a form prescribed by the department.

(3) To be eligible to enter into a transition-to-practice agreement as a qualified supervising provider, a person shall be:

(a) A physician licensed in Nebraska with at least four years and eight thousand hours of obstetric or midwifery-related clinical experience; or

(b) A certified nurse midwife who has completed at least six years and twelve thousand hours of clinical practice.

(4) If a transition-to-practice agreement is terminated, the certified nurse midwife shall have ninety days to establish a new agreement and may continue practicing during such ninety-day period.

JUSTIFICATION FOR CONCERN

- The New Section labeled Transition to Practice Authority spells out very clear regulations and rules regarding the supervision required for a certified nurse midwife with fewer than 2,000 practice hours.
    - This list closely mimics that of APRN-NPs both statutorily and among many hospital credentialing boards.
- I have an issue with item #4 allowing a CNM (with <2000 hrs) to continue to provide care for 90 days after a practice agreement has been terminated.
    - In my personal opinion, 90 days of practice without supervision for a new CNM raises safety issue – for patient & Baby
    - Additionally raises liability issues for the CNM
- Conversations with Applicant revealed historical perspective of requesting ongoing ability to provide care:
    - Abrupt Termination in agreement has taken place in emergency situations, (i.e. death or illness)
    - Change in hospital affiliation of noted supervisor or simply change in policy at the extension facility
    - Lastly, due to perceived “turf wars”

CURRENT LANGUAGE IN NEW SECTION

- Item #2 in this section currently addresses this process:
  - (2) Upon entering or terminating a transition-to-practice agreement, a certified nurse midwife shall report such information to the department on a form prescribed by the department.

- Discussed options for assuring continuity of care, as abrupt termination my be harmful to patients
  - An Example I am familiar is that Physician Assistants have a method for requesting waiver to supervision provisions, if a temporary need is identified and presented to the board.

DISCUSSION

4. **Brief presentation by applicant group**

Mollard thanked Dolphens for her presentation and stated that while Dolphens' language changes were agreeable to the midwives, the applicant group would not be amending their application at this time because they were not in a position to do so.

Mollard then presented a brief overview of the application. She stated that the nurse-midwives were asking for full practice authority and the ability to attend low-risk planned home births. She gave an overview of the process by which the applicant group arrived at the proposed statutory language. It began in January 2025 with the proposed LB676, involved cooperation with a coalition of healthcare organization, and resulted in the current application language. The application as it is written has 25 healthcare organizations that are on record as supporters. Mollard noted that of testifiers, 97.9% of the public were in favor of the changes. She presented a map showing that 36 states and DC grant CNMs full practice authority and only two states, Georgia and Nebraska, have statute requiring physician supervision of CNMs. Next, she showed a map that indicated that Nebraska is the only state that does not allow CNMs to attend planned home births. Mollard noted that this is the fourth 407 process the CNMs have been through on these issues, in 1994, 2006, 2020, and 2026. The TRC has always recommended independent practice.

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5. **Public comments**

Sikes asked for public comments and announced that testimonies would be limited to five minutes.

There were eight members of the public who testified in favor of the application.

There were no members of the public who testified against the application.

There were no members of the public who made neutral statements.

Public comments can be found below:

Heather S. Swanson, DNP, CNM, FNP, PMHNP, IBCLC, CNE, FACNM

November 10, 2026

Jacob Sikes, Chair
Certified Nurse-Midwives Technical Review Committee
Nebraska Department of Health and Human Services
Division of Public Health, Credentialing Review Program
PO Box 95026
Lincoln, NE 68509

Dear Chairperson Sikes and Members of the Technical Review Committee:

REGARDING: Support for Full Practice Authority for Certified Nurse-Midwives, Certified Nurse-Midwife Credentialing Review (407) Proposal

Thank you for your time and for the careful review you have given this proposal.

My name is Heather Swanson. I have been a Certified Nurse-Midwife (CNM) for 24 years and a nursing educator for over 18 years, and I previously served on the national Board of Directors of the American College of Nurse-Midwives. I currently work for a college of nursing in Nebraska and own a private practice, but this testimony is on my own behalf in support of full practice authority for Certified Nurse-Midwives.

