



Illinois Department of Financial and Professional Regulation
Division of Professional Regulation

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M E M O R A N D U M

TO: The Honorable JB Pritzker, Governor
Deborah Hagan, Secretary of the Department of Financial and Professional Regulation
The Illinois General Assembly

FROM: **The Home Birth Maternity Care Crisis Study Committee**

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SUBJECT: Home Birth Maternity Care Crisis Study Committee Report and Recommendations

On behalf of the Home Birth Maternity Care Crisis Study Committee, chaired by Senator Iris Martinez, this Report and Recommendations regarding home birth and midwives in the State of Illinois is hereby submitted in compliance with Senate Joint Resolution No. 14.

Home Birth Maternity Care Crisis Study Committee Report and Recommendations

Mandated by Senate Joint Resolution No. 14
December 31, 2019

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Home Birth Maternity Care Crisis Study Committee Authorizing Resolution

Senate Joint Resolution No. 14 created a fifteen-person Home Birth Maternity Care Crisis Study Committee made up of various representatives appointed by the Department of Financial and Professional Regulation, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House and the Minority Leader of the House. The members of the Home Birth Maternity Care Crisis Study Committee were charged with recommending to the General Assembly a consumer-focused, evidenced-based solution to the Illinois Home Birth Maternity Care Crisis that protects families from the dangers of having inadequate numbers of licensed home birth providers to care for them during prenatal, intrapartum, and postpartum portions of their pregnancies, especially in the underserved communities of Illinois. Senate Joint Resolution No. 14 reads in full:

SENATE JOINT RESOLUTION NO. 14

WHEREAS, The Constitution of the State of Illinois provides for “the health, safety and welfare of the people” and the “opportunity for the fullest development of the individual”; and

WHEREAS, It has been demonstrated that due to deeply held religious, philosophical, or personal reasons, some families will always choose to give birth to their children at home; and

WHEREAS, There were 61,041 out-of-hospital births in the United States in 2015 with a 52% increase in out-of-hospital births and a 45% increase in home births since 2007; and

WHEREAS, 65% of U.S. home births in 2015 were attended by non-nurse midwives; and

WHEREAS, In Illinois, home births increased by 50% between 2007 and 2014; and

WHEREAS, All well-designed studies show that for low-risk women, planned home birth, attended by a trained maternity care provider, is as safe as hospital birth; and

WHEREAS, Over 50 trained Illinois home birth providers, including the last remaining Illinois home birth physician, have ceased providing home birth services since 1996; and

WHEREAS, There now remain fewer than 10 legally recognized home birth practices (nurse-midwives) in Illinois, and these are located in only six of 102 Illinois counties (Lake, Cook, DuPage, Will, Peoria, and McLean); and

WHEREAS, Due to the scarcity of legal home birth providers, approximately 50% of the babies born at home in Illinois are born either with no skilled assistance at all

(unassisted home birth), or they are born into the hands of underground community midwives; and

WHEREAS, Some of these underground midwives are nationally certified and credentialed, while others are not; and

WHEREAS, Underground community midwives have no legal access to life saving oxygen and anti-hemorrhage medications; and

WHEREAS, Underground community midwives have no means of legally completing newborn congenital heart disease screenings, hearing screenings and metabolic screening tests, and no means of legally filing accurate birth certificate information; and

WHEREAS, An underground system of care may cause parents and midwives to delay seeking hospital care in the event of an emergency; parents are afraid of Child Protective Services involvement; midwives are afraid of arrest; and

WHEREAS, Underground healthcare is never safe; and

WHEREAS, The above-mentioned increase in Illinois home births, the shortage of licensed home birth providers, and the dangers associated with families resorting to underground healthcare, in effect, add up to a “Home Birth Maternity Care Crisis” in Illinois; and

WHEREAS, Illinois is surrounded on three sides by states (Wisconsin, Indiana, Missouri) that set educational standards for their community midwives, license and regulate them, allow them to have access to life-saving oxygen and medications, allow them to perform life-saving newborn screenings, and allow them to openly transport to a hospital in an emergency; and

WHEREAS, 33 of the 50 United States also protect their citizens in this way through licensure and regulation of community midwives; and

WHEREAS, Licensure in these states is based upon the requirement that the community midwife earn a Certified Professional Midwife (CPM) credential - the only healthcare credential requiring documented out-of-hospital training and experience; and

WHEREAS, States that license Certified Professional Midwives tend to have lower perinatal mortality rates; and

WHEREAS, More and more states are taking advantage of the cost-savings associated with home birth midwifery care to reduce state Medicaid expenditures; and

WHEREAS, The State of Illinois used to license community midwives under the Medical Practice Act from 1877 to 1963 and ceased renewing licenses in 1972; and

WHEREAS, Home birth mothers and families have been seeking a legislative solution to the Home Birth Maternity Care Crisis for nearly 40 years (since 1979); and

WHEREAS, All Illinois mothers and their newborns deserve access to safe maternity care regardless of place of birth; therefore, be it

RESOLVED, BY THE SENATE OF THE ONE HUNDRED FIRST GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, THE HOUSE OF REPRESENTATIVES CONCURRING HEREIN, that we find it unacceptable that home birth mothers and babies in Illinois are without adequate maternity care providers; and be it further

RESOLVED, That it is in the State's best interest to assure its citizens access to all safe maternity care options; and be it further

RESOLVED, That Illinois families, in order to best meet personal needs and desires, are entitled freedom to choose among all safe, nationally-recognized maternity care options, including home birth; and be it further

RESOLVED, That the Home Birth Maternity Care Crisis Study Committee is hereby created; and be it further

RESOLVED, That the Home Birth Maternity Care Crisis Study Committee be bipartisan; and be it further

RESOLVED, That the Home Birth Maternity Care Crisis Study Committee include members as follows:

- (1) One appointed by the Secretary of the Department of Financial and Professional Regulation;
- (2) One appointed by the President of the Senate;
- (3) One appointed by the Minority Leader of the Senate;
- (4) One appointed by the Speaker of the House of Representatives;
- (5) One appointed by the Minority Leader of the House of Representatives;
- (6) A representative of a statewide association representing professional midwives, appointed by the President of the Senate;
- (7) A representative of a national association representing professional midwives, appointed by the President of the Senate;
- (8) A representative of a statewide association representing advanced practice nursing, appointed by the President of the Senate;
- (9) A representative of a statewide association representing nurse-midwives, appointed by the Minority Leader of the Senate;
- (10) A representative of a statewide association representing hospitals, appointed by the Minority Leader of the Senate;
- (11) A representative of a statewide association representing lawyers, appointed by the Speaker of the House of Representatives;
- (12) A representative of a statewide association representing pediatrics, appointed by the Speaker of the House of Representatives;

(13) A representative of a statewide association representing obstetricians and gynecologists, appointed by the Minority Leader of the House of Representatives;

(14) A representative of a statewide association representing doctors, appointed by the Minority Leader of the House of Representatives; and

(15) A representative of a statewide association representing a consumer organization, appointed by the Minority Leader of the House of Representatives; and be it further

RESOLVED That the Home Birth Maternity Care Crisis Study Committee shall meet monthly until such time that it is prepared to make a recommendation to the General Assembly, but that time shall be no later than January 1, 2020; and be it further

RESOLVED, That the Office of the Secretary of the Department of Financial and Professional Regulation shall provide the Task Force with administrative and other support; and be it further

RESOLVED, That the Home Birth Maternity Care Crisis Study Committee will hear testimony from all interested parties; and be it further

RESOLVED, That the Home Birth Maternity Care Crisis Study Committee will thoroughly consider the role that Certified Professional Midwives may have in helping to resolve the Home Birth Maternity Care Crisis; and be it further

RESOLVED, That the Home Birth Maternity Care Crisis Study Committee will recommend to the General Assembly a consumer-focused, evidence-based solution to the Illinois Home Birth Maternity Care Crisis that protects families from the dangers of having inadequate numbers of licensed home birth providers to care for them during the prenatal, intrapartum, and postpartum portions of their pregnancies, especially in the underserved communities of Illinois.

Committee's Guest Speakers¹

Patricia Sherman Pfeiffer

Ms. Pfeiffer stated that initially she was an activist and a mother, and then became a doula, but she felt that she was not making progress to allow the licensure of midwives, so she enrolled in law school. She noted that the issue was very important to her because she believes that it is vital to all individuals involved in the birth process, including practitioners, the families and the infants. Since the 1970s, people have informed the Illinois Legislature that home births have been, and are, occurring in the State of Illinois. She compiled a chart from vital statistics information that she obtained from CDC Vital Statistics, but that it was not contained in an official report, in that her organization has a contact within the Illinois Department of Vital Statistics, who supplied the data for her organization. The chart below shows the numbers of home births in Illinois compared to the numbers of total births in Illinois from 2007 to 2017.

¹ This Report contains summaries of the witnesses' testimony and are not verbatim transcripts of their statements.

Year	Home Births²	All Illinois Births
2007	703	180,530
2008	763	176,634
2009	715	171,077
2010	738	164,998
2011	728	161,234
2012	751	159,152
2013	835	156,918
2014	880	158,522
2015	803	158,101
2016	824	154,467
2017	762	149,390

Ms. Pfeiffer cautioned that the numbers of actual planned home births in Illinois were larger than those represented on the chart. One reason for this is that a number of planned home births were with unlicensed midwives, and if complications arose during delivery the mother would have been transported to a hospital emergency room (“ER”), so the birth would have been considered a hospital birth rather than a home birth. She also noted that in 2015, two birth centers opened in Illinois, in Chicago and Springfield, and while those were out-of-hospital births, they would have been counted as hospital births. In addition, it was noted that the birth certificate form only provides two options for the location of the birth, which are hospital or home, so birth center births were considered a hospital birth. Ms. Pfeiffer also stated that mothers will often choose to give birth at home and then after the births go to the hospital ER to make sure that the baby is healthy. She noted that a mother who chooses to give birth without a provider is a legal option, although hiring someone who is trained, is not a legal option. So, the mothers often lie, by saying that they had their baby at home alone and asks the hospital to make sure that everything was alright, when they had an assisted planned home birth. She explained that they do this to protect their unlicensed midwives, and it results in an undercount for the home births.

Ms. Pfeiffer explained despite the undercounting of home births, the chart shows that overall birthrates in Illinois have been declining since 2007, while the number of home births increased or remained relatively constant. She asserted that the available information shows that planned home births are happening in Illinois and that they are going to continue to happen even though CPMs are not licensed by the State.

² The numbers of home births during the years 2007 to 2009, were considered Out of Hospital Births. Starting in 2010, the birth certificate form for Illinois was revised to add a category of “Home Birth” for data collection purposes.

Home Birth Maternity Care Crisis Study Committee Report

She also presented information regarding the various individuals who assisted families who have home births as shown on the chart below.

Year	Attendant at Birth	Number of Births	Percent of Total
2013	No Licensed Provider	301	36.0%
	CNM	417	49.9%
	MD, DO ³	117	14.0%
	Total Home Births	835	
2014	No Licensed Provider	321	36.5%
	CNM	448	50.9%
	MD, DO	111	12.6%
	Total Home Births	880	
2015	No Licensed Provider	312	38.9%
	CNM	355	44.2%
	MD, DO	136	16.9%
	Total Home Births	803	
2016	No Licensed Provider	317	38.5%
	CNM	398	48.3%
	MD, DO	109	13.2%
	Total Home Birth	824	
2017	No Licensed Provider	304	39.9%
	CNM	349	45.8%
	MD, DO	109	14.3%
	Total Home Birth	762	

³ “DO” means Doctor of Osteopathic Medicine.

Ms. Pfeiffer stated that while the chart above shows numbers of births that are assisted by MDs or Doctor of Osteopathic Medicine (“DOs”), these are births that occurred at home and then transported to the hospital afterward (as described above), as very few if any physicians are willing to deliver babies at the mother’s home. She explained that there is a crisis in Illinois for families who are seeking home births, in that they are unable to obtain the assistance of medical health care providers. As a labor doula, she has attended over 100 births, in all areas of the State. She said that she has observed both negligence and great care by midwives and physicians in all settings. She said that home births continue to happen in Illinois with all kind of providers, and some home births occur with non-certified providers or no providers. This is going to continue to happen and it is a real problem. Ms. Pfeiffer believed that it was the duty of the State to recognize that the failure to license midwives is “perpetuating a black market which is dangerous.”

She explained that there are a number of reasons why families choose home births. They include: hopes for a more family-friendly setting; increased control over the process; decreased obstetric intervention; and lower costs. She noted that there are also philosophical and religious based reasons for home births, in that the Amish and a number of Evangelical Christians desire home births. In addition, there are a number of highly educated individuals, who prefer to be actively involved in the management of their deliveries and want home births.

Ms. Pfeiffer maintained that there is evidence to support the safety of home births with licensed health care providers. Based on information from an article in the *New England Journal of Medicine* which was published in 2015, planned home births are associated with fewer maternal interventions, such as: labor augmentations; regional analgesia; electronic fetal heart monitoring; episiotomies; operative vaginal delivery, by forceps or vacuum; and cesarean deliveries. A fact sheet regarding home births, also shows that home births have: fewer vaginal perineal and third or fourth-degree lacerations; and less maternal infectious morbidity. She stated that this information shows that home births are a reasonable option.

She said that an important factor for the safety of home births is maintaining an integrated and regulated system with access to safe and timely transport to a nearby hospital. Ms. Pfeiffer explained that there was a review of studies contained in an article from a 2019 edition of the *Lancet* (an Elsevier publication),⁴ which searched five data bases from 1990 onward, and involved a data set that included 500,000 planned home births. This was the largest and most comprehensive data analysis to date. The study concluded that there was no statistical difference between perinatal and neonatal mortality between intended home births and hospital births as long as there was a well-integrated setting with available transport to a hospital for emergencies. Ms. Pfeiffer explained that a “well-integrated setting” was described as a place where home birth practitioners: are recognized by statute within their jurisdiction; have received formal training; can provide or arrange care in a hospital; have access to a well-established emergency transport system; and carry emergency equipment and supplies. “Less well-integrated settings” were those where one or more of these criteria were absent.

Ms. Pfeiffer stated that home births are currently not safe anywhere in Illinois, and noted that the rate of cesarean delivery, 31.1% in Illinois, is one of the reasons that women are choosing home birth. She explained that the World Health Organization recommends an ideal rate of between 10% to 15% of cesarean deliveries. She noted that labor and delivery units are closing across the state, including one in

⁴ The article can be located at [https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370\(19\)30119-1/fulltext](https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(19)30119-1/fulltext).

the region where she lives. Therefore, there is less access to maternal care in the State. Illinois' medical malpractice insurance rates are the highest in the region, if not the country. She questioned whether the State was attracting the best individuals due to the very high costs of medical malpractice insurance. While Illinois has many good physicians, women feel that they are not always receiving the best care, so they are looking for maternal care in other states.

She noted that statistics show that home births in the United States and in Illinois are increasing. She noted that the number of out-of-hospital births in the U.S. increased from 32,596 in 2009 to 58,743 in 2014. Also, noted that in 2014 about 1 in 47 non-Hispanic white women had an out-of-hospital birth. She also stated that while 35 other states have found solutions to the problem of the home birth crisis, Illinois has been lagging in that regard. She explained that none of the States that have licensed Certified Professional Midwives ("CPMs") have decided that they should not be licensed. CPMs have also been included in the States Medicaid programs.

Ms. Pfeiffer argued that Illinois women deserve the same access to home births as other women in the country. Surrounding states have access to medical providers for home births, and in fact, Illinois women are crossing state borders to give birth so that they can have licensed providers in an out-of-hospital setting. She explained that she knows a CPM in southern Illinois who is a great midwife and helped to safely deliver a large number of babies, but she does not practice in Illinois, as she is only licensed in Missouri. Her clients are from Illinois, but she and her clients both have to cross the border to give birth in Missouri. In addition, there are two birth centers just across the border in Wisconsin that are being run by CPMs. So, Illinois CPMs take their businesses in other states and Illinois families, who want consumer protections, also cross the borders to have out-of-hospital births that are regulated.

The only real access that Illinois residents have to out of hospital births is through ten Certified Nurse Midwives ("CNM") practices, which assist out-of-hospital births for all 102 counties in Illinois. Ms. Pfeiffer stated that a recent poll of Illinois Friends of Midwives members found that for every two families who were able to find a home birth midwife, one family was not able to find such a provider. Families who could not find midwives were underrepresented. She noted that there are billboards in surrounding States advertising Illinois' access to abortion services, while Illinois does not provide access to women who want to have home birth services. Illinois women end up traveling to other states to have babies in hotel rooms.

Ms. Pfeiffer stated that people are also having unassisted births when they cannot locate a midwife, which is legal, but unsafe. She believes that failing to license CPMs is perpetuating a "Black Market," and may be attracting midwives who may not be the best providers but who are willing to assist in the delivery at the mother's home. She noted that the biggest difference between the families who chose home births and those who chose hospital births was that they did not have an avenue to complain about the manner of the delivery, if an event occurred. She concluded by stating that there are a body of professionals who are recognized by other States and are pleading to be regulated by Illinois and there are also families in Illinois who want to have CPMs regulated to permit them to have a safe home birth.

Benjamin Rathert, MD

Dr. Rathert testified that he is a family practice doctor from southern Illinois, and currently practices in Du Quoin, Illinois. He explained that he was speaking on behalf of the Illinois Friends of Midwives but noted that no one paid him to provide testimony. He maintains a full range family practice, including pediatrics, sees about 30 patients a day and has about one hospital obstetric delivery every month. He has been practicing for about six years.

He explained that his obstetric practice includes seeing patients in his clinic every two to four weeks for the routine laboratory tests, ultrasounds to ensure that the patients are having a regular and routine pregnancy. He does not manage high-risk pregnancies, which may require a caesarean section, more intensive management, or require maternal medicines. He refers those patients to other doctors in Carbondale or other locations. He explained that this rarely happens because his practice involves low risk extremely routine pregnancies. When his patient is getting close to delivery, he explains what contractions feel like and discusses when would be a good time to go to the hospital. When they hit about seven or eight centimeters the nurse will notify him, and he travels to Carbondale for the delivery. About once a year there is a need to get another obstetrician involved to induce the birth or perform a caesarean section. He tries to intervene only by inductions, augmentations and, as a last resort, medicines to make the labor progress faster. For the most part he believes that a woman's body will do what it naturally does in delivering a baby, and he tries not to get in the way of that natural process.

Dr. Rathert noted that there is excellent data showing that doctors getting involved results in more caesarean sections, so he just wants to make sure that everyone is safe. He believes that his role is just to monitor the baby during the course of the pregnancy and labor, to make sure that everything is going the way it should. For the vast majority of the deliveries with which he has been involved, his involvement was to manage when the baby is crowning and deliver the shoulders. That is the small portion that he covers to ensure that the mother and baby are fine.

He became interested in studies which showed that the "standard of care" for hospital births was not as straightforward as it sounded, in that hospital care could be ineffective. For example, it is extremely routine standard of care to start a woman on IV fluids during the course of her labor, while there is data that shows overhydration slows labor and potentially stops what could have been a successful labor. To that end, he is very cautious about the fluids that he gives to women in labor. Plus, hospital standard of care is to prohibit a woman from eating anything because she may need a caesarean section and could aspirate and die during surgery. However, there is no data to show that keeping a patient from eating is of any value to the labor process. In addition, if a woman is in labor for 24 hours, it is not natural and abnormal for the birth process to prevent her from eating for all of that time, and her body would not respond well to the failure of her to eat. It is also expected that a woman should stay in a bed at the hospital, without walking or moving around, so that the staff can monitor what the baby is doing. The staff thinks that the safest place is in the bed, but that again could slow the labor process.