I grew up in central Nebraska. I became a midwife because I listened to women there who wanted a home birth and couldn't find a midwife. I have practiced in other states, but Nebraska is my home, and it is where I intend to stay.

I was the applicant for the 2005-2006 credentialing review.[1] It was a lot of work, and I fully expected our statutes to change. When they didn't, I left Nebraska twice more to practice as a CNM: in Texas, directing a birth center and home birth practice that cared for low-risk women,[2] and in South Dakota, as a federal Indian Health Service employee, where CNMs are recognized as independent practitioners, caring for mostly high-risk patients, with births in the ER and the nearest providers offering delivery care and an operating room at least 45 minutes away in good weather. I would rather have been working closer to home.

This April, because of a court settlement, I attended Hope Lindstrom's birth, the first legal CNM-attended home birth in Nebraska. We had a transfer plan, and we met with local EMS captains to talk through scenarios. In 2008, my home birth kit held only the basics. This April, I used only the basics, but I took a long list of emergency supplies, just in case.

I often get called by women looking for a CNM to attend them at home. Just this past week, a former nursing student of mine, now friend, Emily Tvrdy, wanted a CNM-attended home birth. Her real choices were staying home with a lower standard of care than I could have provided, or going to the hospital. She sued The State like Hope Lindstrom did, but The State didn't settle with her. She went to the hospital, and her baby arrived before the physician did. Emily deserved the option of a CNM at home.

Nebraska families are already choosing home birth; this committee has heard there were more than 700 planned home births here in ten years.[3] Meanwhile, while I'm doing things like teaching Advanced Obstetric Life Support (ALSO) or Neonatal Resuscitation Program (NRP) courses for providers, I meet CNMs from neighboring states, with less experience than I have, who practice autonomously and run home birth practices. Here, I would risk a felony.

I will be candid: this proposal is more detailed than I would prefer. I believe many of these provisions belong in rules and regulations rather than statute. And if Nebraska ever joins the APRN Compact, as North Dakota, South Dakota, and Wyoming have,[4] we will need more uniform statutes, but I sincerely appreciate the other professional organizations that worked with us to reach a compromise. This proposal addresses the key issues of a more than 40-year restraint of trade on CNMs,[5] while there have been few reins on anyone else who called themselves a midwife and attend women at home. It was discouraging to not have our statutes modernized after the very collaborative nursing work on the 2020 APRN 407 Review,[6] and to not have LB 676[7] pass in the last Legislature. I hope the current proposal continues to have support from those we often collaborate with.

I respectfully ask that you recommend aligning Nebraska with the NCSBN APRN Consensus Model[8] and national professional standards for Certified Nurse-Midwives, by supporting this proposal. Thank you for your service and your thoughtful consideration. I would be happy to answer any questions.

Respectfully,

Heather S. Swanson, DNP, CNM, FNP, PMHNP, IBCLC, CNE, FACNM

References

[1] Wills, D. (Chair). (2006, June 30). *Final report of recommendations and findings by the Midwifery Technical Review Committee on the proposal for a change in scope of practice for certified nurse midwives in Nebraska*. Nebraska Department of Health and Human Services. https://dhhs.ne.gov/licensure/Credentialing%20Review%20Docs/TRCReportMidwiferyScopeOfPractice.pdf

[2] Holy Family Services. (2026). *Home*. https://www.holyfamilybirthcenter.com/childbirth

[3] Nebraska Department of Health and Human Services, Credentialing Review Program. (2026, September 16). *Certified Nurse Midwives Technical Review Committee meeting minutes*. https://dhhs.ne.gov/licensure/Credentialing%20Review%20Docs/CRCNM091626minutes.pdf

[4] National Council of State Boards of Nursing. (n.d.). *APRN Compact*. https://www.aprncompact.com/

[5] Federal Trade Commission. (2014). *Policy perspectives: Competition and the regulation of advanced practice nurses*. https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

[6] The credentialing review process: APRNs working collaboratively. (2020, Winter). *Nebraska Nursing News, 37*(4), 16–17. https://dhhs.ne.gov/licensure/Documents/NursingNewsWinter2020.pdf

[7] LB 676, 109th Leg., 1st Sess. (Neb. 2025). https://nebraskalegislature.gov/bills/view_bill.php?DocumentID=59164&docnum=LB676&leg=109

[8] American Nurses Credentialing Center. (2025). *APRN consensus model*. https://www.nursingworld.org/certification/aprn-consensus-model/



265 22 Rd, Wilcox, NE 68982 | c: 308.830.1435 | oneidahealthaprn@gmail.com

Chairman and members of the Technical Review Committee:

My name is Morgan Kristensen, and I am the Vice President of Advocacy and Regulation and In-house Counsel for the Nebraska Medical Association. I am here today on behalf of the NMA to express our support for the pending 407 application regarding Certified Nurse-Midwife Practice Modernization in Nebraska.

This application reflects more than a year of collaboration between the Nebraska Medical Association and the Nebraska Nurse-Midwives. The NMA has appreciated this opportunity to collaborate with the nurse midwives.

It is important to remember that NMs are already licensed practitioners and have long worked collaboratively with physicians, hospitals, and health systems.

While this application will grant NMs a pathway to independent scope of practice and permit attendance at certain low-risk out-of-hospital births, it will not change the fundamentally collaborative nature of maternity care in Nebraska.

Most Nurse-Midwives will continue to practice in hospitals, physician clinics, and integrated health systems, working closely with OBGYNs, family physicians, pediatricians, and other health care professionals. Even in out-of-hospital settings, under their application, consultation, referral, and transfer relationships will remain essential components of high-quality maternity care.

This application also contains safety guardrails to protect mothers and babies.

- **First, the application contains a transition-to-practice agreement.**

- **Second, it establishes specific informed-consent requirements and a detailed written plan addressing emergent and nonemergent transfer of care.**
- **Third, application makes clear that NMs may attend out-of-hospital births only when the pregnancy is determined to be low-risk — and the application specifically defines what that means**.

These guardrails represent a responsible approach to NM independent practice and home delivery in Nebraska.

We recognize that some Nebraska families want and will choose out-of-hospital birth. When they do, NMs are the best-trained midwives to attend those births and the measures in the proposed application will mitigate the inherent risks of out-of-hospital birth to the greatest extent possible.

For these reasons, we believe 1) the NMs scope should be modernized to help care for and protect Nebraska's mothers and babies, 2) that the proposed changes would benefit the public, 3) that the proposed measures will not create a significant new danger to the public, and 4) there is adequate education to prepare NMs for attending low-risk at home births and that the proposal creates a pathway for experienced NMs to gain independent practice.

In conclusion, the Nebraska Medical Association urges this Committee to support this 407 application. Thank you. (and I would be happy to answer any questions)

PACIFIC LEGAL FOUNDATION

November 10, 2026

Chair Sikes and members of the Technical Review Committee,

Thank you for the opportunity to speak before you this morning. My name is David Iglesias, and I'm a State Policy Manager for the Pacific Legal Foundation (PLF). PLF is a nonprofit public interest law firm that defends Americans' liberties when threatened by government overreach and abuse. In over 50 years, we have won 18 cases at the U.S. Supreme Court and helped enact more than 90 laws nationwide.

Since 2024, we have fought for Nebraskans like Heather Swanson, who, despite her training and years of experience as a nurse-midwife, is barred by state law from attending home births. Not only does this ban interfere with her right to earn a living free from unreasonable government restrictions, but it also interferes with the rights of mothers like Emily Tvrdy, Amanda Musilek, and Kate Ternus who wish to exercise their right to give birth at home with the provider of their choosing. Another one of our clients, Hope Lindstrom, had to file a lawsuit before the state agreed to a religious accommodation for her CNM-assisted home birth. The law itself, however, has not changed.

Heather Swanson and over 100 other licensed CNMs in Nebraska[1] are being unfairly targeted by state laws that not only ban them from assisting with at-home births, but also arbitrarily force them to operate under the supervision of a licensed physician. Meanwhile, the state offers other Advanced Practice Registered Nurses (APRNs), such as nurse practitioners, a path to independent practice.