Dr. Rathert noted that hospital births have five times more caesarean sections than home births but stated that this was not surprising because we are living in a day where lawsuits are very common. He added that no one ever gets sued for having a caesarean section rather than natural birth, even if it was not necessary. He believes that some doctors are being "too careful," which causes them to perform surgeries

that did not need to happen, while he attempts to give a woman every chance to have a normal vaginal delivery. In response to a question, he stated that general interventions, such as having a caesarean section, could create further complications. He provided an example that if a doctor thinks that there is something wrong with the baby's heart rate, a physician could decide to move to a caesarean section. The caesarean section could go well for the baby, but the mother could then have complications from the surgery. He believed that doctors intervening in the natural process can create more problems in the future that would not have arisen otherwise.

He also has an interest in the Amish and similar populations because he grew up in southwestern Illinois, which has a very large Amish population. A number of Amish seek medical care at his clinic. They generally never get health insurance for themselves but pool their money into a large medical fund that is used as needed, so they watch how this money is spent. When a woman is admitted into a hospital to deliver a baby the bill is usually thousands of dollars, where his bill for the delivery is typically from \$600 to \$750. As such there are a number of CPMs who work with this community, as well as other families and communities throughout southern Illinois, in providing safe and much less expensive home deliveries.

Dr. Rathert found from his conversations with CPMs and from national studies that home deliveries are as safe as births in hospitals. So, he has built a relationship with at least three professional midwives in the southern Illinois area, who will consult him not only about the obstetric issues, but neo-natal questions. He is in favor of home births and permits CPMs to call him anytime they have a question or concern. In the three years that he has been working with CPMs he has never had a birth that turned out to be dangerous. On one occasion, he directed the CPM to have the baby taken to an ER, and the baby turned out to be perfectly fine. The hospital did a full review and the baby was back at home within 48 hours because there was nothing wrong. Again, these involve low-risk pregnancies, where the mothers are screened to ensure that they are appropriate for home births.

He believes that a CPM's job is similar to his job. They are monitoring the mother to make sure that their baby's heart rate is good and that certain laboratory tests are completed. Their routine obstetric care is the same as his care. In fact, CPMs are more experienced in other ways to manage labor, such as different motions that a woman can go through to aid the birth, how walking can help with the birth, and how stretching and bending can be more effective to facilitate labor. These are skills that he does not have and are not taught in medical school.

Dr. Rathert stated that midwives' training went deeper than his obstetric training. Yet, because he is Board certified, he can legally practice in the eyes of the State. So, he believed that licensure of CPMs and the creation of an oversight board ensures that bad midwives are not permitted to practice and raises the standard of care for everyone. The home birth patients can be assured that the Board is reviewing the practitioners, that they are certified and that they are using up-to-date practices. Expectant mothers can have their choice in selecting a home birth with a CPM. It also decreases mortality, morbidity and bad outcomes in general. He explained that home births with a CPM need to be legal.

Isis Rose

Ms. Rose provided her personal story about her experience with home birth. She testified that she is an African-American mother, a community-based doula, a PhD candidate in Socio-Cultural Anthropology and a staunch advocate for home birth. She said that she knows that home birth is a healthy and safe

option for most women giving birth. However, due to the continued criminalization of non-nurse midwifery, there continues to be a gap in care for birthing people across the U.S. and in Illinois. She currently resides in Urbana, Illinois, where she lives with her toddler, who was born at home, and her husband who is a teaching assistant.

Her daughter was born in her living room on January 15, 2018. She was an 8-pound, 9-ounce baby. It was an unmedicated water birth, and it was one of the greatest defining moments of her life, but one that unfortunately a lot of people cannot experience because CPMs are not licensed in Illinois.

Ms. Rose also was testifying because, in the words of midwife, Shafia Monroe, she believes that midwifery is actually the first line of defense in combatting racial disparities in maternal health. She explained that in discussing the racial disparities in maternal health, we have to situate the home birth crisis in Illinois within a broader context, and that context is maternal mortality and morbidity. Maternal mortality is the death of a woman during pregnancy or close in time to pregnancy. Maternal morbidity describes a nonfatal birth injury or near misses that occur during pregnancies, birth or post-partum.

A report by the Illinois Department of Health, found that in 2015, 93 Illinois women died from a pregnancy related cause within one year of their pregnancy. Most of these deceased women were identified as black or African-American. According to the Report, these deaths were caused by inadequate provider insight, racial biases that led to misdiagnoses, and no care coordination for these mothers. So structural issues contributed to the deaths of these women.

Ms. Rose personally sought a home birth understanding that black birthing people disproportionately experienced discrimination and racism in clinical settings. She said that she represents an increasing number of black women who are terrified of giving birth in the hospital, in light of increased awareness of racial disparities in maternal mortality. According to Amnesty International, racism and discrimination contribute to the disproportionately high rates of negative pregnancy experiences and negative birth outcomes, which include preeclampsia hemorrhage, pregnancy loss and maternal or infant death. Nationally, black women are three to four times more likely than white women to die from childbirth, but in Illinois, black women are six times more likely to die from pregnancy related causes than white women. This information was taken from the report on mortality and morbidity published by the Illinois Department of Public Health.

She said that she was well-informed about pregnancy before she became pregnant, and many home birth mothers are highly educated. She knew that her level of education, health insurance history, and health history were not enough to ensure a positive outcome in the hospital. She also knew that, as a black woman, these mortality disparities in maternal health persist at the intersection of racism and medicalized child birth. Anthropologist Dána-Ain Davis calls this phenomenon “obstetric racism.” She believes that it is a natural life event that, especially in low risk birth women, does not require active management, technologies, surgery or pharmacological interventions. As a low-risk home birth mother with an above average body mass index, she feared that she would not have the unmedicated vaginal birth that she was seeking in a hospital.

One of the recommendations offered by the 2018 report on maternal mortality and morbidity is that the State should create or expand home visiting programs to target higher risk mothers, such as doula programs, in Illinois during pregnancy and the post-partum period. The Report also states that Illinois

should expand efforts to provide universal home visiting to all mothers within three weeks of giving birth. Studies have shown that doulas improve birth outcomes for mothers representing all levels of risk. However, doulas are not medical providers and have little power to address these structural inequalities that allow these disparities to persist in hospital settings.

Ms. Rose recommended that the maternal mortality and morbidity issue would be improved by enlisting home birth midwives to provide low-cost care to low-risk pregnant women across the State, especially in rural communities, where hospitals are few and far between. Home birth midwives are capable of providing pre-natal care, attending births and providing post-partum medical attention to families in their homes. Also, as a community-based doula, she works with young women and teenage mothers in Vermilion County. All of the mothers that she works with lack reliable transportation. Increased access to homebased midwifery would greatly meet their need for accessible maternity care. Offering clear paths to legal practice and licensure for non-nurse midwives would greatly impact families across Illinois. Yet, direct entry to midwifery, including certified professional midwifery, is illegal. The integration of home birth midwives is important for positive birth outcomes.

Unfortunately, in Illinois non-nurse midwives, like the one that assisted her family, work under fear of imprisonment. At least 16 midwives have been investigated and sanctioned, causing 14 midwives to leave the State. She believes that there are now 17 non-nurse midwives practicing home birth midwifery in Illinois. Two of those midwives are her midwife and the midwife's assistant. So there exists a huge gap in home birth midwifery care in areas of Illinois where no midwives are practicing. Most of the 10 licensed nurse midwife practices in Illinois are operating out of Cook County, and the remaining are servicing the surrounding areas.

Ms. Rose admitted that her choice to give birth at home was illegal. Due to outdated laws related to licensure, her midwife and her assistant committed a felony when they assisted with the birth of her daughter. Anthropologist Robbie Davis-Floyd would describe her home birth and her midwife and her assistant as “renegade midwives,” “rogue midwives,” “underground midwives,” or “black market midwives.” Whatever they are called, most of them have achieved licensure or certification from professional midwifery organizations, and they have demonstrated that they possess the requisite knowledge, skills and experience to practice midwifery safely, yet they must operate outside of the law.

While her midwife was competent and had the necessary skills to ensure a safe delivery, some would say that her birth scenario was not completely safe. For example, in the event of a hospital transfer her midwife would have had to represent that she was only acting as her doula. Were she to share too much information about what she might be experiencing physically, she could blow her cover risking professional liability and prison time. It is true that as the reluctance to disclose critical time-sensitive information about a birthing person's labor progress to emergency care providers could pose a threat to that person's safety and/or the safety of their unborn child. Nonetheless, underground assisted midwife home birth is somewhat of an open secret in her town. Despite the fact that providers know that there are midwives working in this capacity, the local hospitals have yet to establish any home birth transfer policies in the event that a pregnant woman requires emergency transport from home to hospital. Therefore, she argues that Illinois' midwifery laws coupled with our hospitals' lack of protocols for home birth emergency transfers puts people who choose home births at risk.

The home birth crisis in Illinois particularly affects black and brown women. She has made it her personal mission to debunk the myth that home birth is not safe and that black families do not birth at home. In order for more women, who are the population most greatly affected by maternal mortality and morbidity issues, to have safe home births, the law in Illinois has to be changed. It is absolutely critical that the State normalizes home births and home births with midwifery.

Ida Darragh, CPM, LM

Ms. Darragh is the Executive Director of the North American Registry of Midwives (“NARM”), as well as a CPM and has been a licensed midwife in Arkansas since 1983. She noted that many states had licensure even before there was a certification process for midwives, and that she had her licensure prior to the development of CPMs. She has lived through the periods of being illegal, being licensed, being nationally credentialed and now speaking about becoming credentialed.

She provided an overview of the education of CPMs, how it compares to the education of CNMs, the national standards for CPMs, a description of the US Midwifery Education, Regulation and Association (“US MERA”) and the national accreditation process. NARM has been accredited to issue the CPM credential since 2002, and they maintain that on a regular basis. The CPM credential requires didactic education, in that even programs involving apprenticeships are required to include didactic education and clinical education. To graduate as a CPM, a student must be instructed about specific content areas, which can be obtained through accredited schools. In addition, there can be one-on-one educational periods with other practicing registered preceptors who are required to provide extensive period of clinical supervision. There is a minimum requirement of two years training to graduate as a CPM, but the average is three to five years of training, so, students spend a large amount of time of working under the practice of registered preceptors who review all of their activities.

She explained that the last step in the certification process is a requirement to pass the NARM examination. This credential, as well as the examination, are accredited by the National Commission on Certifying Agencies (“NCCA”), which focuses on test development, and the validity and reliability of the examination. In addition, every CPM must be certified on cardiopulmonary resuscitation (“CPR”) and neonatal resuscitation program (“NRP”) and must have had some course in their training about cultural awareness. CPMs are also required to produce and maintain certain documents, which include practice guidelines, informed consent forms and emergency care plans. In addition, there is a requirement for documented recertification every three years, which includes continuing education, peer review and recertification for CPR and NRP.

The NCCA is the primary agency in this country that accredits schools that issue CPM certifications, and it also accredits schools that issue CNM credentials, Certified Midwife (“CM”) credentials and many other related health care credentials. Credentialing requires an extensive 500 page application, which covers: the organization’s governance; how the organization’s policy is determined; the organization’s policies; how the organization determines the requirements for certification; whether the determination was made in the appropriate manner; whether tests reflect the knowledge and skills required for certification; the common reference educational texts given to applicants; the way in which a passing score was determined; eligibility requirements; and board representation. All factors are intensively evaluated before the organization receives the accreditation, as similar for schools providing other health care credentials.

NARM has met these criteria and received this accreditation. Also, this accreditation process is required for schools issuing CPM credentials every five years, however the organization completes a report every year, which is reviewed by a third party to keep accreditation current.

Ms. Darragh stated that her specialty is test development to issue CPM credentials, and she works closely with the States which require a test of CPMs for licensure. She explained that 34 states license CPMs, and one state has granted statutory permission for CPMs to practice but does not license CPMs. The 34 states that license CPMs have enacted various laws to legalize CPMs, as well as requiring varying amounts of regulation. Most states regulate CPMs through health departments, but some states regulate through boards of medicine, boards of midwifery, boards of nursing, boards of alternative health care, boards of education and even a board of commerce. While the method of regulating CPMs is not standard, CPMs are always regulated by the states in some manner. The regulatory body issues the licenses, monitors that CPMs meet the required criteria, renews licenses on a periodic basis and oversees the administrative procedures of having a license.

She explained that accreditation of schools for CPMs and CNMs and graduation requirements are similar. Both CPM and CNM schools are accredited by the Department of Education (“DOE”). Specifically, CPM schools are accredited by Midwifery Education Accreditation Council (“MEAC”), and CNM schools are accredited by Accreditation Commission for Midwifery Education (“ACME”), which are comparable agencies under the DOE. Upon completion of the programs, both CPMs and CNMs receive a national certification accredited by the NCCA. NARM administers the CPM credentialing, and the American Midwifery Certification Board (“AMCB”) administers the CNM and CM credentialing.

Ms. Darragh explained that there is a need for CPMs to assist home deliveries in Illinois. She stated that most CNMs across the country work in hospitals. While Illinois is a state having among the largest number of CNMs in the country, there are not enough CNMs in Illinois who do home births to meet the need of Illinois residents because most CNMs do not assist in home births. CPMs receive specific training necessary to assist women who choose to have out of hospital births, which is not required for any other profession that permits people to deliver babies. All of the training for typical CPM students involves out of hospital births, with a required minimum number of participations with actual planned home births.

To illustrate the differences in schooling for these certifications, Ms. Darragh presented the following chart which compares the minimum number of clinical maternity care requirements that students must successfully complete to obtain certification.

**Preparation for Providing Care
Normal Full-Term Pregnancies
Minimum Clinical Maternity Care Requirements**

	Certified Professional Midwives	Certified Nurse Midwives	Family Practice Physicians
	Absolute Minimums	Suggested Minimums ⁵	Recent Updates Beyond 2016 Unavailable
Prenatal Exams	100	100	200 hours or 2 months ⁶
Initial Exams	23	Not specified	Not specified
Births Attended	55	35 ⁷	200 hours or 2 months
As Primary Attendant	25	Not specified	Not specified
With Continuity of Care	5	Not specified	“Some”
With at least 1 prenatal prior to birth	10	Not specified	None
Out-of-Hospital	10	None	None
Newborn Exams	40	30	40
Postpartum Exams	50	50	200 hours or 2 months

The chart shows the absolute minimum number of participations in prenatal exams, initial exams, births attended, newborn exams and postpartum exams required prior to completion of the training. She noted that CNMs do not always have as many required participations in various aspects of the birthing process. It is very difficult for a CNM student to attend a home birth during their clinical education, while all of the CPM education is out of the hospital, in birth centers or at home births. She would like to see all students work in all settings like they do in Canada, but it is not required in the United States. In addition, the CPM education is shorter because it only involves women in the childbearing years, rather than other times of their lives, such as childhood or menopause. The scope of practice for CPMs is prenatal care, delivery, postpartum care and new born care for a very short period, while CNMs education encompasses all aspects of the woman’s entire life span.

Ms. Darragh also compared other aspects of training for CPMs and CNMs. Schools for CPMs and CNMs use the same textbooks and have similar curricula. Regarding the certification tests for NARM and AMCB, Ms. Darragh noted that she could not compare the examinations because they must reflect the blueprint which is established by the differences of the jobs of CPMs and CNMs. However, the questions for the CPM certification examination are written and reviewed by trained writers, and then they are reviewed by a committee made up of CPM practitioners who develop accurate questions and answers and

⁵ “While an absolute number of clinical experiences is not required for program accreditation, these recommendations guide programs in selecting clinical sites and assuring adequate experience for competence across the full scope of midwifery practice.”

⁶ 200 hours are spread out between all three parts of care. Family Practice Residents “must document 200 hours (or two months) dedicated to participating in deliveries and providing prenatal and post-partum care.”

⁷ “Includes access to or opportunity to attend at least 35 births” An additional category “intrapartum care” requires 60 experiences resulting from a combination of labor assessment, labor management & births.

a scoring standard. The current NARM examination contains 300 questions, which must be completed in a six-hour time period, with a short break in the middle of the time frame. The NARM test for certification of CPMs, which can be taken after becoming qualified, is a computerized test given at university testing centers around the country. The NARM examination has always been much longer than the CNM examination because NARM believed that they had to prove that CPMs are adequately qualified.

Ms. Darragh stated that the United States is the only country that divides its midwives into nurses and non-nurses, all other countries just call them midwives. This makes it difficult for international midwives when they come to the United States, because they have to recomplete their education to become a midwife in this country. Ms. Darragh explained that the international confederation sets the criteria for competencies, education and regulation for associations of midwives, which is called the Midwifery Education, Regulation and Association (“MERA”) standards. The United States established the US MERA because of the differences in the US system so it could create its own standards for CPMs and CNMs. This organization has worked with various states in the US for licensure of CPMs because needed more midwives.

While US MERA has supported licensure of CPMs, one of the groups opposing CPM licensure were the CNMs. This was frustrating because CPMs had the same goals as CNMs. Obstetricians have also opposed the licensure of CPMs for a long time. Then, CPMs worked with CNMs and obstetricians to learn why they opposed licensure, and the organizations worked out language which led to licensure. In large part, CNMs opposed licensure because of the lack of accredited education. This concern was addressed with the requirement of having accredited schools.

In addition, CPMs worked with the American College of Obstetricians and Gynecologists (“ACOG”) and family physicians to discuss how to overcome the lack of understanding about the competencies of CPMs and agree on a standard which would be acceptable to both parties. That language consisted of two standard provisions which were included in legislative language for states that were considering licensure statutes for CPMs. The language required that all CPMs certified after January 1, 2020, go to an accredited school to be licensed. The language also required apprentice trained CPMs, who had been practicing for a long time, to take an accredited educational component, which became known as the Midwifery Bridge Certificate (“MBC”). The MBC is continuing education involving accredited hours regarding maternal emergencies and complications, newborn emergencies and complications, and other professional issues. When this language was included in licensure bills, they have passed in almost every state attempting to establish licensure requirements in the past three years. She acknowledged that the form language stated that an apprentice trained CPM “may” take the MBC to become licensed as a CPM but noted that some states have used that language while others have used the word “must.” She explained that the purpose of MBC is to create a pathway to licensure for very experienced CPMs without requiring them to complete a full education program accredited by MEAC. Currently, the American College of Nurse-Midwives (“ACNM”) and ACOG support licensure for CPMs, because this additional language assures these organizations that CPMs have completed every one of the competencies.

Ms. Darragh stated that the language requiring certain CPMs to obtain an MBC must be included in the licensure bill in Illinois, so the legislation will not be opposed by ACNM and ACOG. Moreover, NARM advocates that the language including the requirement to obtain an MBC be included in a bill licensing CPMs in Illinois. She also noted that ACOG has issued a statement regarding the organization’s support

of the requirement of the MBC for CPMs who lack accredited education and who do not currently meet the criteria of the International Confederation of Midwives (“ICM”). Through this language NARM has addressed the opposition from those groups that did not support licensure over the past decades.

Erin O’Brien

Erin O’Brien is a lobbyist for the Illinois State Medical Society, and her presentation touched on three basic issues: adverse events, education, and briefly, liability. She referred to an article that was published on August 17, 2019, which reported on the death of six infants and one mother and catastrophic or potentially life-threatening injuries to three infants and one mother during planned out-of-hospital births in Florida. She believed that it was important to know what happens when things go wrong during a home birth. This explains the concerns among physicians who have historically wanted to know what happens in the home when emergency situations arise during labor. She said that doctors need to know how to minimize the risks when emergency situations present themselves, and to limit midwives from taking on more risks than they are trained to handle. The article also highlighted that there is very little data describing events which occur during home births. She explained that Florida has a reporting requirement in their midwifery law that actually had to be strengthened because there was a failure of reporting on adverse events.

While acknowledging that adverse events happen everywhere, even in the hospital system, she believed that legislation that addressed the maternal health crisis could lessen the harm from these events. Part of that, which her organization supported, was adequate and full insurance coverage for doula services. However, she desired that there be a greater discussion about what happens when adverse events occur in the home, in that there has to be discussion about how the system can best be integrated so that it focuses on the health of the baby and the mother. She also stated that most physicians do not view transferring a home birth to a hospital due to an event as a negative. She noted that Florida law contains a number transfer and consultation protocols, similar to those contained in previous Illinois bills, but somehow the protocols continue to become lost. Moving forward, the Committee needs to make sure that when risky situations present themselves, those risks are dealt with by the most highly trained individuals available to deal with that risk. Secondly, there has to be a consideration about how data is obtained and the need for real reporting requirements for CPMs. People need to know what is happening with home births and where it is happening. When asked about the lack of information about the causes of deaths or injuries which occur in hospital births, Ms. O’Brien noted that there is difficulty in presenting accurate comparisons due to the lack of data for hospital births.

Ms. O’Brien was also asked about patients being required to make an informed consent for home births and noted that her organization has resisted bills that require doctors to provide a written informed consent because it is a very informative process, as opposed to simply providing a pamphlet. Currently, as she understood the process, when doctors talk to patients about any procedures, whether it is a pregnancy or any other medical procedure, the physician orally reviews the risks and benefits, which is part of the patients informed consent. In previous discussions about legislation, she has talked about CPMs being required to provide that informed consent, and she urged that it definitely has to be part of the process by CPMs moving forward.

Regarding training of CPMs, physicians continue to have many questions about the training that midwives receive. She admitted that she had learned a lot regarding the MEAC program, but her organization still

have some additional questions about the training for CPMs. For the physicians, there has also been a huge concern about the Bridge Certificate, and they did not understand why all applicants would not be required to qualify under the MEAC program. Also, because it is not consistent with other Illinois licensure laws for health care professionals, it is viewed as a loophole to avoid meeting the MEAC requirements. Moving forward, the physicians want a standardized program which will make sure that all individuals within a profession are equally trained to deal with events that are presented. However, she stated that doctors are looking to gain a better understanding of the requirements of a Bridge Certificate education and how it is consistent with the three-year MEAC program

Concerning medical liability, Ms. O'Brien understands that it is a touchy issue, and she appreciates the advocates who have placed vicarious liability language in the bills. That is something that her organization supports. Moving forward, she believed that it would be great if the parties could come to a resolution, although she acknowledged that it would be difficult. She stated that she would be willing to take any proposal back to her physician leaders to determine if a compromise could be reached. She explained that there was a large amount of information that she will be taking back to her organization and a lot of discussion will take place after the hearing about possible solutions to the patient care issues, and that her organization is definitely trying to work through the issues involving the licensure of midwives.

Tina Wheat, MD

Tina Wheat, MD represented the Illinois Academy of Family Physicians as a board member. She is also a family medicine program director at Northwestern University McGraw Family Medicine at Erie-Humboldt Park. As a family physician who delivers babies and teaches resident physicians in obstetrics care, she sees wide-ranging pregnancies and outcomes.

Even in a hospital setting with her credentials and six years of independent experience, she is not alone when delivering babies. Since many obstetrical complications cannot be anticipated until the actual delivery, she is assured back-up by a subspecialist "at-the-ready." A woman can be considered low-risk for her entire pregnancy until delivery when any of these are possible: maternal or fetal hemorrhage; prolapsed umbilical cord; shoulder dystocia, making it difficult to properly deliver the infant and can result in paralysis; and placental abruption resulting in uncontrollable maternal bleeding. When these complications occur, there are only minutes to intervene to prevent death of the mother and/or the baby, or brain damage of the infant. The infant is also at risk for complications, including hypoglycemia, jaundice, and infection, which are things that cannot be seen right away.

Dr. Wheat recounted what had occurred just two weeks before she spoke. She was on call and unfortunately had several unexpected emergencies involving births on her shift. Her first emergency involved a 29-year-old woman who was having her third baby. She had no problems with her previous pregnancies or deliveries, and she also had no problem with this current pregnancy. She would be considered low-risk to anyone who was practicing. She went into labor on her own and the labor progressed normally with no medical intervention by anyone. Everything was going normally until the baby's head came out. After delivery of the baby's head, the rest of the baby's body would not deliver, which is an emergency called shoulder dystocia.

If this complication is not successfully managed, it could lead to death. So, she called out shoulder dystocia, which caused extra nurses to run to the patient's room, along with an additional obstetrician, a

pediatrician and a pediatric nurse. This is the hospital's standard way of managing this emergency and it includes obtaining additional help. Others in the room help position the women so that her pelvis was opened at its widest position so that there was more space for the baby. Also, someone provided a specific type of pressure on the outside of the mother to help turn the baby, while she was performing maneuvers to turn the baby from the inside of the mother for a safe delivery. This emergency took about one minute. There was a successful delivery of the baby, but when he came out, he was not crying and initially he was blue. After clamping and cutting the cord, she was able to give the baby to the pediatric nurse and pediatrician, who began caring for the baby.

As a family physician, one of the reasons that she chose her job is that she was able to care for both mother and baby. However, in this case she was very happy to have someone else skilled to focus on the baby while she focused on the mother. In this case, having additional help was a good thing because immediately after the baby was given to the pediatric nurse, the mother began bleeding briskly. Fortunately, it all ended well for this family, the baby is doing well and so is the mom. However, she wondered what would have happened if she had not had that team immediately available to assist with the birth.

She explained that as a female physician and mother, she values and respects women giving birth and the autonomy involved in that process. Even with advances in modern medicine, childbirth is still traumatic at times, for both the mother and child. It is critical to be prepared for any scenario. Family physicians, pediatricians, and other health professionals believe each infant deserves a safe delivery by trained medical professionals with enough experience to intervene should problems arise. When questioned about transferring mothers from a home birth to the hospital, she stated that she has often transferred patients to another doctor, and she views a transfer as a "correct decision," in that something was identified before the birth could go very wrong.

However, Dr. Wheat stated that according to new research from Israel, babies born outside of a hospital were around three times more likely to die than those born in a hospital. This study matches findings of larger studies conducted in the United States and confirmed that childbirth in nonhospital settings is far more dangerous than in hospitals. The coauthor Eyal Sheiner, MD, PhD, chair of the Obstetrics and Gynecology Department at Soroka University Medical Center stated, "There is no question that a hospital provides the most secure environment to give birth, both for mothers and their babies." Their research was presented in March at the Society for Maternal-Fetal Medicine's 39th Annual Pregnancy Meeting in Nevada.

Dr. Wheat acknowledges that she was not aware of any studies regarding how women would obtain the information that they need to make an informed choice about where to best deliver their babies. She stated that a close analogy would be the birth mother's positive interactions with doulas and how such interaction improves the birthing experience. She knows that when there is a better advocate presenting information to the mother in a more meaningful way, it can lead to a better birth experience. She acknowledged that physicians do not always talk to patients the way that they should, and that physicians have to change this in order to improve the mother's birth experience.

While planned home births in Illinois are lawful, currently the only people legally allowed to deliver babies are medical doctors and CNMs. Placing mothers and babies at risk for a bad outcome happens when attempting home births without medical supervision. Lack of a requirement for a physician or nurse

practitioner oversight means that when a mother in distress is brought elsewhere for care, her history and condition will not be well known to the medical providers, which only magnifies the possibilities of poor outcomes. There is no medical team present when those quick emergencies happen. Moreover, it is a concern that lay midwives do not have hospital admitting privileges, nor do they have the education and training to make medical diagnoses and keep medical records. In addition, there is a concern that midwives are not prepared to deal with emergencies, especially in a day and age where information overload sometimes leads to inaccurate messaging of the mother's and child's condition to hospital personnel.

Illinois residents may wrongly be led to believe that home births by lay midwives are safe and that having emergency transport protocols in place is enough to handle complications. She believes that physicians have a responsibility to safeguard their patients by ensuring that they are providing the best possible care, which can only be provided by teams of medical doctors and CNMs in home births.

Maura Quinlan, MD, MPH

Maura Quinlan, MD, MPH is an obstetrician-gynecologist physician practicing at Northwestern, and the Legislative Chair of the Illinois Section of ACOG, which represents about 1,500 obstetrician-gynecologist in the State. Over her time in ACOG, which has been since about 2011, she has had the opportunity, with our Illinois Advisory Council, to respond to various Illinois legislation regarding licensing home birth midwives.

She wanted to explain the concern that obstetricians in her organization have about the safety of women having their babies at home, and what can be done in a concrete way to make it safer for the mothers and babies. All physicians who practice obstetrics have the health of women and infants in mind. All physicians want a healthy outcome, which is why they all went to medical school, completed four years of residencies, and work in the middle of the night. Physicians also know that complications in birth can happen without warning. People talk about the good old days when babies were delivered at home, but in 1900 the leading cause of death for women of reproductive age was childbirth. This was a time when deliveries happened at the mother's home.

She explained that we now have resources to make home birth safer, but we need to make sure that it is clear that there is an additional risk and we all need to find ways to lower that risk. There have been a number of studies written about the risks of home birth, but she thought that it was important to stress that the Oregon data discussed "planned home birth." She believed that it was important to note this because some studies consider a birth, which is attempted at home but after a complication occurs the woman is brought to a hospital and delivers at the hospital, a hospital delivery. The Oregon study was able to determine that the delivery was planned to be in the home or at a hospital. The data from the Oregon study showed a two-fold increase risk of death to the infant if the baby was planned as a home delivery. The study also showed a three-fold risk increase of the baby having seizures or serious neurologic dysfunction if the delivery is at home. She acknowledged that other studies have concluded that the outcomes were equal for women and infants if the midwifery birth is carried out in a well-integrated setting, but she noted that Illinois did not have a well-integrated setting and the arrival of a mother in labor at an ER is a disaster. She also acknowledged that the licensure of CPMs would be a small step on a big ladder toward developing a well-integrated health care system. Regarding the transfer of a mother from

a planned home birth to a hospital, she explained that if a transfer was necessary to obtain a healthy outcome, was clinically appropriate and not too late, she would not view the transfer as a failure.

She believed that the central requirement is that families choosing home birth are well informed about the risks. She was not aware of any studies about how to best inform birth mothers about the risks of home births. She noted that in other countries, the first pre-natal visit is with a physician or a CNM, where a decision is made permitting low-risk births at a home and high-risk births in the hospital. She thought that the risks were discussed during that meeting. She believed that proposed legislation could require the disclosure of home birth risks in a clear and understandable format.

She believed that as safety is discussed, it is important to discuss how home births can be made safer. The national ACOG's position has evolved regarding home births, and the Illinois Section has to evolve as well. Prior to 2011, ACOG had opposed legislation to license home birth providers, but as the interest in home births has increased, the position of ACOG has evolved. There is a Committee Opinion which provided the statement that although the ACOG believes that hospitals and accredited birth centers are the safest setting for births, every woman has the right to make a medically informed decision about delivering their baby. The Illinois Section of ACOG has adopted that huge policy shift.

In 2011, ACOG had opposed home birth legislation because the organization wanted certain requirements, such as: minimum educational standards for providers; only involve low-risk mothers; criteria for hospital transfers; and a requirement to report complications during home births. Also, in 2011, Illinois required providers to complete training in obstetric hemorrhage for the safety of patients. So, in the early stages of this legislation, physicians did not understand how the State could license providers that were not required to participate in required training for physicians and other providers that had been deemed essential to improve safety.

The proposed legislation regarding home birth licensing in 2018 was quite different. Illinois ACOG was asked to participate in the writing of the legislation. This bill included all the details that ACOG had outlined to make home births as safe as possible. For example, it included the appropriate selection of candidates for home birth, in that only low-risk women could deliver at home. She explained that if a woman was considered high-risk for birth complications, she could not make the choice to have a birth at home with a CPM and believed that most midwives would agree that the delivery of twins or other high-risk births at home would not be safe. She also noted that ACOG already has a standard of care which defines high-risk and low risk births.

In addition, the bill included clinical details of events during prenatal care, labor, postpartum, or the infant that would require transfer to the hospital. Obstetrician-gynecologists believe that it is not safe for women who are considered being at high risk of complications to deliver at home. These risks include women with diabetes, hypertension, twins, history of a caesarean section or if the baby is breeched. The second thing last year's bill included was standards of training. That bill stated that licensure of CNMs, CMs, or CPMs would require the global standards established by the International Confederation of Midwives for midwifery education. The third component of last year's bill was access to safe and timely transport. She noted that when some of the data involving studies are discussed, the studies involve well-integrated systems in other countries. However, even in those studies the chance of a required transfer to a hospital for delivery is often as high as 1 in 3 women attempting to deliver at home. So, an integrated system is essential. The last thing was that there would be clear reporting requirements for complications and a

review board of CPMs, CMs, and physicians to review those complications. This would ensure that just like in a hospital setting, there would be ongoing evaluations of the outcomes.

For the above reasons, last year, Illinois ACOG for the first time removed their opposition to a home birth licensing bill. Unfortunately, liability issues arose which changed the bill enough so that ACOG was required to oppose it. She again thought that it is important that everyone should have the same goal, which is to help women have a healthy pregnancy, labor, and deliver a healthy infant. Illinois ACOG wants women to have the experience that they hope for and knows that we can do better in the hospital setting to help women have the low intervention delivery that is safe for the mother and her infant. But as was mentioned, those of us that deliver infants know that complications happen unexpectedly and can lead to long-term consequences. Illinois ACOG believes that hospitals and accredited birth centers are the safest setting, but we agree that we need to work together to make sure that women who request home birth are informed of the risks and that there are requirements in place to make it as safe as possible.

Dr. Quinlan believes that the growing interest in home birth is a wake-up call for physicians, in that they need to do better to honor the wishes of the patients in labor and provide an experience which is as safe and patient directed as possible. She would love to see birth centers attached to every labor and delivery, which is low in intervention but nearby, so that it is available if needed. Even in those settings, there will be women who want to deliver at home. There are risks and benefits to delivering at home and in a hospital. She said that everyone needs to move as a group, with professionals on all sides, to help women have the lowest intervention delivery that they choose in a hospital setting, and to make it as safe as possible if the mother chooses to deliver at home.

Stephanie Martinez, CNM

Stephanie Martinez⁸ provided a personal statement as a CNM practicing in the largest and oldest home birth practice in the state of Illinois. Along with being a nurse practitioner, Stephanie holds a bachelor's degree in Latin American studies and Latinx studies from UIC. Stephanie is one of only four certified nurse midwives of color in Illinois who practice out-of-hospital births. Stephanie's decision to become a midwife was partly formed by the story of Stephanie's own birth, which Stephanie's mother described as abusive and traumatic.

Stephanie maintained that unfortunately, Latinx and immigrant communities are all too familiar with abuse when accessing healthcare. In recent years, there has been more coverage in the media about how the U.S. has the worst maternal health outcomes of any industrialized nation in the world. More specifically, the world is coming to terms with the fact that racism in the U.S. is killing black and indigenous families. More Americans are learning that black women in New York have a lower chance of surviving childbirth than women giving birth in Syria or Iraq. While babies of Hispanic origin made up 23.3% of births in the U.S. in 2017, Hispanic babies made up 21% of all births in Illinois. That same year, the American College of Nurse Midwives most recently available data on the demographic makeup of CNM's report that less than 1% of CNM's in the U.S. are Hispanic. Simply put, CNM's in the U.S. do not reflect the communities they serve.

⁸ Stephanie Martinez request that the Department use only non-gender pronouns, so the Report will use only Stephanie's first name, or the pronoun "They."

Stephanie also believes that there are actually more Hispanic babies being born than reported. Since the U.S. Census began using the term Hispanic, people who are ethnically Hispanic are notoriously underreported and underrepresented. The U.S. Census does not adequately acknowledge people of either black and/or indigenous ancestry who can also be categorized as Hispanic. Likewise, people who are undocumented are more likely to report data inaccurately if at all. Some Latin American immigrants categorize themselves in the U.S. Census according to the boxes they checked in their home countries, which ignores the “Hispanic” category all together, and instead checking the box of “White,” due to internalized racism, fear, or both. In the past, Latinos generally saw the best birth outcomes in the U.S., with lower rates of maternal and infant mortality, prematurity and low birth weight. However, since 2016, rates of pre-term births, low birth weight, and birth by caesarian section have increased among Latinos. Rates continue to increase every year, in which Latino communities live in increasing fear of immigration raids, deportation and detention, family separation, children dying in captivity or being targeted by a mass shooting.

In spite of the stereotype of immigrants over-using Medicaid, rates of birth covered by private insurance has risen among Latinos. Hispanics grow wearier and more distrustful of the medical industrial complex, and traditional Latino birthing customs become appropriated and repackaged to Hispanics by white business owners in the birthing industrial complex. Low-risk Latino parents desire and need the availability of home births. For immigrants from rural areas of Latin America, home birth is still commonly practiced today and is not regarded as unsafe or unusual.

Stephanie recognized quickly after starting midwifery school that They would be an anomaly by becoming a CNM because in the U.S., this certification is an expensive and time-consuming process, which is unavailable and inaccessible to many birth workers of color. Hispanic women are the lowest earning demographic in the U.S. and have been so since the Department of Labor started collecting data on this topic. There are many Latinas who assist with deliveries and who hunger for more education and training but have young families to support and a minimum of seven years of school is simply not an option.

Legalizing CPMs in Illinois will be better for the State. The State needs higher paying jobs for skilled birth workers who do not have access to the schooling that being a CNM requires. Likewise, Illinois needs to do better for parenting and pregnant families. Illinois holds some of the highest rates of maternal and infant mortality, prematurity, and low and very low birth weights in the U.S. The statistics are more glaringly apparent if you compare the data from the Chicago area to the rest of the country. Black, Indigenous, and Hispanic babies, and their mothers are dying. It is clear that our current medical system is not serving these families of color. Giving CPMs licenses to practice in Illinois will save lives.

The Committee should recommend the end of the archaic belief that home birth is unsafe, that midwives are ill-prepared, and that home birth is not desired by communities of color. Illinois should to catch up with the rest of the country by allowing CPMs to practice legally. Everyone deserves the option to be born in a safe and loving home environment with trained professionals. The Committee Members should do what they can to: prevent mothers and babies from dying; protect the most vulnerable residents of Illinois; and make home birth safe and accessible to everyone in Illinois by legalizing CPMs and mandating insurance companies cover out-of-hospital births.

Tayo Mbande

Ms. Mbande is a mother, a doula and the cofounder of Chicago Birthworks Collective, which is birth and postpartum collective for women of color on the southside of Chicago. She provided her personal story regarding giving birth twice in a hospital and once at home, without a midwife and around family. She stated that her home birth was the best experience she has ever had.