Unfortunately, this leaves women in Nebraska with limited access to high-quality CNM care across the state, and virtually no professional support if they choose to give birth at home. In fact, while on my flight yesterday, I was informed that Ms. Tvrdy, who had hoped to deliver at home, gave birth at the hospital instead, because at home the law would have left her without a professional attendant. Nebraska is the only state that bars certified nurse-midwives from attending home births. Lifting that ban and giving CNMs a path to full practice authority would significantly expand access to high-quality care for Nebraska families.

PLF supports independent practice authority for all APRNs, including CNMs, to the full extent of their training without having to pay for collaborative practice agreements (CPAs) or operate strictly under the supervision of a physician—over thirty other states already offer this path to CNMs. The research shows that nurse-midwives provide high-quality care, and that removing supervisory requirements has not diminished patient safety but expanded patients' access to professional care:

- A 2026 review of 66 studies found that **CNM care is associated with outcomes that are comparable to or better than physician care** across multiple domains of health care quality.[2]
- According to a 2023 study of U.S. birth and death records from 2008 to 2019, **when states granted CNMs full practice authority, obstetric outcomes, maternal mortality, and neonatal mortality changed little,** while reported **CNM-attended deliveries rose by about one percentage point.[3]**

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[1] https://epubs.thinknurse.com/publication/?i=868419&p=6&view=issueViewer

[2] Clark EV, Schafer R, Walden RL, Blumenfeld J, Neerland CE, Page K, Schorn MN, Chimata S, Bradford HM. A Scoping Review of Certified Nurse-Midwife and Certified Midwife Care in the United States: Assessing Outcomes Across Six Patient Care Domains. Milbank Quarterly (2026), 104: 220-291.

[3] Lauren Hoehn-Velasco et al., "Health Outcomes and Provider Choice under Full Practice Authority for Certified Nurse-Midwives," *Journal of Health Economics* 92 (2023): 102817.

PACIFIC LEGAL FOUNDATION

- **C-section rates were 7.5 percent lower** for women in states **where CNMs have independent practice authority,** a 2017 study found, **suggesting potential nationwide savings of more than $101 million a year.**[4]
- **Forty to fifty percent of APRNs** surveyed in 2019 **reported irregular communication with their supervising provider** and **no formal review of their medical records.**[5]
- A 2024 study found that **full practice authority for nurse practitioners did not increase NP malpractice claims** and was associated with **a 21-24% reduction in physician malpractice rates.**[6]
- Finally, the findings from a 2020 study linked independent practice authority **to lower costs, larger APRN workforces,** and **increased access to care for patients.**[7]

Supervisory requirements and collaborative agreements have not been shown to make patients safer. Instead, they act as barriers, limiting where and how CNMs can practice and making them pay their direct competition for the privilege. For Nebraska mothers planning to deliver at home, the ban on CNM-assisted home births goes further, leaving them to choose between giving birth without a credentialed provider or leaving the state altogether.

PLF encourages this body to approve the proposal to allow CNMs full practice authority as well as the ability to assist with low-risk, at-home births.

Thank you for your consideration. I'm happy to take any questions.

Respectfully,

David Iglesias
State Policy Manager
diglesias@pacificlegal.org
801-615-9375

[4] Sara Markowitz et al., "Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?," *Journal of Health Economics* 55 (2017): 201–18.
[5] Brendan Martin and Maryann Alexander, "The Economic Burden and Practice Restrictions Associated with Collaborative Practice Agreements: A National Survey of Advanced Practice Registered Nurses," *Journal of Nursing Regulation* 9, no. 4 (2019): 22–30.
[6] Sara Markowitz and Andrew J. D. Smith, "Nurse Practitioner Scope of Practice and Patient Harm: Evidence from Medical Malpractice Payouts and Adverse Action Reports," *Journal of Policy Analysis and Management* 43, no. 2 (2024): 420-445.
[7] Brendan Martin and Kyrani Reneau, "How Collaborative Practice Agreements Impede the Administration of Vital Women's Health Services," *Journal of Midwifery and Women's Health* 65, no. 4 (2020): 487–495.

Nebraska Nurses Association

c/o VTL Solutions
217 Oscar Drive, Suite C
Jefferson City, MO 65101
(888) 885.7025
nebraskanurses.org

Testimony in Support of the Certified Nurse-Midwife Scope of Practice Proposal
Nebraska 407 Credentialing Review
November 10, 2026

Members of the Technical Review Committee,

My name is Blake K. Smith, MSN, RN, FADLN, FAAN, and I serve as President of the Nebraska Nurses Association (NNA), representing the interests of approximately 30,000 registered nurses across our state. On behalf of NNA, I appreciate the opportunity to express our continued support for Certified Nurse-Midwives (CNMs) practicing to the full extent of their education, training, and national certification. I also want to recognize Dr. Elizabeth Mollard and the Nebraska Certified Nurse-Midwives team for their leadership and dedication throughout this process.

NNA has consistently supported removing unnecessary regulatory barriers to advanced nursing practices. Our previous legislative testimony and advocacy efforts reflect that longstanding commitment. Today, I want to focus on what this proposal means for Nebraska communities and families who depend on our healthcare workforce.

Consider a family in rural Nebraska preparing to welcome a child. Their concern is not which statute governs a healthcare professional license, or which practice agreement is required. Their concern is whether qualified, safe, and accessible care will be available when they need it. According to the March of Dimes' 2026 data, approximately 54.8% of Nebraska counties are classified as maternity care deserts, meaning they have neither a birthing facility nor an obstetric clinician. At the same time, Nebraska remains among the most restrictive states in the country and the world for Certified Nurse-Midwives. Those two realities deserve our attention.

However, access alone cannot drive this discussion. Patient safety must remain central, and that is why the evidence matters. A 2026 peer-reviewed analysis of 66 studies examining Certified Nurse-Midwives and the care they provide, found outcomes comparable to, or improved over, physician care across multiple measures of healthcare quality, including safety and effectiveness. Additionally, according to the American College of Nurse-Midwives, 31 states in addition to the District of Columbia, allow CNMs to practice without mandated physician supervision or collaborative practice agreements.

We are not asking this committee to make its recommendation based simply on professional loyalty or belief. We are asking the committee to examine the evidence, evaluate the public benefit, and consider whether Nebraska's current regulatory restrictions remain justified. As the broader representative professional nursing association of Nebraska nurses, we recognize that the CNM team is best positioned to present the specialty-specific clinical evidence supporting this proposal. Our role is to reinforce the broader implications for Nebraska's healthcare workforce, patient safety, and the communities we serve.

I also want to emphasize an important distinction: Full practice authority does not mean practicing alone. No individual healthcare professional operates in isolation, nor should they. Physicians, nurses, advanced practice providers, hospitals, emergency medical services, and other healthcare disciplines depend upon one another every day to provide safe, coordinated care. This is especially important in maternal and newborn healthcare, where appropriate consultation, established referral relationships, and timely access to

higher levels of care are essential. Professional autonomy and interprofessional collaboration are not competing principles; they are complementary responsibilities within a safe healthcare system.

NNA also recognizes that our responsibility does not end with this review or any future legislative action. We remain committed to working alongside CNMs, physicians, hospitals, emergency responders, and our other healthcare colleagues to strengthen the relationships, resources, and systems necessary for successful, safe, and collaborative care across Nebraska. Removing unnecessary regulatory barriers is an important step, but ensuring our healthcare workforce has the support needed to succeed is a shared and ongoing responsibility.

NNA appreciates the responsibility entrusted to this committee and the importance of an evidence-based recommendation as this proposal moves through the 407 review process toward potential legislative consideration. On behalf of our organization and the nurses serving communities across our state, we respectfully express our support for the proposed changes and ask that you consider the substantial evidence of safety, professional accountability, and potential public benefit in your recommendation.

Ultimately, this discussion is about more than professional licensure. It is about ensuring that Nebraska families have access to qualified healthcare professionals who can work together, with the appropriate authority, accountability, and resources, to serve the communities that depend on us and safely welcome the next generation of Nebraskans into this world.

Thank you for your time, service, and your thoughtful consideration.

Blake K. Smith, MSN, RN, FADLN, FAAN
President
Nebraska Nurses Association

Testimony of Certified Nurse-Midwife Jen Jacobitz

My name is Jen Jacobitz. And I'm a nurse midwife from central Nebraska. I've been a labor nurse for almost 20 years. There's so much that happens in a 12-hour shift. Women have stories and when you meet them at a vulnerable and painful place like labor, there's sometimes a lot of work to do.