Her son was born before her daughters, and during her son's pregnancy she had experienced the most trauma that she had ever come in contact with in a hospital. She had what looked like a pattern of pre-term labor contractions, so she was hospitalized for 10 days. During those 10 days she felt that: she was abused; her protests were dismissed; and she was given procedures without her consent. She was given two different doses of medicine back-to-back, when no one else was in the room with her. She is both married, and a college graduate, but these facts did not place her in any greater category to not experience abuses. During the 10 days she repeatedly asked to be allowed to go home. Her providers told her that they would hold her in the hospital indefinitely until she most likely would have given birth to a pre-term baby. She was told if she did not agree with what was being recommended as her care plan, then she would most likely give birth to a baby that would not survive. She decided to sign an Against Medical Advice ("AMA") form to gain her release from the hospital and went home to care for herself with her family. She eventually gave birth to a full-term baby at the hospital without her obstetrician, and only with nurses who were very uncomfortable being present while her child was being born. She said that the birth went great because her family was present and took the lead, and not because of an obstetrician, nurses or medical staff, who were either not present or did very little.

For her third child, she made sure to take matters into her own hands and she educated herself and her family regarding the method of giving birth at home as safely as possible. She looked at all of the risks she could possibly experience based on her past pregnancies. When she was about 13-weeks pregnant, she lost her father and decided to pursue care in the hospital. Her first pre-natal visit with her third pregnancy was exactly what could be expected for a black woman getting pre-natal care in America. She was told about all of the required tests and risks, instead of asking how the loss of her father had affected her pregnancy and the types of outcomes she hoped to achieve with the pregnancy.

So, she decided to go to a CNM, who she thought and hoped would help her. She went to the only free-standing birth center in Illinois and got the exact same care as a hospital. She asked if she could be cared for by the only black midwife in their practice. For the bulk of her pregnancy, she felt that was the best pre-natal care that she could have received. She was able to talk openly with her black midwife, her visits were an hour, rather than just ten minutes. The black midwife was very accommodating to her and her children and helped her talk about things that she was experiencing physically and emotionally. The black midwife also helped her work through her physical and emotional issues. However, towards the end of her pregnancy, the black midwife transitioned out of the practice, and Ms. Mbande was left with only white midwives.

Then, the white midwife told her that she was required to attend weekly pre-natal visits and ignored the difficulty that she had bringing her two other children the long distance to the birthing center. Ms. Mbande told the white midwife things that she would not like to do, and the white midwife almost chastised her about the importance of the procedures. Ms. Mbande decided that she did not want to give birth at that

location because she was not being respected. Ms. Mbande wanted to be respected as an adult who was pregnant and be the person who would decide how her child should be brought into this world and the manner of her care. Ms. Mbande's baby was born after an uneventful labor at home, assisted by her family, and was full-term, being one-day prior to her due date.

Ms. Mbande believed that if she would have had access to midwives of color, particularly CPMs who were comfortable treating her from the beginning of her pregnancy, then she would not have had to change providers. She wanted to give birth with a black midwife who looked like her, because such a person would understand the stress and the trauma from a birth at a hospital, which was a huge detriment to her and her child's health. She stated that for some people hospitals are not considered safe. Anytime a member of her family is not with her in a hospital room, she feels that something bad can happen, especially when she is being administered a drug by injection, because she feels that she is being stabbed especially when it is without her consent. Those types of things, along with being told that you would be giving birth to a four-pound baby creates anxiety. It is known that anxiety is not good for anyone, especially for a pregnant woman who is about to give birth. These experiences are what led her to choose a home birth.

Barbara Belcore, CPM

Ms. Belcore is currently the President of the Illinois Council of Certified Professional Midwives and the President of the Illinois Chapter of the National Association of Certified Professional Midwives. She is a CPM and has been certified since 2010. She has been practicing in birth work in a variety of capacities, including working in other group practices of CNMs and doctors since 2006. She is also licensed in the state of Wisconsin as a CPM.

She discussed the challenges that CPMs practicing in Illinois face, and reminded the Committee Members that Illinois has 102 counties and 10 licensed home birth practices that serve all of these counties. Most of these practices are north of I-80, which leaves a large area that is not covered by licensed practices. If families who live in those areas choose to have a midwife present at a home birth, they will likely choose a midwife who is working underground, rather than delivering by themselves. She fully believes in choice in birth with informed consent. The families who choose to be assisted by a midwife, or choose midwives that look like them, deserve that option.

It is not against Illinois law to give birth at home, even without a licensed practitioner. Illinois residents can choose whoever they want to attend their birth. They bear no legal responsibility for that choice. There are compelling religious, philosophical, and personal reasons to choose home birth. In addition, some choices are driven as a result of prior birth trauma and these families may no longer trust the medical establishment. Some families may not cooperate or even appear to act in a hostile manner if they are transported to a hospital. Any midwife who has transported with a client to a hospital has experienced some hostility, not just from the patient but toward the patient from the hospital. However, providers feelings about home birth and about these families does not matter. The bottom line is that if somebody gives birth at home for whatever reason, all individuals who are present should work to maximize the chances of good outcomes for the mother, baby and family in whatever way they can.

CPMs' efforts to assist in achieving good outcomes are being prevented by their current illegal status. As an example, while it rarely occurs in healthy low-risk women that CPMs serve, all births carry the risk of fetal distress. Oxygen is a well-known option to provide inter-uterine resuscitation, which allows enough time for a birthing person to travel to a facility for an emergency caesarian section and still have a good outcome. Oxygen may also help a new born immediately after birth. Currently, CPMs carry oxygen tanks and are certified in neo-natal resuscitation. CPMs learn from the same book that doctors in the hospital and nurse midwives are required to use for training. In most resuscitations CPMs use room air, but a midwife may need oxygen during a birth. However, in order to fill their oxygen tanks, CPMs in Illinois must cross a state border and go into a state where they are licensed in order to obtain that oxygen or find someone who is sympathetic to them and is willing to fill the oxygen for them. This is not a reliable way to ensure that midwives have oxygen at a birth, when they assist a birth and sometimes they just do not have oxygen, which does not make home births safer.

Ms. Belcore also stated that all births carry the risk of postpartum hemorrhage. Herbal treatments have been used since the dawn of time and can sometimes be very effective in curing hemorrhage, and some parents prefer to use those methods. However, every CPM knows and is trained in the necessity in carrying pharmaceuticals that can be used to save a woman's life in the case of a hemorrhage. Currently, CPMs must do the same thing, but they cannot obtain those medications, which CPMs are trained to use and administer, that will save lives. Again, CPMs need to find the medications in other states or find sympathetic providers who will provide the medications to them. CPMs will look for Pitocin, Methergine or Cytotec in various different places or online services and hope that they can get the medications. Sometimes midwives drive several hours to get those medications, and sometimes they are unable to obtain the medications, which does not make home birth safer.

Mothers whose babies' heart tones show lack of variability or certain types of decelerations may need immediate intervention during a home birth. There is recognition by the Emergency Medical Services ("EMS") crew that a midwife on the scene, who makes an emergency call, is qualified to make the call that there is no time to attempt to stabilize a mother and that she needs immediate transport to a hospital. Also, a phone call to the nearest hospital could result in having the Operating Room opened and a surgical team ready and waiting while the transport is taking place. If all is ready and the providers know how to interact with each other, then a life can be saved. Currently, CPMs face hostility from providers who refuse to accept their reports. Moreover, the providers upon arrival will treat mother as if she has never had pre-natal care or lab results, despite the fact that her midwife is present and attempts to provide a packet of information including the lab work that they are requesting. This can lead to a loss of precious time and sometimes lives. Ms. Belcore stated that midwives need to be accepted as a part of this team, which cannot happen without licensure and the education of both the EMS teams and hospital providers on appropriate transport.

After the birth, mothers who are RH negative may need an injection named RhoGAM. It is a blood product that prevents the mother's body from developing dangerous antibodies against future babies who have an RH positive blood type. A mother who needs this medication but does not receive it within 72-hours of birth, may never be able to deliver a live baby again. Right now, for CPMs, RhoGAM is as difficult to obtain as anti-hemorrhage drugs and oxygen. Without CPMs having access to RhoGAM, then a mother's reproductive future may be at stake. Also, within twenty-four hours after a birth, the infant should be screened with a simple application of a Pediatric Pulse Oximeter, which is used to detect several

of the most common congenital heart defects. Discovering these defects can also prevent a sudden unexpected death of an infant in the days following the birth. Newborns must also be screened for metabolic disorders, which is a State mandate. The test can screen for galactosemia, sickle cell anemia or cystic fibrosis. This testing requires that midwives interact with the State of Illinois screening unit, which involves performing tests, completing test cards provided by the State and sending the results to the Illinois screening unit. However, midwives are not currently doing this because they fear putting their name on paper work, which could lead to a disruption in the communication if the test comes back positive. In some cases, this can be destructive to the baby's immediate health or even life. These screenings must be done but are impeded by our current legal status.

Finally, there are security issues, because a baby needs a properly filed birth certificate, which requires a CPM to interact with the State of Illinois to report the live birth. Many CPMs hesitate to sign birth certificates, which requires that the parents bring the baby to the county office, file the birth certificate themselves, hoping that the county: accepts the validity of their birth story; believes that the baby is theirs and it was born at home with no assistance; and gives them a certificate of birth and a social security number. Families of color, especially Latinx families may have trouble with this very thing. Sometimes a midwife does sign the birth certificate but given that she is not recognized by Illinois, the validity of that certificate may be called into question. Some families may never file on their own. She is aware of several Illinois children who have had trouble obtaining passports later in life because there is no record of their birth. Because of CPMs illegal status, there are difficulties with the smooth transport in emergency situations, obtaining necessary lifesaving medications, performing potentially lifesaving newborn screening, and filing proper birth certificates. All of these concerns could be remedied simply with licensure.

Ms. Belcore stated that failing to remedy these things shows a disregard for the health and wellbeing of the babies whose families choose home birth. Providing CPMs with legitimacy and the tools needed to safely carry out the job is the only ethical choice. Home birth becomes less safe by limiting the number of trained providers.

Melissa Cheyney, PhD, CPM, LDM

Dr. Cheyney is a Medical Anthropologist at Oregon State University and has served for six years as the Chairperson of the Board that oversees the practice of midwifery for Oregon. She explained that in Oregon there were similar conversations about midwives in the early-nineties, as midwives have been licensed in Oregon since 1993. Currently, the Committee on which she was serving is discussing the issues involving the inherent injustice of allowing only white college educated women to have access to a full range of birthing options. The Committee in Oregon is tasked with determining how to expand the home birth option to all of the people in Oregon.

Dr. Cheyney is also a member of the Oregon Perinatal Taskforce, and a member of the National Academies of Science Study Committee on Birth Settings ("NASSCBS"). The NASSCBS has prepared a report, but it is out for review by external reviewers, so she cannot comment on it until it is released. She wanted to let the Committee know that the report should be released in the next several months, and she encouraged the Committee to review the report closely after its release. She stated that any overlap

in her presentation with the NASSCBS' report represents only her opinion and not those of the NASSCBS. Her presentation did not disclose anything from the NASSCBS report because it will first be presented to Congress, as that study was Congressionally mandated by the Maternal Health Caucus.

Dr. Cheyney explained that when the very large body of literature describing prior studies is reviewed, there are a few significant things that are revealed about how to make births in the community setting or at home, as safe as possible. It is important that training and preparation for practice are high. It is also important that midwives are people who are capable of engaging in ongoing risk assessment and client selection and have the ability to manage first line complications. In addition, there has to be systems integrating home birth with other health systems. There must also be complex care planning, which speaks to the point that there are occasions when someone is higher-risk, yet they still would like to have a home birth. Of all of the things which will make out-of-hospital births safer, the inherent and first step is she licensure and regulation of midwives. Moreover, she noted that there is no evidence that making something illegal or keeping CPMs illegal, will make out-of-hospital births safer. In fact, there is evidence to the contrary. She recommended that legalization and regulation of CPMs would make home births safer.

Ms. Cheyney discussed the appropriate training and preparation for practice as a CPM, or what she referred to as the "MEAC vs. PEP" routes to certification. She explained that there are two ways to become a CPM in the U.S. One route is through a MEAC accredited school, which is perceived as the preferred route to licensure; however, there are only 10 MEAC accredited schools in the U.S., and none of them are in states where CPMs are not legal practitioners. The second route for certification is the "portfolio evaluation process" ("PEP") process, or the which is an approach that is focused on experiential learning. This process involves a midwife initially practicing as a student midwife apprentice, and advances to become a more senior midwife, as she learns through the process of attending births with the senior midwife and through self-study. At the end of both forms of training the students must take the same exam to become a CPM. She also wanted to clarify that the "Bridge Certification" is not a replacement for a MEAC accredited school, in that it requires an additional 50 hours of training that a PEP certified midwife takes as it is believed that some forms of learning that are best done by book or didactic learning. Therefore, it is not the only training that they have, but additional training that they received with the training on the other pathway to certification.

Licensure and regulation allow the regulating body to set standards for continuing education. So, not only is there preliminary education, but the education and training are ongoing. Without licensure and regulation, Illinois has no ability to require re-licensure or evidence of continuing education, so this is a critical piece for training and preparation. Dr. Cheyney also mentioned that with licensure, there is the ability to require data collection, as well as quality improvement programing through professional organizations. This allows midwives to reflect on what they are learning in practice, peer review hopefully in a legally protected setting, and learn from what their colleagues are doing and what they are doing in practice. She asked the Committee to remember that training is not a one-time thing and is something that is on-going, and regulation sets the stage for continuing to make sure that you have the highest quality of practitioners in Illinois.

She emphasized that while ACOG generally opposes home birth, the organization stands behind CPMs, CNMs and CMs. ACOG supports licensure if CPMs have either gone through an accredited educational

program, or they have learned through the PEP process with the completion of the Bridge Certification pathway. She did not want the Committee to overlook the years of dialogue and discourse between these organizations to come to this agreement. She hoped that the Committee would not simply dismiss the Bridge Certification as a “loophole,” because it was very well thought out route to become a CPM. She encouraged the Committee to look very closely at all of the US MERA materials that document this process.

Regarding the women who are appropriate for home births, Dr. Cheyney noted that there is a lack of agreement in the literature about what constitutes low-risk pregnancies. She stated that when you look across the nation at the 35 other states that currently license midwives, they often consider the length of the baby’s term, vertex, singleton and no pre-existing medical conditions or co-morbidities. However, it is not as simple as these terms might indicate. Often states have absolute and non-absolute risk factors. The absolute risk factors would disqualify someone from delivering at their home, but a non-absolute risk factor would require consultation before a decision could be made about the appropriateness of a home birth. She also encouraged the Committee to consider ways that they could foster close collaborative relationships between a group of providers so that collaboration is possible. She also encouraged the Committee not to “reinvent the wheel” when they come up with their own rules regarding integration. She mentioned a study that has ranked the amount of integration among providers throughout the states and encouraged the Committee to closely review the legislation in states which have the highest level of integration, because these states also have the best outcomes in the United States.

Dr. Cheyney stated that over the last year, the NASSCBS has considered the safety of births in the home setting. She explained that she was able to locate a total of 70 studies on the safety of home birth, of which 24 involved home births in the United States. There are some key take away conclusions from the entire body of studies. The first conclusion which can be drawn from a review of all 70 studies is that in the home setting, morbidity is reduced for the mother. Her review showed that all of the studies show lower rates for birth by cesarean section, lower rates of post-partum hemorrhage, lower rates of perineal tearing, and higher rates of breast feeding. Much was said about the health of the new born baby, but she wants the Committee to remember that the mother is more than a “vessel,” and that her health absolutely matters as well. What we know about the place of birth is that there is a delicate balance of maternal and fetal harm and benefits, and that there is no birth setting that is “risk free.” What women are actually negotiating is a complex set of social, cultural and clinical factors when they make their choice of delivery location. So, she explained that it is not as simple as saying that the risk is two times higher for the baby born in a home setting.

Dr. Cheyney explained the different ways to describe the risks to the babies for home births. One of the risks is called relative risk and the majority of studies from the U.S. show that there is a slightly elevated relative risk to the baby when they are born outside of a hospital setting. That relative risk is as high as two-fold. However, the absolute risk for the baby in connection with home births is only an increase of .6 out of 1,000, verses 1.2 out of 1,000 on average. She explained that for many mothers considering where to give birth, the difference of between .6 and 1.2 out of 1,000 is not as meaningful as two-fold. She believed that it is very important in providing information to patients to provide both the absolute risk and the relative risk. It would be like her saying that if you move to Florida, you would be ten times more likely to be hit by lightning, but not mention that you still only have 1 in 500,000 chance of being struck

by lightning in Florida. She stated that both of those pieces of information must be conveyed to consumers.

She also mentioned that the populations reviewed in these studies must be considered because any one individual person can have mitigating or complexifying risk factors that either make them more at risk or less at risk than these large national levels. She provided a chart showing how the risks involved in child birth have been evaluated in Oregon for 2019.

MEDICAL HISTORY OR OBSTETRIC HISTORY	
Cervical conditions	<ul style="list-style-type: none"> • Insufficiency or cerclage
Collagen-vascular diseases	<ul style="list-style-type: none"> • Any collagen-vascular disease
Delivery history	<ul style="list-style-type: none"> • Prior cesarean section
Endocrine Conditions	<ul style="list-style-type: none"> • Type 1 diabetes • Type 2 diabetes • Endocrine conditions other than diabetes (e.g. hyperthyroidism)
Genetic/heritable disorders	<ul style="list-style-type: none"> • Family history of genetic/heritable disorders that would affect labor, delivery, or care of newborn. Examples include family history of thrombophilia
Hematologic disorders	<ul style="list-style-type: none"> • History of thrombosis or thromboembolism • Maternal bleeding disorder
	<ul style="list-style-type: none"> • Anemia with hemoglobin < 8.5 g/ dL during prior pregnancy • Hemoglobinopathies • History of postpartum hemorrhage requiring intervention
Hypertensive disorders	<ul style="list-style-type: none"> • Eclampsia • HELLP syndrome (hypertension, elevated liver enzymes, low platelets)
	<ul style="list-style-type: none"> • History of pre-eclampsia not requiring preterm birth.
Fetal demise or stillbirth	<ul style="list-style-type: none"> • History of unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty
	<ul style="list-style-type: none"> • Prior unexplained stillbirth/neonatal death or death unrelated to intrapartum difficulty

As shown on the chart, the risk factors that are lightly shaded would mean “caution,” which means that Oregon’s rules state that these factors require that midwives reach out to a collaborating physician or someone with hospital admitting privileges and have consultation, since they are not absolute risk factors. The heavily shaded risk factors are considered absolute risk factors. Dr. Cheyney mentioned that the Committee should remember that low-risk factors have blurry distinctions, yet this is one method to

consider which births are appropriated for a home setting, because it easily conveys the complexity of assessing the risks involved of the delivery. She also stressed that it is essential to support midwives who work in the community setting because they are the nearest provider to manage first-line complications.

Ms. Cheyney stated that an enormous amount has been written about a midwife's support of physiologic birth, and in fact this does seem to be the case in very large data sets that she has reviewed. The studies show that physiologic birth, or birth that occurs under the power of the woman's own body occurs in about 95% of cases. Certainly, midwives are experts in normal physiologic births, but they must also be experts in the ability to manage first line complications. That mean managing hemorrhage, neonatal resuscitation, as well as many of the other complications. CPMs are trained to address these complications and can provide relatively safe support in the home birth setting.