I would connect with patient and do work, then never see them again. One day I realized, as a midwife, I could not only start the prep work during pregnancy but then support in labor and beyond that.

I know not everyone has the experience I do, so I want to tell stories to pull you in several labor rooms so you can experience the difference of midwifery care. Nurses are trained to connect, to see deep needs.

One labor patient I had, she was pushing and almost at delivery and I could tell the patient didn't like the physician's touch. He told me I needed to be more firm with her to get her to push. He got frustrated and left the room. She looked me in the eyes and told me I did nothing wrong. I told her, neither did you, this is your birth space. She needed to feel safe. With one more push, the baby was coming. The doctor didn't make it back because he started another procedure and I caught that baby.

Another patient was Sudanese, she had only been on the country for 2 months. The baby's heart rate did not look good on the monitor. The physician stood by the sink and used a translator and told her she needed to have a C-section or the baby could die. She said no. The physician conceded. I was kneeling on the ground beside, maybe had been starting an IV, but held her hand and asked, "what is it that scares you?" "The spinal needle" she says. I replied, "it is very safe, you don't need to be afraid, I will stay right here with you. I'm not going anywhere. Do you think it would be okay to get your baby safe?" "Yes." She replied.

Another time, a Somalian woman's husband was determined the doctor should come and pull the baby out. She was complete and didn't want to push. When I told him he couldn't be called in to do that, he called the office, who told him the nurse needed to call. So, he told me they were ready for section. The whole surgical team was called in and when the physician came in the room, he said to him, "now you pull out the baby." I can't" he says. I convinced the doctor to meet in the middle and check her to see if he can help with vacuum. He didn't and the baby wasn't low enough. They began arguing. The physician that the baby would die. The dad that the

physician wasn't God and they were leaving now. Meanwhile, I was again on the ground trying to find a fetal heart rate that had dropped to the 70s. I talked to mom about my concerns and she consented to surgery.

Overall to say that midwifery training teaches connection. And that midwives have a lot to contribute in women's healthcare.

I'm considering travel jobs in Florida and Oregon. States who are already blue on Libby's map, adding to their numbers.

I believe changing the scope of midwives will make a difference on how many of us are able to stay instead of go. I'm married to a farmer. I'm not moving anywhere.

NCSBN
Leading Regulatory Excellence

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

November 10, 2026

Members of the Technical Review Committee,

Thank you for the opportunity to comment in support of the Proposed Change in Scope of Practice for certified nurse midwives (CNMs), which seeks to remove unnecessary barriers in the state that prevent CNMs from practicing to the top of their education and training. My name is Blair MacDonald, and I am representing the National Council of State Boards of Nursing (NCSBN), a non-profit organization dedicated to empowering and supporting nursing regulators in their mandate to protect the public. This proposal would align Nebraska with the APRN Consensus Model, the national model for advanced practice registered nurse (APRN) regulation and practice, which NCSBN co-authored in 2008.

CNMs play a vital role in providing high-quality, evidence-based care to women and families across the state. To gain licensure in Nebraska today, CNMs must have an active registered nurse license, complete an approved graduate-level midwifery education program, and hold national certification from the American Midwifery Certification Board (AMCB). These licensure requirements are in alignment with the Consensus Model and ensure public protection.

Despite their extensive training and high licensure standards, Nebraska law currently requires CNMs to hold an antiquated and unnecessary contract with a physician in order to provide care for their patients. While the Nebraska legislature has led on removing barriers for other APRN roles, they have yet to take similar steps for CNMs. This unnecessary restriction creates barriers to care, particularly in rural and underserved communities, where Nebraska already faces its greatest access challenges. Removing these outdated barriers will increase access to safe and high-quality CNM care.

CNMs already practice independently in 35 states, including neighboring Colorado, Iowa, Kansas, South Dakota, and Wyoming. In Nebraska, CNMs already practice independently within the Veterans Health Administration and Indian Health Services. When CNMs are able to practice to the full extent of their education and training, they still collaborate and consult with other providers on a patient's care team, like obstetricians and family medicine physicians. By granting CNMs independent practice, Nebraska will modernize the practice environment for CNMs, which is necessary to attract and retain these skilled providers.