Dr. Cheyney also mentioned that in Oregon, part of the way that they ensure that CPMs can address complications is that they have a formulary. Once a person becomes licensed as a CPM in Oregon, that person is allowed to carry and use certain medications. CPMs in Oregon renew licensure every year and take additional training to demonstrate that they still understand how to use certain drugs and devices because they may be necessary to address complications from home birth. CPMs in Oregon carry the following as their formulary: Rhogam; vitamin K; suture material; lidocaine, plus additional pain medications for numbing; oxygen; erythromycin; epinephrine, for the mother; sterile water; GBS prophylaxis; pulse oximeters; and metabolic screening devices. CPMs also have devices to conduct hearing screenings for new born babies.

In Oregon, CPMs are also seen as highly valuable maternity care extenders. Oregon is similar to in Illinois in there are major population densities along the I-5 corridor, and everyone else is disbursed within the state. Oregon has to get creative regarding how to extend services to the individuals in rural areas. Dr. Cheyney explained that licensure is the first step in being able to use CPMs as health care extenders to those most in need.

Dr. Cheyney then discussed system integration, meaning to integrate the home births into the medical service systems. She explained that system integration is measurable, and it has been measured. One of the differences between the U.S. studies and the international studies is that in international studies there is no difference in perinatal outcomes for the baby, in for home and hospital births. Only in the U.S., with all of the additional problems that exist around access, quality of care, legalization of all practitioners, does the difference in perinatal outcomes arise. If the U.S. wants to be more like our European counterparts, the U.S. must have a more integrated system. There was a study that measured integration in each state and provided a guide for regulations that Illinois could emulate. She and her group met with experts around the country and reviewed the entire body of literature on what makes home birth safe. They identified numerous factors that contributed to safety and to integration, and created an index which started at 0, but could go up to 100, as being the most highly integrated health systems. Having a score of 0 meant that the state was not integrated at all. The data about each state was quantified and tested with experts from all 50 states. Her group created an index so that every state received an index number. The integration scores went from a low of 17 in North Carolina to a high of 61 in Washington state. Illinois was listed as 9th from the last state, or the 41st state, in the rankings with a score of 25. No state had achieved the score of 100, as would possibly be achieved by a country like the Netherlands.

Complex statistical models were created to discover how much the value of integration predicted birth outcomes in the U.S. They learned that it was not the most reliable predictor of birth outcomes, which was the race of the mother. If the mother is black or indigenous, the study showed that the mother was likely to not have a good birth outcome in the U.S. The second-best predictor of birth outcomes was an integrated delivery system. The integration of the delivery system predicts 12% of the variations that they observed across states. The more integrated states have the lowest rate of preterm birth, the lowest rate of low birth weight, the lowest rate of neonatal death, the highest rates of spontaneous vaginal birth, highest rates of labor after cesarean section, and highest rates of breast feeding. She explained that when CPMs are integrated into the health care system, both home and hospital outcomes improve. The survey covered midwifery in general, and the states that do not have regulation for a whole group of midwives had a lower integration score. In completed the survey, she said that they considered dozens of variables, and race and integration were the top two predictors of achieving better outcomes. Dr. Cheyney strongly encouraged the Committee to focus on the legislation, regulation and relationships among providers for states that are highly integrated.

She said that she works in a community that has home birth, birth center birth and hospital birth options, including having midwives work with a birth unit within the hospital. Midwives and mothers see their collaborating obstetrician in the hospital twice during the pregnancy: once, for a 20-week ultrasound; and once in the third trimester, so that if the mother has to transfer to the hospital during birth, they have midwife-to-midwife transfers. The community midwife transfers to the nurse midwives in the hospital, and they only ever see an obstetrician if the mother needs a caesarian section. For Oregon, this only occurs 5.8% of the time, when the national rate was 32%. She added that the 32% percentage rate was for low-risk and high-risk women, but for low-risk women, the percentage of women having caesarean sections was 16%. The World Health Organization recommends that this rate should not exceed 10-15%. She is working hard to reduce the percentage of women getting caesarean sections.

Dr. Cheyney also discussed her efforts to reach policy agreements with obstetricians and others. She explained that in 2011, stakeholders from across the entire health care system, including members of ACOG and all professional midwifery groups, met for a Home Birth Summit. After lengthy discussions, the group developed nine consensus statements, on which they could agree. The first statement was “Legislation and Regulation in Every State.” The second statement was a “System for Transfers from Home to the Hospitals.” Also, in their discussions with a past President of ACOG at these meetings, they agreed to a statement called *Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*. This document describes the basis for interprofessional communication and collaboration just at the time when it is most important to enable providers to speak across differences during an intrapartum transfer. She said that these are all tools that the Committee can use to think through the development of rules and regulations in Illinois to create a full range of birthing options for Illinois residents. Regarding complex care handling she quoted ACOG’s statement which was:

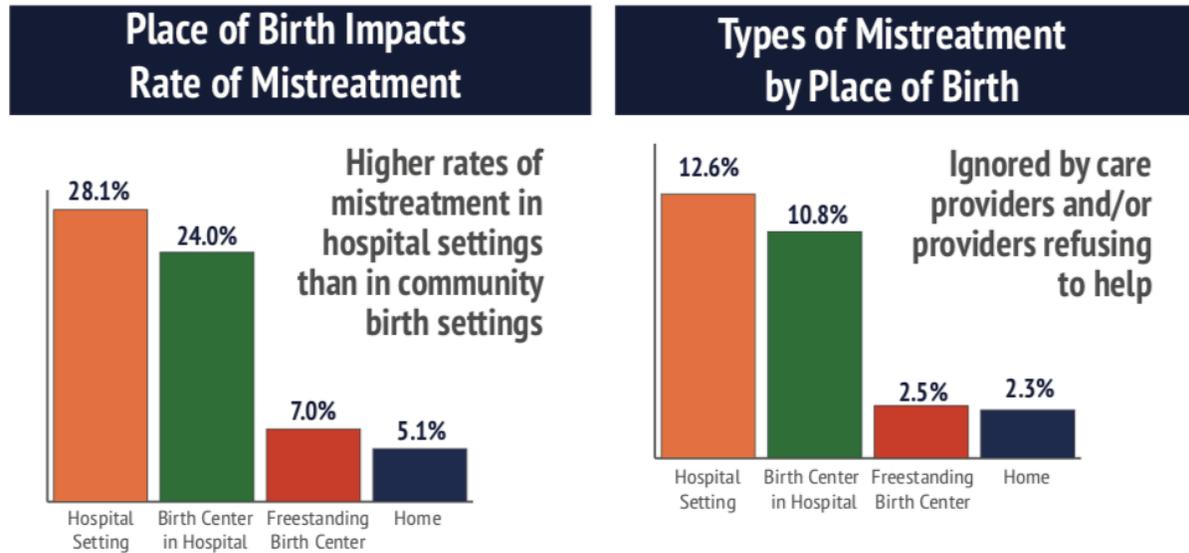
While women must receive accurate and complete information regarding their choices and the risks, benefits, and consequences of their choices, maternal autonomy must never be overridden even when there is a clear fetal harm incurred by the mother’s choice.

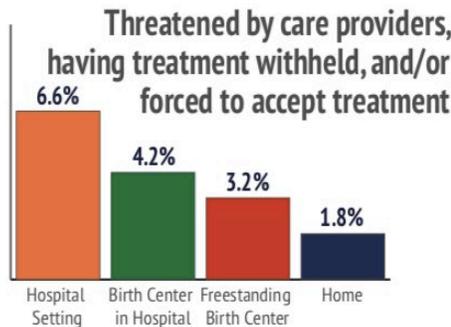
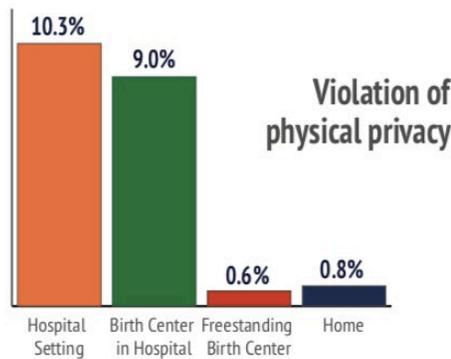
Dr. Cheyney next discussed an article entitled *Too Much Too Soon and Too Little Too Late Systems*, in which the author states that across the world there are these two kinds of health care systems both of which could lead to harm. She explained that because of rampant inequality both of these can exist in one country. She said that we predominately suffer from these systems in the U.S. She quoted a position statement from ACOG on preventing primary cesarean as well as an article in which the researchers stated that when deaths occur in a hospital setting often they are associated with too much too soon. When deaths occur in a home birth setting it can be because there has been too little too late, because there are barriers to providing care. She said that we should work for the right amount, at the right time, and in the right way. By saying the right way, she meant that care should be provided in a way that respects maternal autonomy for all people, not just for white women.

Dr. Cheyney next discussed a Giving Voice to Mothers study, which asked mothers about their experiences in hospitals. She explained that stories of mothers having bad experiences at hospitals are not anecdotal stories, but part of a wide spread problem in our country. This study compared levels of mistreatment felt by mothers based on the place of the birth. The study showed that overall 28.1% of women who have had a birth in a hospital setting feel that they experienced some form of mistreatment. While it may have not been the hospitals' intention to mistreat women, there may be systems in place which unintendedly impact women negatively. The study also reviewed for specific reasons why women feel that they were mistreated. The charts showing the percentages are below:

Impact of Place of Birth on Mistreatment

Global health experts agree that how people are treated during childbirth can affect the health and well-being of mother, child, and family. How does the place of birth - hospital or community - affect rates of mistreatment?





Dr. Cheyney stated that she understood from the response that people provided why they would choose home or birth center births over a hospital birth, if they want to have continuity of their healthcare provider in giving birth. In situations involving a midwife, with whom the mother has a connection, the women have this relationship and give birth without additional trauma. However, when the mother does not know from the dozens of people who interact with her care what kind of treatment that she is going to receive, that will often shade the mother’s perception about the safest place for them to give birth. Also, types of mistreatment vary by place of birth. For women who believe that they were ignored by the providers or denied help, these rates are much higher in a hospital setting compared to freestanding birth centers or home birth. The charts above also show that the hospital setting had the highest rates of women feeling that: there was a violation of their privacy; they were threatened by care providers; had treatment withheld; or were forced to accept treatment. Dr. Cheyney explained that she showed this information to help the Committee understand why people chose to have home births, even though it is relatively uncommon in the U.S.

The survey also found that the percentages of women of color who felt that they were mistreated in a hospital was higher at 33.9%, while only 6.6% of women of color felt that they were mistreated in a birth in the community. Dr. Cheyney believes that the U.S. has a “home-hospital” divide but she wants to work across that divide because the overall goal is to improve the quality of care in every birth setting in the U.S. Midwives working at home can work to reduce the perinatal mortality rate. In addition, midwives working in the hospitals can work to bring down the caesarean section rate and support the number of women who can access a physiologic birth. She concluded by stating that another goal that she has is working together to produce creative and collaborative solutions aimed at solving both access and equity issues involving births in the U.S.

Edward Pont, MD

Dr. Pont is a past president of the Illinois Chapter of the American Academy of Pediatrics (“ICAAP”) and is currently the chair of its government affairs committee. He has been a community pediatrician in Chicago’s western suburbs for over 20 years. He explained that ICAAP has concerns regarding current efforts toward the licensure of CPMs, and ICAAP’s position has remained straightforward: the organization believes that all infants, irrespective of venue, deserve a safe and supported birth environment, with appropriate medical resources readily available should an emergency occur. This commonsense philosophy informs ICAAP’s opposition to the current effort to license CPMs in Illinois. He stated that the ICAAP is not against home births *per se*, but only against the licensure of CPMs.

CPMs make two principal arguments to promote their licensure. One is that they are adequately trained to anticipate and respond to issues involving the perinatal and immediate postnatal period. They often point to other countries’ experiences to bolster this claim. Yet the training and requirements for midwifery in other countries are often significantly more intensive than those to become a CPM in the United States. In Canada, for example, the program is four years long, and is a blend of university academics and an apprenticeship model of clinical education. The midwives earn a bachelor’s degree, taking 18 university level courses, which including four separate apprenticeship placements. In contrast, almost 40% of CPMs in this country have less than three years of training. Ironically, Illinois CPMs would likely not be allowed to practice in the very countries they routinely cite as examples of successful midwifery.

Dr. Pont stated that another critical aspect of midwifery in other countries is collaboration with the larger medical community. ICAAP has consistently maintained that any discussion of licensure must include this requirement. In California, data from 2015 shows that relatively one half of the clients served by midwives received collaborative care. In that same year, a baby was urgently transferred about once a week from a home birth setting to a hospital. This emphasizes the importance of collaboration. Put simply, an infant crashing the ER with no prior collaboration is an inherently dangerous situation that any rational home birth system should take every measure to avoid.

He asserted that this was not just the opinion of the medical community. CPM advocates themselves also argue for integration of home birth midwifery into the larger medical system. One of them writes, “The lack of integration across birth settings ... contributes to intrapartum mortality due to delays in timely transfer related to fear of reprisal.” ICAAP remains adamant that any home birth licensing effort include ironclad regulations ensuring babies delivered at home have the same resources available as those delivered in a hospital.

In addition to these training and collaboration concerns, ICAAP opposes the CPM licensure effort because of insufficient personnel at deliveries. Current American Academy of Pediatrics (“AAP”) policy states: “[T]here should be at least one person present at every delivery whose primary responsibility is the care of the newborn.” Situations in which both the mother and the newborn infant simultaneously require urgent attention are infrequent, but they do occur. Thus, each delivery should be attended by two individuals, at least one of whom has the appropriate training, skills, and equipment to perform a full resuscitation of the infant. As a clinician, he knows how quickly a routine birth can become one where both the mother and infant are in distress, and it is imperative that both be attended to without distraction.

CPMs also assert that licensure will make home births safer by establishing clear standards to which all midwives must adhere. ICAAP would first note that this already exists under Illinois law. CNMs, who form a collaborative relationship with the medical community, ensure as safe a home birth experience as possible, and ICAAP would not oppose any efforts along those lines. ICAAP also would not oppose any effort to increase the number of CNMs, who would be willing to form a collaborative relationship with a doctor to address the issue of home births. However, ICAAP would insist on a requirement that CNMs maintain robust collaboration with a physician and would be happy to discuss ways to make a more functional pathway for assisted home births. He noted that there was evidence from several countries that this would promote the safest birth environment. However, he stated that collaboration cannot totally eliminate the danger of going to an ER, but it can limit the number of times that a mother and baby are brought to an ER, when the hospital staff has no information about the birth. ICAAP would support grants for more individuals to become CNMs, and barriers that CNMs face in assisting in a home birth in collaboration with a doctor. However, he explained that other barriers that CNMs face in assisting home births were outside his expertise.

As several states now license CPMs, including some that have licensed CPMs for decades, it is reasonable to ask for evidence that CPM licensure improves the overall safety of home births. Yet, he and ICAAP are not aware of any studies that demonstrate this. In contrast, increasing evidence documents the risks of home births, as shown by a recent report from Florida detailed eleven serious incidents, including seven deaths, in less than a year.

Yvonne Oldaker, APN, CNM, MPA

Ms. Oldaker stated that she is an Advanced Practice Nurse and Certified Nurse Midwife. She serves as the Board President of the Illinois Affiliate of the American College of Nurse Midwives (“ACNM”). ACNM supports CPM legislation that meets International Confederation of Midwives (ICM”) standards. She explained that this chapter has a long history of encouraging and supporting licensure for CPMs in Illinois. In addition, as a practicing advanced practice nurse, she provides reproductive health care to patients at Planned Parenthood of Illinois. Planned Parenthood has been neutral on the midwifery legislation that has been introduced in recent years. As an organization, Planned Parenthood wants to support the ability of individuals to access the birth option that is best for themselves, and wants to ensure that care is provided in a safe and effective manner.

She explained that years of experience in the field of reproductive health have taught her that underground healthcare is dangerous for the people seeking care. When existing healthcare systems are limited by geography, income, insurance status, race, gender, gender identity, sexual orientation, or other social factors, people will find and use whatever care is available. Also, when certain aspects of care are criminalized, resources become even scarcer because access to needed medications and other life-saving tools are denied, putting people’s health and lives at risk.

She spoke about her personal experiences giving birth at home 11 years ago, and how her life was threatened by Illinois’ restrictions on midwives. Her first daughter was born at home, in Washington State where her care providers held licenses, and her health and safety were codified into law. As she had no insurance, she only could rely on Medicaid. She learned that she could deliver the baby at her home with a midwife and that Medicaid would pay for her care. The midwives had licenses in Washington State to

order labs, ultrasounds, medications, and had transfer agreements with an obstetrician at a local hospital. Her daughter was born at her home into the hands of her midwife in the middle of the night. She hemorrhaged after the delivery, but she was stabilized at her home with medication. The midwives returned the following day to check on her and her baby. They returned a few more times in the first two weeks after her birth to see that both her and her daughter were healthy.

She moved back to Illinois in 2007 and became pregnant again. She wanted to have another home birth and found only two home birth midwifery practices that were located on the north side of Chicago, over an hour of travel away from her home. She arranged interviews with these practices, took time off of work, and drove over two hours round trip to interview them. Both practices told her they would not take her as a patient, because they were not willing to travel “so far” for her delivery. She noticed there were many more midwives listed online, but they all delivered babies in hospitals, which was still a place she wanted to avoid. She learned that a midwife could deliver her baby at home “under the table.” She learned that her health insurance would not pay for her home birth so, if she wanted a home birth, she would have to pay cash for “underground” care. She found out these “underground” midwives had attended the same schools as her Washington midwives, but Illinois did not legally recognize them as a profession. Her midwife assisted with her home birth delivery and after a protracted labor she delivered at home.

A few minutes after delivery, Ms. Oldaker hemorrhaged, and lost consciousness. When she came to, her midwife told her that she lost a lot of blood, and they talked about going to the hospital, or calling an ambulance. Her midwife stated that she may need a transfusion, but there were stronger more effective medications that would stop hemorrhaging that she could receive through an ER, but without a license in Illinois, she could not access them. Despite her midwife’s appropriate recommendations, she did not go to the ER because she felt that her midwife did not deserve punishment; her midwife had performed life-saving procedures and administered life-saving medications immediately following delivering her baby. Certainly, this did not make her midwife a criminal.

A week after her daughter was born, Ms. Oldaker developed a fever. Her abdomen hurt with the slightest movement and ached constantly. She called her midwife and told her how she felt. Her midwife told her to go to a doctor immediately; that she had the symptoms of uterine infection and if she did not start antibiotics immediately, she could become septic and possibly not survive. In the doctor’s office she was feverish and tachycardic; and she told the doctor that she believed she needed antibiotics. The doctor told her to see her obstetrician. She explained that her daughter was born at home. Her doctor refused to examine or treat her and told her to go to the ER. She explained that she had the baby with her, had another child at home, and was getting a ride from a family member. The doctor refused to prescribe any antibiotics and refused to call the ER ahead for her.