Along with our written comment, we submitted a packet of several academic studies that demonstrate how CNMs deliver safe and patient-centered care, leading to improved maternal and infant health outcomes, and how independent practice for APRNs is shown to promote economic benefits and support patient provider choice. Patients cannot afford policies that increase costs and deter CNMs from practicing in rural Nebraska.

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In summary, voting in support of this proposal is a necessary step to modernize Nebraska's healthcare laws, improve maternal and infant health, and ensure the regulatory model for all APRNs in the state is aligned with the Consensus Model that promotes evidence-based regulation of APRNs. We urge support for this proposal to increase access to safe and quality CNM care for Nebraska patients.

Thank you for your time and consideration.

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Testimony of Samantha Kenning
AWHONN Nebraska Section Leader
Nebraska 407 Review of Certified Nurse-Midwife Scope of Practice

Good morning, Chair and members of the committee. My name is Samantha Kenning. I have served as a Perinatal Quality Nurse for the last ten years, and I am here today as Chair of the Nebraska Section of the Association of Women's Health, Obstetric and Neonatal Nurses, known as AWHONN. On behalf of our members, I am testifying in support of Certified Nurse-Midwives, which would modernize the scope of practice for certified nurse-midwives.

AWHONN is a national professional nursing organization dedicated to improving the health of women and newborns through evidence-based practice, education, advocacy, and nursing excellence.

AWHONN supports the Essential Competencies for Basic Midwifery Practice and the Global Standards for Midwifery Education established by the International Confederation of Midwives. These are endorsed by both the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists as minimum standards for midwifery practice. Certified nurse-midwives meet and exceed these standards.

Importantly, CNMs are nurses first. According to the American Midwifery Certification Board, CNMs have an average of approximately eight years of nursing experience before entering midwifery practice. They build on that foundation with graduate-level education, advanced clinical training, and national certification.

Nebraska has a clear need. According to the most recent March of Dimes report, more than half of our counties are maternity care deserts. In addition, 7.5% of the counties that do have care have only low or moderate access, not full access.

Allowing nurse midwives to fully practice their scope is essential. In addition, expanding midwifery care is a cost-effective way to improve access, quality, and birth outcomes, particularly in underserved areas. Research summarized by the National Partnership for Women & Families shows that midwifery care provides equal or better outcomes than physician care on many key indicators. These include higher rates of spontaneous vaginal birth, higher rates of breastfeeding, greater patient satisfaction, and lower overall costs.

In my current role, I travel across Nebraska working with hospitals to strengthen their readiness to provide safe labor and delivery care. I see firsthand the challenges our hospitals face, especially in rural communities. Expanding access to certified nurse-midwives can support existing care teams and help communities keep high-quality maternity care close to home.

As perinatal nurses, we recognize and appreciate the value of CNMs' preparation and their role within collaborative, integrated systems of care.

AWHONN supports updating the CNM scope of practice to reflect their education, certification, and demonstrated competencies. We believe this proposal strengthens our hospitals, supports our workforce, and maintains high standards of patient safety.

Thank you for your time and consideration.

AWHONN statement (https://www.jognn.org/article/S0884-2175(16)30003-X/pdf)

Samantha Kenning, MSN, RN, C-EFM, C-ONQS, C-OBE

Perinatal Quality Nurse Specialist

Testimony in Support of the 2026 CNM Credentialing Review from the Nebraska Board of Nursing

Good morning – members of the Credentialing Review Committee:

My name is Gina Crudden, and I am testifying in support of the Credentialing Review application for the Certified Nurse Midwives in Nebraska. I am the APRN-CNS member of the Nebraska Board of Nursing and was selected to bring testimony from our Board in support of this endeavor.

As an Advanced Practice Registered Nurse in Nebraska, I support the move for full-practice authority for the Certified Nurse Midwives, which follows in line with other licensed Nebraska APRNs – the Nurse Practitioners and Certified Registered Nurse Anesthetists, who already have full practice authority. This supports Nebraska's movement to adopt the APRN Consensus Model, which promotes uniformity in the regulation of APRN roles, licensure, accreditation, certification and education for all states in the US and better positions Nebraska to join the APRN Compact to enhance practice mobility across state borders.