At the ER, she was again told to see her obstetrician. Again, she explained that she did not have one. Being seen in an ER immediately following a delivery, staff at hospitals get very nervous about not having any history or labs or information about prenatal care. She endured a very painful exam. After the exam, the doctor advised starting IV antibiotics. After receiving a bag of fluids and antibiotics, she left the hospital. Her hemoglobin was 7 (meaning that she was very anemic) but for some unknown reason, there had been no discussion whether she should receive treatment for anemia. She slowly recovered from the anemia that resulted from the hemorrhage.

The fact that she could have died at two separate points from very manageable complications that occurred during her home birth in Illinois stuck with her for a long time. The laws that limited access to medication and supplies to her CPM in Illinois set the stage where the same kind of hemorrhage she had experienced in a different state with the same type of provider had a more dangerous outcome that required ER intervention. This is one of the main reasons she decided to become a midwife. She weighed her options professionally, which were to become a CPM and practice underground with the constant threat of arrest which would impact the daughters she was raising or become a CNM. She went back to school to become a Registered Nurse and then a CNM, so that she could practice legally.

Ms. Oldaker stated that a small home birth practice would do nothing to help the countless mothers who choose a home birth if they are living in the many parts of Illinois that have no coverage by anyone other than community midwives. She hopes to help establish licensure for these community midwives, so that they can practice with legal access to life-saving medications, as well as collegial legal relationships with the CNMs, obstetricians and hospitals in their area. Keeping CPMs unlicensed will expose more birthing mothers to the same dangers she faced when birthing in Illinois. Licensing CPMs can save lives.

Michelle Breen, MHS

Ms. Breen quoted Eugene DeClercq, a CDC Statistician, who opined that instead of asking “Is home birth good or bad?” we should ask “How can we make home birth better?” From a public health perspective, licensing home birth providers is essential for making home birth safer and better. Improvements from licensing CPMs include increased accountability and recourse to consumers, reduced maternal health morbidity, creating cost savings through Medicaid, increased opportunities for initiatives to reduce health care disparities and improved local and state levels for disaster readiness.

Ms. Breen has been a volunteer consumer advocate for home birth safety for 25 years. She has experience as a working board member on numerous local, state and national midwifery organizations. Her educational background is in public health, and she has earned a Master of Health Science degree from Johns Hopkins University, where she studied in the Department of Maternal and Child Health. Ms. Breen is currently a statistician with the federal government, although she is not representing her employer in providing the statement but was appearing as a volunteer.

Based on her studies at John Hopkins, where she read about home birth, Ms. Breen knew that she did not want a birth in a hospital setting. She explained that she had a home birth for her child. When she first started advocating for midwives, she used the language from the Midwives Model of Care, a wellness model of care with health promotion and disease prevention. She came to learn that health care licensure is not about wellness, but about public safety, based on the need to assure that: providers are safe and competent; and also providing recourse to consumers. So, she changed messaging away from the midwives’ model of care toward home birth maternity care crisis and black-market maternity care, because she believes that black market maternity care is not just a bad idea but is a bad reality in Illinois.

Ms. Breen explained that licensing CPMs is a public health win-win, because it creates lower costs and better outcomes. First, there would be lower costs and the opportunity to use Medicaid. Currently, 14 states have Medicaid programs that reimburse CPMs, with three more stated in the process of establishing such programs. Decades ago there was a community group that successfully sued Illinois for Medicaid reimbursement for CNMs. This provides a legal precedent for ways to receive medical reimbursement

for the use of CPMs. Additionally, Federal legislation has been introduced that would require state Medicaid programs to cover services provided by CPMs. There was also similar language in the Affordable Care Act for birth centers, but not for home births. So, CPMs can get Medicaid reimbursement in all 50 states based on the Affordable Care Act if it is a birth center birth. She estimated that on average, there would be a savings to Medicaid of \$4,531 per birth based on 2017 dollars. She explained that she calculated this amount based on a comprehensive cost savings study conducted in Washington state, which had licensed CPMs, and then projected the cost savings to 2017 dollars based on national cost data. She then projected the overall annual cost savings based on the numbers of home births in Illinois and arrived at an estimated \$3.3 million in annual Medicaid offset savings. While acknowledging that figures were estimates, she maintained that this was a conservative estimate based on 1% of women on Medicaid having home births being attended to by CPMs. In states where CPMs are licensed and are covered by Medicaid, approximately 1.5% of births are covered by Medicaid, while some states which have licensed midwifery for a number of years, such as Washington State, the numbers are much higher. She explained that the cost savings from home births were due to: the elimination of hospital facility fees, which are very high; the expenses for cesarean sections, which are much less frequent in-home births; and other hospital interventions, which are not included in home births.

Ms. Breen explained that the reduced rates of cesarean section involves a significant topic for maternal health. CPMs substantially reduce a woman's rate for having a cesarean section. Results of the CPM 2000 study demonstrated a 3.7% cesarean section rate for CPMs compared to 19.0% in a low-risk, hospital control group. Cesarean section involves major abdominal surgery and it is very common, as 31% of births in Illinois involve this procedure. However, there is no good data about a link between home birth and maternal mortality because maternal mortality is fortunately very, very rare. She explained that while the United States ranks 17th in the world in maternal mortality, there are 55 other countries with lower percentages of maternal mortality.⁹

She stated that to study the issue of maternal mortality the U.S. has established Maternal Mortality Review Committees. These Committee consider all of the maternal mortality in the country and associate them with common factors. Preliminary findings of these review committees have found an association of both cesarean section and fragmented care with maternal death. Maternal Mortality Review Committees have found that two-thirds of maternal mortalities in Illinois have a co-association with cesarean sections. She explained that this does not mean that cesarean sections cause maternal mortality, just that there is a relationship between the two. She received the data which she used to establish this relationship from Dr. Cheyney through a personal communication and noted that the data was preliminary and has not been used in a publication. She also noted that while there is no direct link between maternal death and home birth, home birth is directly associated with reduced risk of having a cesarean section delivery. Therefore, she could not say that CPMs reduce maternal mortality, but could only say that maternal mortality has an association with cesarean sections, which is not causal, and home births with CPMs have an extremely low rate of requiring cesarean sections.

Upon questioning, Ms. Breen agreed that higher-risk patients are having cesarean sections, so there would naturally be a high morbidity and mortality for those patients who need cesarean sections. She acknowledged that she could not state that there was a direct relation between home birth and maternal mortality. She explained that the number are too small to measure because there are small number of

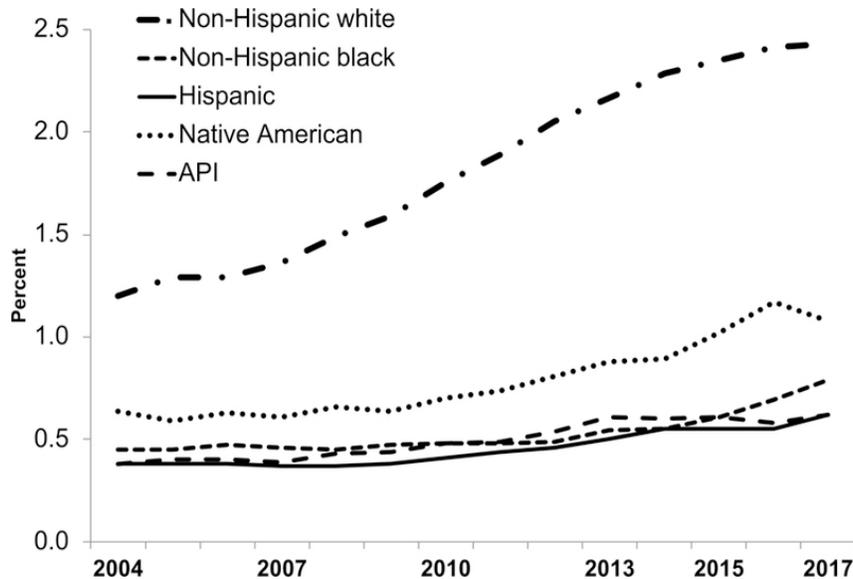
⁹ The reason that the United States does not rank 56 is because there were numerous ties in the ratings of maternal mortality above the rating for the U.S. For example, there are 6 countries that rank 16th in the world.

incidents of both home birth and maternal mortality. Due to the small numbers of events, there could not currently be a study that establishes a direct relationship in the U.S. In addition, she agreed that women who have high-risk births should be excluded from the comparison because home births involve only low-risk women. However, she stated that she does know that when there is a comparison between low-risk women who give birth in a hospital and women who have home births, the women who have home births have fewer cesarean sections. In fact, when comparing the rates of cesarean section for only low-risk women for home and hospital births, the study showed that only 3% of home births have cesarean sections, while 19% of hospital births by low-risk women have cesarean sections. She agreed that any effective comparison between home births and hospital births should only involve low-risk women.

Ms. Breen also stated that there was also a co-association between maternal mortality and fragmented care, or care by multiple care givers, in that an increase in fragmented care was associated with an increase in maternal mortality. She also pointed out that the midwife model decreases fragmented care, because under the midwife model there is same provider for prenatal care, labor, delivery and post-natal care.

Ms. Breen stated that health care disparities are another measure of health care outcome. Racial and ethnic disparities in maternal and infant outcomes are well documented. The chart¹⁰ below illustrates that these disparities are also present in out-of-hospital births.

**Percentage of Births Occurring Out of Hospital by Race and Hispanic Origin of Mother
In the United States from 2004 to 2017¹¹**



Ms. Breen explained that the top line is the percent of out-of-hospital births among non-Hispanic, white mothers. The dotted line, which is the second lowest, is the percent of out-of-hospital births for Native

¹⁰ The chart is from MacDorman, Marian, et al., “Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017,” *Birth*, 46 (2): 279-288 (2019).

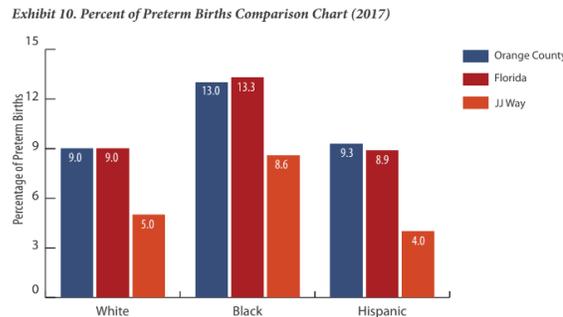
¹¹ The source of the information is birth certificate data from the National Vital Statistics System. “API” stands for Asian or Pacific Islander.

American mothers, and the bottom 3 lines represent the percent of out-of-hospital births for non-Hispanic black mothers, Hispanic mothers, and Asian and Pacific Islander mothers. All groups show an increase over-time from 2004 to 2017. The non-Hispanic white group shows both the greatest percent of out-of-hospital birth and the greatest increase over time. The increase in home births among non-Hispanic white births accounts for 81% of the overall increase from 2004 to 2017.

She then discussed the characteristics of women who have planned home births versus those that have a hospital birth. The data showed that 85.5% of the women who have a planned home birth are white non-Hispanic, while only 51% the women who have a planned hospital birth are white non-Hispanic. The data also showed that 68% of women who have a planned home birth intend to self-pay for the delivers, as opposed to only 3.6% of the women who have a planned hospital birth. Ms. Breen explained that this shows that a woman is more likely to have a planned home birth if she is white non-Hispanic and if she has resources to self-pay.

Ms. Breen maintained that licensing CPMs provide opportunities for cost effective and community-based health care innovations to address disparities. One example of this initiative is the National Perinatal Task Force (“NPTF”). The NPTF was founded by a Florida-based CPM, Jennie Joseph, in association with Paula Rojas, CPM. The NPTF has endorsed two innovative model programs, which are entitled the JJ Way developed by Jennie Joseph, CPM, and The Maternal Justice Model, developed by Paula Rojas, CPM. The NPTF supports the creation and expansion of grassroots networks establishing Perinatal Safe Spots, targeting communities at-risk of poor maternal child health outcomes, such as low birth weight, preterm birth, infant mortality and maternal morbidity. These safe spots target areas of infant mortality or low birth weight that they can access and develop them in high-risk areas. So, if there is someone in the community that wanted to develop a para-natal safe spot, but they did not have high morbidity and mortality child health outcomes in their neighborhood, would be directed to another neighborhood where their help is necessary.

She explained that all of the perinatal task forces are set up in communities that have poor maternal and child health outcomes. Currently, there are 31 Perinatal Safe Spots located in 22 states. Fourteen states, or 81%, of the Perinatal Safe Spots are located in states that license CPMs. The chart¹² below shows the percentage of preterm births for mothers using the Jenny Joseph method (the “JJ Way”), compared to the preterm births for the state of Florida and the preterm births located in Orange County.



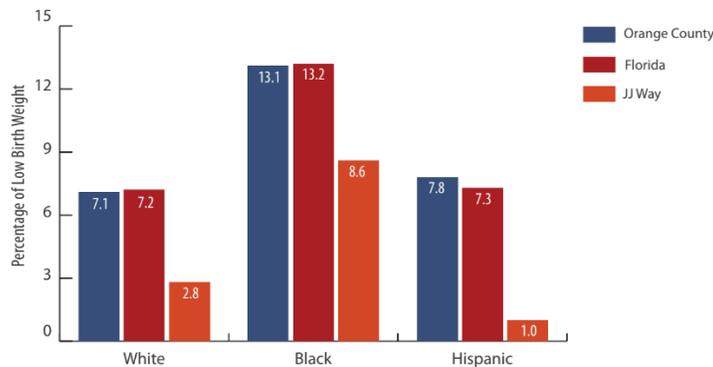
The information from 2017 shows that the JJ Way resulted in the reduction of the percentage of preterm births. Jennie Joseph has been documenting her program’s birth outcomes for decades. Jennie Joseph is

¹² The chart is from Visionary Vanguard Group, Inc. JJ Way® Community-Based Maternity Center Final Evaluation Report (2017).

a CPM and practice the Midwifery Model of Care. Her most recent statistics were from 2017 and were published in the 2018 NPTF Report. The chart above shows that birth centers and CPMs using the JJ Way can be innovative and effective in reducing health care disparities by reducing preterm births for newborn babies among all groups. All women involved in this study were socio-demographically at-risk for poor birth outcomes. The data is broken down by white mothers, black mothers and Hispanic mothers and shows improvement in all demographic and racial categories. The JJ Way reported the following preterm birth rates: 5.0% for white mothers; 8.6% for black mothers and 4.0% for Hispanic mothers. As way of background, the Healthy People 2020 (“HP 2020”) target for preterm birth is 9.4%. The JJ Way program surpassed HP 2020 targets for all ethnic and racial groups.

A similar chart¹³ below shows the low birth weight outcomes of the JJ Way, compared to the low birth weight outcomes for the state of Florida and the preterm births located in Orange County.

Exhibit 11. Percent of Low Birth Weight Comparison Chart (2017)



The JJ Way program achieved similar outcomes for low birth weight babies: 2.8% for white mothers; 8.6% for black mothers; and 1.0% for Hispanic mothers. The HP 2020 target is 7.8%. The JJ Way with CPMs surpassed the target for white and Hispanic mothers, but missed the target for black mothers, although it was better than the percentages for Orange County and Florida.

Ms. Breen continued that one last public health advantage of licensing CPMs is integrating these out-of-hospital birth experts into our Disaster Preparedness Preparation and Planning groups. It is well understood that pregnant women and newborn babies have special needs during a disaster event, when hospitals may not be accessible. It would improve disaster preparedness if the planners have a home birth expert to help with the preparation and planning. She emphasized how home birth is different from hospital birth. Physicians raise concerns about the amount of time that CPMs spend being educated, as compared to CNMs, but educational programs for CPMs must be different from CNMs, as CNMs classes include caring for patients other than pregnant women. Home birth is a different field from physicians and the things that CPMs can bring in a disaster is beneficial. Internationally, disaster preparedness groups include a home birth provider. The professionals that are making recommendations for pandemic flu preparedness recognize that one recommendation is home birth to reduce contacts or separation between infected individuals and pregnant women and newborns. Childbirth is the second most common reason for hospitalization. If there is pandemic flu in the hospital and babies need to be born at home, it would be nice to have licensed CPMs available.

¹³ The chart is also from Visionary Vanguard Group, Inc. JJ Way® Community-Based Maternity Center Final Evaluation Report (2017).

Ms. Breen stated that since 2001, the American Public Health Association (“APHA”), has recommended that the states license CPMs through nationally certified credentials. The APHA supports efforts to increase access to out-of-hospital maternity care services and increase the quality maternity care choices to consumers, through recognizing legally-regulated and nationally certified direct-entry midwives. The organization also encourages the development and implementation of guidelines for the licensing, certification and practice for direct-entry midwifery practitioners.

Deborah Fisch, JD

Ms. Fisch is an attorney licensed in Michigan, where a law licensing CPMs was approved two years ago, and the State just started issuing licenses in August 2019. She sits on the Michigan Board of Midwifery but is not representing them at this meeting.

Midwives were licensed in Illinois until the 1970s, and they served their communities until they were forced out, often by criminal prosecution. An Illinois Supreme Court decision in 2003 held that if a person was practicing midwifery in Illinois and was not a Registered Nurse or doctor, the person is guilty of the unauthorized practice of nursing or advanced practice nursing in the State. She said that criminal prosecution is not an efficient way to regulate a healthcare profession, because it is very costly, and it is a very blunt tool.

Ms. Fisch explained that while obstetricians and surgeons experience highest rate of malpractice claims, they also presume possible claims which are three times higher than actual number of claims that they receive. Moreover, physicians are employees of institutions or large systems that are heavily risk-averse, which adds to the atmosphere of fear of litigation. She explained that the malpractice system is set up to work as a feedback loop, in that if a doctor provides inadequate or negligent care and damages are assessed, then the doctor and all other doctors know that they should be not providing such care. However, most cases are settled out-of-court, so the feedback loop is disrupted, in that the other doctors do not know whether providers were actually negligent or not, or the amount of the actual damages. Also, physicians particularly fear lawsuits because doctors are unlikely to be sanctioned by a medical board or arrested for gross negligence following a bad outcome. In response to questions about the fear of lawsuits, Ms. Fisch explained that the data shows that doctor’s estimates of liability are much higher than their actual potential liability. People will always bring lawsuits, especially in the absence of other structures that are set up to care for children who suffer lifelong health problems. Ms. Fisch explained that the care for these children is a much larger problem than the Committee can solve.

She stated that malpractice liability arises if there is a relationship between parties (so the provider owes a duty of care to the patient), the provider breaches the duty to provide adequate care, the provider’s action caused an injury, and the patient suffered an injury resulting in damages. A subset of liability is vicarious liability: one provider is held responsible for the harm or damages that are caused by another provider. This requires a relationship between those two providers, usually one of employment or supervision; if you do not have a relationship, you do not have vicarious liability.

A corollary to that relationship is a compulsory collaborative relationship, which can create potential liability. Ms. Fisch explained that this involves a written collaboration agreement which details the responsibilities of the doctor and midwife and is signed by both parties. These agreements would join the doctor and midwife in liability. However, if the law required CPMs to enter into collaborative agreements

with doctors, but doctors refuse to enter into such agreements, then the CPMs would be shut out of practice. Ms. Fisch explained that this has happened in Delaware and California. In Delaware, there was only a single CPM who could get a collaborative agreement with a doctor, because she worked with the Amish population, who are unlikely to bring lawsuits. In California, CPMs were ignoring the law because they could not reach an agreement with any doctor. She also stated that she recognized that hospitals and doctors are unable to enter into such agreements because their liability insurance carriers will not permit them to do so. She noted that there is no research regarding the reasons that insurance carriers refuse to insure CPMs or doctors who collaborate with them, however there are insurance carriers in the country which insist that the midwives they insure only provide hospital care, rather than home births. She emphasized that no one is opposed to having inter professional relationships between doctors and CPMs, but they should not be made compulsory because licensure allows inter-professional relationships to flourish. Requiring collaboration will not make it happen, but licensure of CPMs will permit collaboration.

To avoid vicarious liability, one must ensure that there is no formal legal relationship between CPMs and other providers, and therefore a statutory protection from vicarious liability is then unnecessary. There are also additional defenses that providers can raise to protect themselves from liability, such as assumption of risk, comparative negligence, or lack of agency relationships. Regarding the assumption of risk, if a patient receives adequate informed consent, knows the risks and benefits, and chooses a riskier procedure than the physician recommends, the patient assumes the risk. The provider cannot be liable for damages if the patient assumes the risk, but this has to be defended and not settled. If a doctor or hospital uses these defenses, then they are protected from liability.

She explained that the problem with the liability language in the original draft of Senate Bill 1754 is that it potentially would make midwives accountable for potential negligence of other providers. Ms. Fisch stated that she drafted compromise language regarding this issue which states as follows:

An LCPM [Licensed Certified Professional Midwife] is not an agent, ostensible agent, or employee of a Health Care Practitioner (“HCP”) who is consulted with or who accepts a referral from the LCPM based solely on the consultation or referral.

If there is no agency relationship, there is no vicarious liability, and she noted that the proposed compromise language states that there is no agency relationship. In addition, she noted that midwives practice autonomously. If there is autonomous practice, then there is no agency relationship and that is supported by the US MERA, which is supported by ACOG and ACNMs. She maintained that the only thing that needed to be added to this language in the bill is substantial informed consent provisions, because that complies with case law which states that you cannot have vicarious liability if the patient does not have reason to believe that providers are holding themselves out as an agent of another, so it’s about the appearance of agency as well as the actual relationship.

Ms. Fisch explained that this was also supported by caselaw in the District of Columbia Appellate Court, in a case entitled *Gilbert v. Miodovnik*, 990 A.2d 983 (D.C. App. 2010). That matter involved a birth center and a transfer to a hospital. That case held that a consultation or referral could not create liability, and that the hospital was not liable for the patients’ injuries, except for injuries which happened after the patients’ transfers were complete. In response to doctor’s concerns about the removal of the vicarious

language from a proposed bill licensing CPMs, she responded that ACOG and similar groups should have discussions with malpractice carriers and risk management departments regarding what is necessary to protect mothers and babies and whether licensing home births midwives is really the problem.

Regarding professional liability insurance, Ms. Fisch stated that people believe that carrying liability insurance creates safety, but she does not agree with that belief. She believes that safety is created by credentialing and licensing of professional skills and expertise, transparency about these requirements through strong informed consent, and accountability through administrative disciplinary measures. She explained that sanctions can be levied against bad providers, including the removal of the person's license. On the other hand, Midwives' Model of Care is a reason that they have good outcomes because they care for fewer patients, which allows them to provide extensive and personalized care. However, this very model of care sets midwives up in an economic relationship where the cost of liability insurance can be prohibitive. Plus, that cost gets passed on to patients, which would increase the costs for home birth. When questioned about whether a hospital offers an inferior standard of care, Ms. Fisch explained that everyone is a product of their institutions and the structures that surround them, and the institutions encourage certain behaviors, such as limiting the time that a physician meets with patients. Ms. Fisch could not speak to who is a better practitioner but can speak about systems of care that force people to behave in certain ways.

Ms. Fisch stated that it was instructive to compare the requirement to obtain professional liability insurance ("PLI") with other medical professions in Illinois and laws regulating CPMs across the country. In Illinois, physicians are not required by law to obtain PLI, but often are required to obtain PLI by group practices and institutions. In addition, it is not required by law in 36 other states. Of the 35 states that currently license CPMs, only three require that they purchase PLI. Two of those states, Florida and Washington, were forced to enact joint underwriting agreements, where the States take care of the PLI, because private PLI was not feasible, and the third, Colorado decided not to enforce it because after 20 years the State believed that it was unnecessary and unworkable. She was also informed that Pennsylvania in some way subsidizes PLI. In addition, Indiana law requires PLI and then requires midwives to say whether or not they are carrying PLI, so there is statutory conflict.

She continued that PLI is unavailable to CPMs in states where they cannot be licensed, and once CPMs are licensed then insurance becomes available. Another option is that after licensing, CPMs may choose to join managed care groups or birth centers, which might require CPMs to acquire PLI, or CPMs may choose to obtain insurance themselves. She believed that the market will take care of this, and there is no reason to legislate this requirement. She also felt that if CPMs are required to acquire PLI by law, then there should be parity with other health care professions, in that they should be required to acquire the insurance as well.

Ms. Fisch stated that she is strongly in favor of requiring the disclosure of whether CPMs have PLI, because people who hire midwives have a right to know whether their CPM has acquired PLI or not. This position is supported by US MERA as well. The patients can then decide whether it is worth the additional cost of care. She explained that this is the choice that patients have to make on their own. Part of the low cost for midwives is that they are not paying large PLI premiums. Patients can decide about home birth based on: their own risks; what they think will happen; and their available resources.

Ms. Fisch concluded by stating that if there is going to be statutory provisions regarding liability, these provisions should reinforce the common law protections that already exist. She agreed with questioner that legislation should clearly explain that anything prior to the transfer of a mother to a hospital is the responsibility of the midwife, because everyone wants people to be liable for their own negligence and not someone else's negligence. In addition, Ms. Fisch stated that additional basis for liability should not be created through compulsory collaborative relationships. Statutes and rules should require only disclosure of insurance status, rather than requiring PLI, which she believes is the case for physicians in Illinois. She also recommended that policymakers should develop guidelines about the contact between midwives and the medical system, that is not an issue of liability, but about safe integration of systems. The goal should be to determine how this contact can be managed to protect the public. The interaction and transfer of patients between home births and hospital births should be designed to make it safer for the public, pursuant to safe transfer guidelines. Licensure would actually improve the midwives' relationships with hospitals.

Robert Minkus, MD

Dr. Minkus stated that of all of the Board-Certified pediatricians in the Chicago area, he is positive that he has seen more home births than anyone else. He said that he strongly supports the licensure of CPMs. He graduated from Northwestern University Medical School. He is a Board-Certified pediatrician with the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics and an Associate Professor of Clinical Pediatrics at what is now called the Feinberg School of Medicine (but used to be called Northwestern University Medical School). He has taught high level courses at the school for over 45 years. He said that his main credential was that he has been practicing pediatrician in private practice for 45 years. He is currently the senior physician for his group in the NorthShore University HealthSystem.

He initially became aware of, and interested in, home births in medical school. As a Northwestern University Medical School student, he had the amazing opportunity to work with midwives with the Chicago Maternity Center, which delivered babies all around Chicago. He saw the dramatic differences between hospital and home deliveries and believed that it was an epiphanal experience. His experiences in going with midwives to all of the home births taught him that babies are not born lethargic and blue in color like the babies born in hospitals. Most of the home births were actually beautifully controlled experiences without drugs.

Over his 45 years, he has had thousands of patients who have been born at home, and he feels that he has a deep insight into home birth and its implications. He has been continually impressed with the competence and professionalism of the midwives with whom he has shared patients. Continuity and communication between him and midwives have never been an issue. He has found that parents who chose the home birth option are not crazed, irresponsible flower children. On the contrary, he saw that they are almost always very well educated, thoughtful and well informed. They have chosen this unpopular option after very careful consideration.

He has always been impressed that properly done home birth is as least as safe as hospital deliveries. He stated that "properly done" means that: midwives have to be properly trained and equipped; pregnancy

needs to be properly and carefully monitored, so that any problems are appropriately treated and high-risk pregnancies can be selected out and diverted to a planned hospital deliveries; and lastly, labor needs to be properly screened so that developing problems can be treated, and if necessary, the mother will be expeditiously and efficiently transferred to a hospital for delivery. He noted that multiple studies around the world, including one published in 2005, in the British Medical Journal, have shown that competently attended midwife assisted home births are safe. Summarily, a large 2007 study analyzing midwife assisted home births in Washington State found them to be not only as safe as hospital births, but also showed that they generated huge cost savings to the State's Medicaid system.

He explained that the cost savings were why the United Kingdom has actively encouraged home births as part of their health system, and why home births account for a significant number of births in the Netherlands. It is also why the American Public Health Association has supported home births as an option and advocated in favor of licensure of CPMs. He believed that Illinois, which has not licensed midwives, is behind the other 35 states that have licensed them and noted that none of the 35 states or various nations have repealed laws that license CPMs, because they have been successful everywhere.

His peers would have you believe that home births are risky and hospital births are safe. He believes that this is untrue. Nothing in our world has zero risks, but there are significant risks inherent in hospital births that are completely lacking from home births, including hospital acquired infections, like Methicillin-resistant Staphylococcus Aureus ("MRSA") infections, which are not unusual in hospitals. These infections do not occur in home births. He also stated that hospitals have an unacceptably high rate of cesarean sections, which are often in the 30% to 40% range. He believed that this was enormously high, and well beyond the percentages in other countries. He stated that cesarean section is major surgery with many risks. The cesarean section rate for planned home births, including those that are transferred to a hospital is about one-tenth of the hospital rate. Also, hospital births commonly include multiple drugs which have side effects that sometime severely effect the mother or the baby and are drugs that are almost never used in home births.

Dr. Minkus stated that his peers would have the Committee believe that administering these standard drugs requires years and years of medical training. He believes that this is "nonsense." He provided an example of a mother who delivered in a hospital that received an epidural, and her daughter was born profoundly brain damaged from the birth. He said that it was something that could not happen in a home birth but was an avoidable complication of a hospital delivery. The story was provided to illustrate his position that hospital deliveries are not without their own unique risks.

He understood that there are "minor issues" involving liability that have to be resolved, but as a physician, he understands both sides of the controversy very well. He acknowledged that it was a very complicated issue, but he cautioned everyone about "going down that rabbit hole," and let the issue prevent the licensure of midwives because it would be a shortsighted tragedy. He explained that the prior bill should have been passed so that properly done home births could have been the norm. The bill mandated strict education and certification requirements to become a CPM. Regulated midwife assisted home births offer a financially attractive and safe birth option to countless thousands of Illinois residents, many of whom lack the insurance to afford the extremely expensive hospital deliveries or live in areas where providers are totally lacking. He fears that if another bill licensing CPMs fails, Illinois citizens will still avail

themselves of CPMs, but we will have passed up great opportunities to regulate them and ensure that these births are safe.

Dr. Minkus maintained that there are virtually no physicians and few CNMs in Illinois who assist home births. Well trained and regulated CPMs are the only alternative, because home births are the reality and they are here to stay. As a physician he has taken the Hippocratic Oath, which he believes is about one thing, which is to do the best for his patients. The Committee needs to do the right and ethical thing, by protecting patient safety, which trumps all other considerations. He asked the Committee to protect mothers and babies by recommending the licensure of CPMs and noted that to do otherwise is unconscionable. He added that this was literally a life or death issue.

Michelle Minikel, MD, MS

Dr. Minikel stated that she was asked just this week to testify to the Committee. She works in Wisconsin, where CPMs can be licensed and did not realize until last week that there were still states that did not license CPMs. She received her degree from University of California in San Francisco. It was a combined MD and Master's degree, with her Master's degree in Statistics in Epidemiology. She is also an Adjunct Medical Faculty for the Medical College of Wisconsin in Green Bay. In addition, she is a Family Doctor and Board-Certified in family medicine.

Dr. Minikel first learned about home birth when she became pregnant. She did not have any exposure to home birth during her medical training other than to be told that it was not safe. She described a traumatic event which she witnessed prior to her pregnancy which caused her to explore the possibility of home birth. Several of her colleagues had home births and they were resources for her. Also, having a Masters in Statistics, she needed to look at the literature regarding home births and researched the issue. Based on her research, she was convinced that it was equally safe for her to have a birth at home as compared to a hospital. So, she made that choice for a home birth, and had her second child at home as well. She believed that both of her home births were phenomenal experiences, because she had a known birth attendant at delivery, was in her own environment, and trusted that she was allowed to make her own decision about where to deliver her baby.

Dr. Minikel explained that she moved to Wisconsin four years ago, where she still practices obstetrics in a family medicine practice located in Green Bay. About three years ago she was approached by a CPM to be her collaborating physician to permit the CPM to acquire prescription medications that may be used in delivering babies, and she agreed to establish the relationship. She explained that in Wisconsin, a CPM needs a collaborating physician to sign-off on her standing prescription orders to ensure that the CPM can get medications that she uses with her protocols. The CPM is allowed to order and access all of the required medicines because of their collaboration. However, she did not have any other written collaborative agreement with the CPM. She also explained that Wisconsin is a state what has a limitation of liability in connection with an becoming a collaborating physician. Before Dr. Minikel agreed to the collaboration arrangement, she researched the issue of her liability from the CPM and was reassured that she would not be liable for anything that happens prior to any transfer to her.

She explained that so far it has been a great relationship. Based on her conversations with the CPM, Dr. Minikel has learned that it has become increasingly difficult for the CPM to obtain needed medication,

because most of the larger pharmaceutical companies require physicians to collaborate with a CPM to supply the necessary medications.

Dr. Minikel added that their collaboration goes much deeper than just providing medicine, in that the CPM will call her to discuss questions about prenatal issues from time to time. In addition, there are more urgent situations that come up, in which she felt that she was helpful in expediting the care of the expectant mothers and babies to achieve a successful outcome.

She mentioned that the CPM had one hospital transfer to her hospital that involved an obstructed labor, which ultimately had a great outcome. The CPM also had a neonatal transfer with respiratory distress, and she was able to expedite that, and everything went very smoothly. The child is doing great and continues to be one of her patients. Also, recently there was a preterm vaginal bleeding case and because of some of the factors in that case, she recommended that she transfer to an obstetrician-gynecologist and the transfer was made to the other doctor instead of her. She believed that in all of those cases, the CPM had the confidence that she could collaborate with who she needed to on a timely basis and that improved the outcome for all of those patients involved.

Dr. Minikel related that she did not know what it was like to work in a state without licensure of midwives, but at least for her, she feels that it has been a really healthy and beneficial relationship. She also said that she consults the CPM on some occasions, because she is an expert when it comes to complementary and alternative medicine. She explained that some of her patients are not interested in pharmaceutical options when they have various conditions, and she will often consult with the CPM with questions about herbal remedies for various ailments. She noted that the CPM has a wealth of information in that regard. She said that her collaboration with the CPM goes both ways for them.

Marilee Clausing, JD

Ms. Clausing explained that it was her hope to provide the Committee with a backdrop of the current obstetrical liability environment as the Committee considers its recommendations. She has been a defense medical malpractice attorney for 34 years. Prior to that she worked as an obstetrical labor delivery nurse caring for patients in the hospital setting. She went to DePaul Law School, and her undergraduate education was at Marquette. She is currently the Managing Partner of Hall Prangle & Schoonveld, LLC, which is a defense firm that is dedicated primarily to the defense of health care providers in different kinds of cases. Her personal background has made her focus primarily on obstetrical cases. She noted that obstetrical cases form the majority of the lawsuits which she handles, and the individuals that she represents. She stated that she represented hospitals, obstetricians, midwives and doulas. Most of her cases involve obstetrical situations that arise at the hospital, although there have been cases involving failed home births that present later to the hospital.

Ms. Clausing stated that the number of filings in the obstetrical arena, as well as the medical malpractice arena generally, is basically flat. However, she explained that what is striking, and undeniable, is that in these cases the severity of the verdicts, and the settlements that go along with the verdicts, have increased in amount. She explained that there are significant key trends involving health care liability claims. She said that the average claim severity continues an upward trend, with some jurisdictions seeing a significant increase in severity. Regarding Illinois, as a jurisdiction, the overall claim severity is higher than the

national average, and the Chicago area, including its collar counties, consistently has two to three times the national average loss cost, which means that the indemnity dollars paid, whether in settlement or in a judgment if the case goes to verdict, combined with the costs associated with those cases, are significantly high.

Another trend that she discussed was that claim costs are rising as the severity of the cases rise, which she said makes sense because the defense bar needs to defend them with greater intensity by retaining additional numbers of expert witnesses. She also noted that some of the cases are very broad in their scope and depth and, as a result, the kinds of costs and expenses that go into these cases are substantial. As a result, in Illinois the total payments, whether paid in settlement or judgment, for 2018 were over \$204 million.

Ms. Clausen then discussed a recent survey completed by the U.S. Chamber of Commerce Institute for Legal Reform, entitled the “Lawsuit Climate Survey,” from 2019, which found that out of all 50 states, Illinois ranks number 50, meaning it was the most unreasonable and problematic litigation environment for these cases.¹⁴ The respondents identified two Illinois counties ranked in about the top half dozen counties that are the most problematic, and those were Cook County and Madison County. She said that they were considered to have the least fair and reasonable litigation environments in the entire country. Ms. Clausen explained that the report arrived at the states’ ranking of the states by surveying all participants on the following ten elements: enforcing meaningful venue requirements; overall treatment of tort and contract litigation; treatment of class action suits and mass consolidation suits (she noted that this element does not apply to the kind of cases that she is discussing); damages; proportional discovery; scientific and technical evidence; trial judges’ impartiality; trial judges’ competence; juries’ fairness; and the quality of the appellate review.

Ms. Clausen then discussed three particular verdicts. The largest verdict was approximately \$53 million for a brain damaged infant who had cerebral palsy. The second largest was a \$50,300,000 verdict for cerebral palsy and the last verdict was for \$23,138,380, again for cerebral palsy. She said that these are examples of the kinds of verdicts that she is seeing in obstetrical negligence cases. She also noted that these occurred between 2016 and 2018. She acknowledged that these matters all involved hospital births, rather than home births, and that there were no reported verdicts that involved a failed home births in Illinois. However, there was one instance of a failed home birth which ended up at the hospital. She also made a personal observation that these kinds of remarkable verdicts are similar to the verdicts over the last several years, as the size of the verdicts trends upwards in terms of case severity and the kinds of damages that are sought. She explained that the point of discussing verdicts against hospitals is to show the significant dollar value associated with obstetrical litigation where the choice is made to take the case into the court room.