I would also like to point out that based on the initiatives proposed in the Rural Health Transformation Program (RHTP) for Nebraska, full practice authority for the APRN-CNM will provide for growth in the rural health workforce and expand much needed maternity care in maternity deserts in rural areas of the state. Clearly, the time is right to enhance the ability to practice the full scope of Certified Nurse Midwifery across the state in conjunction with the resources provided through the RHTP.

In closing, the Nebraska Board of Nursing supports full-practice authority for all APRNs based on advanced education and certification for their specific advanced nursing role. Certified Nurse Midwives exemplify this and are certainly well qualified for full-practice authority in Nebraska. We urge the committee to carefully review the evidence, consider the support and opportunities provided through the RHTP program, and support the change in practice authority for this group of Advanced Practice Nurse providers.

Are there any questions?

Thank you!

Gina Crudden DNP, APRN-CNS, ACCNS-AG, CMSRN, FCNS, CDP

6. **TRC questioning and voting**

Sikes asked if the TRC had any questions or comments.

Dolphens initiated more discussion about her concerns regarding the transition to practice agreement. Holt asked Mollard back up so the TRC could discuss with her. Mollard noted that there is currently no transition to practice agreement in place for CNMs, that the applicant group added one at the behest of some of their collaborators to exercise caution, and that there is no evidence that these agreements necessarily improve outcomes.

Neville asked for clarification about the meaning of the TRC's vote. It was clarified that the 407 process is advisory to the legislature, no actual changes are implemented as a result of the TRC's decision necessarily.

Dolphens asked if her legislative concerns could be addressed in the TRC report.

The TRC asked Mollard why the other CNM bills failed. Mollard explained that there was strong opposition in the past from the broader healthcare community, who they've now worked with in order to write the current proposal.

Sikes asked for more comments or questions.

Sikes asked for more public comments.

Low said it was time to vote.

Dolphens asked for voting instructions. Sandberg suggested the TRC should vote regarding whether or no they should add comments to the report. Neville said she would vote against adding comments to the report because the applicant group had done their due diligence.

Holt made a motion to vote on the application as is without any augmentation or changes that had been suggested. Neville seconded the motion.

- Voting in favor: Malesker, Low, Neville, Holt, Waldron, Sikes.
- Voting against: Dolphens.
- Motion carried, the TRC voted on the application as it is and will not include comments in the TRC report noting they recommend changes or augmentation to the application.

The TRC then voted on the six criteria by which they are to judge the applicant group's proposal:

1. The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.
    a. Voting YES: Malesker, Dolphens, Low, Neville, Holt, Waldron.
    b. Voting NO: None.
    c. Abstained: Sikes (chair).
2. Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.
    a. Voting YES: Malesker, Dolphens, Low, Neville, Holt, Waldron.
    b. Voting NO: None.
    c. Abstained: Sikes (chair).
3. The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.
    a. Voting YES: Malesker, Dolphens, Low, Neville, Holt, Waldron.
    b. Voting NO: None.
    c. Abstained: Sikes (chair).
4. The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

a. Voting YES: Malesker, Dolphens, Low, Neville, Holt, Waldron.
b. Voting NO: None.
c. Abstained: Sikes (chair).

5. There are appropriate post-professional programs and competence assessment measures available to ensure that the practitioner is competent to perform the new skill or service in a safe manner.
    a. Voting YES: Malesker, Low, Neville, Holt, Waldron.
    b. Voting NO: Dolphens.
    c. Abstained: Sikes (chair).
6. There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.
    a. Voting YES: Malesker, Low, Neville, Holt, Waldron.
    b. Voting NO: Dolphens.
    c. Abstained: Sikes (chair).
7. Vote on the proposal as a whole.
    a. Voting YES: Malesker, Low, Neville, Holt, Waldron.
    b. Voting NO: Dolphens.
    c. Abstained: Sikes (chair).

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7. Last call for public comments

Sikes made one last call for public comments. There were none.

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8. Meeting adjourned

The meeting was adjourned. The next meeting, to approve the TRC report, will be held on November 17th at 1pm in the Nebraska State Office Building, lower level, Otoe Room.

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

Updated: November 12, 2026