Ms. Clausen noted that these kinds of verdicts cause fears that if an obstetrical provider or a hospital takes a case into the court room that these are potentially the kinds of verdicts that can result. She said what

¹⁴ According to the report, the “participants in the survey were comprised of a national sample of 1,307 in-house general counsel, senior litigators or attorneys, and other senior executives at companies with at least \$100 million in annual revenue who indicated they: (1) are knowledgeable about litigation matters; and (2) have first hand, recent litigation experience within the last five years in each state they evaluate.” U.S. Chamber, of Institute for Legal Reform, *2019 Lawsuit Climate Survey, Ranking the States*, at 3 (September 2019).

follows from the trending verdicts are the settlements, which we see in Illinois. The largest settlement that she could locate in her research is a \$35 million settlement in an obstetrical case. She listed various other settlements that have occurred over the last five years and noted a trend that the amounts of the verdicts are customarily in the eight-figures. She stated that it was her observation, which the Verdict Report would show, that reaching an obstetrical settlement in seven-figures is unusual. For most of the cases, the plaintiff's attorneys are holding out for an eight-figure settlement. She noted that there were a number of settlements in the \$15 million range, which is being sought even in a case where the defendants have a causation defense, which means that the injury was not caused by the obstetrical provider's care based on the opinion of the defense and defense experts. She said that what these results reflect is if a hospital or provider wants to settle their portion of an obstetrical negligence case, it is increasingly costing these kinds of dollar amounts, even if there is brief involvement in the patient's care and there is a viable causation defense. Ms. Clausing stated that was because of the concern about bringing the case into the court room and potentially being assessed a verdict that is substantially in excess of those kinds of settlement numbers. She was asked whether a system of home birth midwife licensure could actually reduce the liability and exposure of the hospitals and physicians, and responded "no," because in her 34 years of practicing this type of litigation, she has never seen the dollar amounts of verdicts or settlements go down. She also admitted that she was unaware of any Illinois cases involving CPMs which caused physicians or hospitals to pay more in a verdict or settlement.

In response to a question, Ms. Clausing explained that she was only discussing the litigation environment at the current time and not whether she is in favor or opposed to the licensure of CPMs. She stated that her point was that when a home birth fails, and some do fail, the patient has to be brought to the hospital, causing the patient to be a hospital patient, and there may be a problem for the hospital to treat that patient. She added that the need for the hospital to act quickly in response to the unknown patient increases the potential liability exposure once the patient arrives at the hospital. To illustrate, she explained the details of a planned home birth, which required a transport to the hospital, that was settled for \$35 million with the hospital-based healthcare providers shouldering all of the child's damages based solely on their relatively brief management of the patient.

Karen K. Harris, JD

Ms. Harris focused her comments on liability issues related to CPMs and home births. She noted that of states that license CPMs, only three require professional liability insurance, which are Alabama, Florida and Colorado. She said that her research showed that the minimum limits for professional liability insurance were \$100,000 for each incident and \$300,000 in the aggregate. Moreover, it sounded like two of the states are subsidizing the insurance pool, and the other has abandoned the requirement to purchase insurance because it is not feasible. She noted that given the Illinois verdicts and settlements described by Ms. Clausing, professional liability insurance with these limits, would not even be a drop in the bucket compared to the potential liability. She stated that whether the Committee decides to require midwives to obtain professional liability insurance or not, the amount of coverage from that insurance would be very low or even insignificant based on the verdicts and settlements involved in these types of cases against hospitals, physicians or CNMs. She noted that she mentioned this to put the benefits of requiring CPMs to purchase insurance in perspective.

She then noted that 16 states require that midwives disclose whether they have professional liability insurance as part of their laws requiring informed consent. Ms. Harris believed that if the Committee decides not to mandate midwives to purchase professional liability insurance, then the Committee should require such disclosure as part of informed consent, so that patients know the amount of professional liability insurance that is potentially available because it is an important consideration. She also believed that the notifications in the informed consent should include a specific statement that the CPM is responsible for the care which he or she provides and not the responsibility of another provider whether that is a hospital or obstetrician, unless they are providing the care. She said that it is important to make a clear distinction when liability attaches and when it does not.

Ms. Harris also found that 21 states that license midwives have some form of liability immunity provision. The states vary how it is written, but they all say that health care providers, whether they are obstetricians, hospitals or emergency technicians, are not responsible for any actions, except for their own. She believes that this is all that the Hospital Association and the physicians are asking for in this matter. She summarized that if the injury is the hospital's or the physician's responsibility, then it should be their liability; if the injury did not come from care that they provided then the hospital or physician should not be liable for the injury. She believes that this is the crux of the matter on this issue and is the hospital's main concern. She wanted to make sure that there are adequate remedies for when something does happen. Otherwise, you have a family, a mother and child who do not have any resources after a negative outcome. She said that her Association does not believe that the financial burden of a negative outcome should fall solely on the hospital, if the hospital was not the cause of the negative outcome. However, she explained that the financial burden will fall on hospitals because they are the deep pockets, unless it is very clearly spelled out in the legislation who is liable and when liability attaches.

In closing, Ms. Harris stated that if the Committee ultimately reaches the conclusion that CPMs should not be legislatively required to purchase professional liability insurance, then other provisions in a proposed bill become more essential. For example, the proposed legislation should require informed consent language to inform patients that the CPMs do, or do not, have professional liability insurance. She added that when a bad outcome happens, and a life plan, which will cost a minimum of \$40 million is necessary for a disabled child, the mother will still sue despite the fact that the mother signed the consent stating that there is no coverage, because the mother needs the money to take care of her child. That is why it becomes even more essential that language is placed in the legislation to specify very clearly when liability attaches for each parties' action. For midwives, it should be their responsibility before coming to a hospital or before the patient is seen by a doctor. When it is the physician's or the hospital's responsibility, they should take that responsibility.

Antonio Romanucci, JD

Mr. Romanucci stated that he is a practicing attorney in Chicago. His law firm, Romanucci and Blandin, LLC, handle cases of medical malpractice. He has been a practicing attorney for 34 years, after graduating from University of Wisconsin at Madison and John Marshall Law School. He started his career as a Cook County Public Defender. He is also President of the Illinois Trial Lawyers Association ("ITLA") and is speaking on behalf of the more than 2,000 members of the ITLA and more importantly the victims that they represent.

He initially noted regarding a study about the fairness of the judicial system, that if it was truly unfair and unreasonable to both sides, then it would be a fair study because that is how you reach a settlement, when both sides are not happy with the result. He explained that the reason that there are such high numbers in verdicts for obstetrics cases is very simple, those cases typically involve catastrophic injuries. He said that when discussing catastrophic cases, he means that they involve harms or losses to a baby which were caused by doctors or hospitals that are in the millions of dollars, or some in the tens of millions of dollars. Typically, these resolutions involve a “life care plan,” associated with a catastrophic injury, which would provide care for the life of a child, even if the child has a normal life expectancy. He explained that it was not that the numbers were artificially inflated, but the numbers are based on empirical data. Also, life care plans are approved by a life care planner and a doctor, they are reviewed and there is data to support the amounts. He stated that Illinois is not unique in that any state that allows a consideration of economic damages for negligence, torts or medical malpractice will have verdicts with similarly large dollar amounts.

Mr. Romanucci addressed the preservation of victims’ rights and raised his concern that it was incumbent on the Committee to ensure that any law passed provides protections for victims of negligence. In this context, he is focused on ensuring justice for mothers and babies that may have become victims during maternal care or delivery. He explained that the unfortunate reality is that adverse outcomes for mothers and babies occur and will continue to occur in the future. He described his job as ensuring that victims of adverse outcomes resulting from the negligence of health care providers have access to justice in Illinois courts, as guaranteed under the Seventh Amendment of the United States’ Constitution.

He noted that health care professionals have referenced their concerns relative to liability, if the General Assembly creates a pathway for licensure for midwives. In sharing their concerns, those health care professionals alluded to proposed language which contemplates vicarious liability. He said that he has read the language of those proposals, and it creates a clear departure from the status of current law relative to victims’ rights. This language proposes to create an immunity from liability for providers of care and creates a fire wall between providers and patients with whom they consult. He believed that the language contained in the proposed bill was unduly restrictive, and it unnecessarily exculpated the wrongs of care managed by more than one individual. He added that Illinois currently has comparative fault, under which fault can be attributed by percentages, and the ITLA wants to ensure that this process is not taken away. He explained that if you look at the draft bill, it clearly states either “shall not” or “will not” be liable. He noted that it is now rare that care in any circumstance is managed by just one health care professional, but rather it is managed by teams. It would naturally follow that harms are not always caused merely by one, but by teams. He explained that fault could lie with more than one individual, but the language of the previously proposed bill could shield providers from negligence claims made by mothers and babies who were injured through no fault of their own. He added that no such language exists for other providers’ negligence under Illinois law.

Mr. Romanucci noted that Ms. Harris provided a slide regarding the dollar amounts of PLI that some states required CPMs to maintain, which was startling to him. He explained that insurance amounts of \$100,000 per occurrence, and \$300,000 aggregate is considered low in the auto litigation arena because of the seriousness of injuries which could occur. When talking about CPMs and the potential for catastrophic consequences of injury, compared to the low coupon value of insurance, he believed that it does not make sense to only require such low levels of PLI compared to the potential costs of negligence in regard to a

birth. Typically, physicians purchase higher dollar amounts of PLI because they have more to lose from a negligence lawsuit. Doctors maintain practices, they earn money, they save money, and as a result of that they typically do get PLI. The typical amount of the insurance by a doctor is \$1 million, but sometimes a doctor would have \$2 million in insurance, while in rare cases it is \$5 million in insurance. He noted that these amounts do not satisfy the numbers involved in verdicts and settlements for cases involving catastrophic injuries, but in some circumstances that insurance is enough. Regarding CPMs, if something goes wrong with the birth of a baby, the chances of catastrophic injury increases proportionately based on the extent of the injury.

Regarding a requirement that CPMs obtain an informed consent form from the mother which states that she understands that the CPM does not maintain PLI, Mr. Romanucci stated that he does not like the issue that the mother can assume the risks for her and her unborn child. He explained that when he thinks of the “assumption of risk,” he thinks of an example of a person doing something clearly risky, like jumping on a scooter without a helmet. However, when a mother is giving birth to a child, she has an expectation in dealing with her midwife, doctor, hospital or nurse practitioner that the she and her child will be safe, and the child will be born without injury to the mother or child. Regarding the assumption of risk because the CPM has no PLI, Mr. Romanucci stated that he is in favor of informed consent. However, he believed that the Committee has to weigh the issue of whether the tax payers would be willing to accept the costs of a life care plan for the child if something should go wrong during the birth. He acknowledged that tax payers could assume the risk of injury when an unlicensed midwife leaves a family which had a birth event at a hospital’s ER door.

Mr. Romanucci concluded that there has to be a consensus regarding just, fair and legal language for a bill that would approve licensure of CPMs. He stated that he believed that additional work was necessary to reach a consensus on the language contained in a proposed bill regarding liability. He also believed that CPMs do, and should, play a role in assisting home births in Illinois. The parties just have to determine what language would be acceptable to everyone.

Darren Covington, JD

Darren Covington, the Director of the Medical Licensing Board for the State of Indiana, spoke with the Committee about Indiana’s experiences in licensing and regulating Certified Direct Entry Midwives (“CDEMs”). Initially he gave some history regarding midwives’ path to licensure in Indiana. Since the 1980s, midwives sought licensure, but their efforts were met with strong opposition from physicians and others within the Indiana General Assembly. It was not until 2013, after about 20 years of lobbying, that a bill was finally introduced that allowed CPMs to become licensed.

The Act permitting licensure imposed a number of limits and restrictions. Indiana’s law contains stricter requirements on midwives than most other states laws and regulations. The Act was effective in 2013, but CDEMs quickly realized a problem with the legislation. The law required that CDEMs reach a collaboration agreement with physicians before they can become licensed. CDEMs were having trouble finding physicians who were willing to collaborate with them. The primary reasons for this related to malpractice issue, since physicians were being told by their malpractice carriers that their premiums would increase (in some cases the premium would quadruple), if they collaborated with CDEMs. Also, the State’s

largest health system told its physicians that they were not permitted to collaborate with midwives. This was a huge challenge for the licensure of CDEMs.

As a result in 2015, the legislature added specific language to the Act, which stated physicians who collaborated with midwives were immune from certain civil lawsuits in order to alleviate physician's concerns about collaborating with midwives. The new language expressly stated that except in cases of willful misconduct or gross negligence, physicians could not be held liable for collaboration with CDEMs. He stated that the language was intended to address the concerns of the malpractice carriers and health systems in Indiana. However, Indiana University, the largest health care system in Indiana, informed their many providers that they are not permitted to collaborate with a CDEM. He speculated that Indiana University's decision was based on liability concerns. He also noted that he is not seeing an increase in physicians who are willing to collaborate, in that there remains only a handful of physicians who are willing to collaborate and utilize midwives as a part of their practice.

Mr. Covington then stated that after the amendment to the Act, the Medical Licensing Board began working on rules, which were completed in 2017, and licensing began shortly thereafter. Indiana currently has fourteen CDEMs who hold an active license in the state. The Annual CDEM Report for the reporting period of January 1 to December 31, 2018 stated that there were 300 total live births, and no still births or maternal deaths. The Report showed that in 2018 there were two emergency intrapartum transports, four emergency postpartum transports and three emergency newborn transports. Currently, the key barrier to CDEMs getting a license remains the collaboration requirement, due to a reluctance of physicians to enter into the agreements, and the geographical limitations on those physicians who are willing to collaborate. Mr. Covington explained that CDEMs are prohibited from having privileges in hospitals, so they are not able to assist with deliveries in a hospital. These are the reasons that there were so few CDEMs who are currently licensed in Indiana. However, he noted that there are a few birthing centers at various locations in Indiana, and there are physicians who collaborate with CDEMs at those locations so the CDEMs can become licensed to work at those locations.

Mr. Covington stated that he did not believe that the requirement that CDEMs maintain PLI was a barrier to the licensure of CDEMs. He explained that there was quite a bit of discussion about the requirement that CDEMs obtain malpractice insurance while the rules were being drafted. He noted that the Medical Licensing Board determined that there are policies available to midwives for purchase and that the minimum insurance policy amounts of \$100,000 per incident and \$300,000 aggregate were appropriate. The Board believed that these minimums were the most accessible for midwives to obtain. Mr. Covington stated that the only other professionals in Indiana that are required licensees to carry malpractice insurance by law were podiatrists and massage therapists.

Mr. Covington suspected that there are many midwives still practicing in Indiana without a license for various reasons. He noted that Indiana has a large Amish population who operate within their own system and do not want the assistance from the State. They may use unlicensed midwives, both within and without the Amish community to assist home births. He explained that his office has not received a complaint from anyone in that community, but if they did it would be treated in the same manner as other complaints received by his office. In addition, there are some midwives who are philosophically opposed to licensure and do not believe licensure is necessary. They believe that the arrangement is an agreement between the midwife and the mother, and the State should not be involved. Other midwives would like to be licensed but cannot find a collaborating physician. In addition, there are midwives who have been

performing midwifery services, but do not meet the education requirements. He noted that when the law was first enacted there was a grandfathering provision that allowed an applicant to substitute experience for education, but that provision was opened only for about a year and is now closed, so now applicants must have at least an Associate's Degree in Midwifery, but a lot of midwives do not meet that educational requirement and did not apply for a license based upon experience.

Mr. Covington stated that his office does not typically pursue actions against unlicensed practice of CDEMs, unless there is a bad outcome or death from a home birth. Practicing without a license can subject a person to both civil and criminal action. He stated that generally, county prosecutors will not pursue a criminal case unless there has been some harmful event, such as a death of a mother or infant. He also cautioned that largely his Department does not have the resources or investigators to search for unlicensed midwives and will not know who is practicing as a midwife without a license until someone complains. Enforcement actions are all complaint driven. The Medical Licensing Board has so far issued one cease and desist order against an unlicensed midwife in northwest Indiana.

Theresa Hubka, MD

Dr. Theresa Hubka stated that she was speaking on behalf of herself and the Illinois Osteopathic Medical Society ("IOMS"). She is an obstetrician/gynecologist, and has received 12 years of training with college, medical school, and four years of residency. She has also taken licensing boards and state medical exams to keep her training up to date. She has had 25 years of experience in obstetrics and gynecology as a sole private practitioner in Chicago. She is also on the Board of Trustees in the American Osteopathic Association, the Illinois Osteopathic Medical Society, as well as the board of the American Osteopathic College of Obstetricians and Gynecologists. She has had many deliveries all in the hospital throughout the years.

Dr. Hubka explained that she has wonderful friends in the midwifery community, but that she has experienced some sad cases where patients were handed off to her without collaboration. These instances involve planned home births, but she received the expectant mothers who were already in labor because she was the doctor on call for the hospital at the time. She described two instances where a mother having a planned home birth was transported to the hospital ER, but she did not know if the mothers were being assisted by a CPM or a lay midwife. Also, she said that she was not given the midwives' names, or any medical records showing the mothers' previous care to let her know if the mothers have received any standardized Group B Strep testing, an ultra sound or other testing. Dr. Hubka admitted that it would be beneficial if CPMs were licensed, and they would inform hospitals of their certification and provide the mother's medical records of tests and ultrasounds.

She said that some of the most significant health issues involving home birth derive from no collaboration between the midwife and physician and differences in the educational backgrounds of doctors CNMs and CPMs. Dr. Hubka explained that she trains medical students on obstetrics/gynecology which consists of a six-week rotation, where the students work approximately 80 hours a week, just like physicians, and attend five to ten deliveries. After the rotation, Dr. Hubka asks all of the students if they would be willing to do a home birth, and they all respond "no," because they are nervous. She also stated that CNMs who train in university settings or in educational programs and then are licensed, as well as work in the hospitals or birth centers, do a very good job. She believed that CNMs follow protocol and guidelines, while CPMs are not aware of these which is a reason that physicians do not collaborate with CPMs. She explained that

education and experience are more important for CPMs than a collaborative agreement because the training is necessary for them to be able to respond appropriately in an emergency with a delivery.

Dr. Hubka stated that training for CPMs is not as rigorous as it is for physicians. She explained that she has a dear friend who is a CPM who has worked all over the world doing home births. In areas that have no access, using a CPM is better than nothing. She is very skilled and trained and has experience, which CPMs do not have. She is concerned about the safety of the patients. In addition, she believed that most of the CPMs in Illinois practice in Chicagoland area. Therefore, she did not believe that the issue was a lack of access to safe assistance in birthing, but more so simply the mother's choice to have a home birth. If it was an issue about access to safe births in Chicago hospitals, she would understand the need for CPMs. As there is access to safe births in Chicago, there is no need to license CPMs. Regarding the cost of giving birth in a hospital, she understood hospital bills for a birth are expensive, but noted that midwives also charged \$4,000 for a patient's delivery in one instance, and that she and the hospitals sometime provide reduced charges for low income patients.

When questioned about home births in rural areas of Illinois, Dr. Hubka explained that she understood mothers in rural area have less access and less backup, which is a concern. When comparing no birth assistance to a CPMs birth assistance, she would absolutely say an expectant mother needs some assistance to have a safe birth. She stated that it cannot be just one individual, but at a minimum, there should be one individual aiding the mom and one individual aiding the baby. She also raised a concern about the Amish community, but noted that was the practice in that community, as it is a low access area. If the State was going to begin licensing CPMs, she suggested that it needs to support the mothers in that community to assist in their births. She stated that the State would have to do more to educate and train with CPMs, so they can effectively respond to events. Some of the issues that can arise are postpartum hemorrhage, and CPMs must know how to treat that issue. Other issues that may arise could be resolved with medications, as CPMs do not have a Drug Enforcement Authority license to dispense medications, which was also a problem.

Dr. Hubka stated that she has collaborated with midwives in the past. She explained that while she has never delivered a baby for the midwives, she has been collaborative with them in communication and reviewed their charts when they worked in the hospital system. To her, a formal collaboration agreement would mean that she knows the midwife and her practice style and was comfortable with that style. An informal collaboration agreement would mean certain guidelines exist and the midwife is geographically a great distance away. Dr. Hubka viewed collaboration as a plan of action, in that if the midwife was to do the home birth and something went wrong, the next steps are clearly established with safety of both the mother and the baby being the foremost concern. She explained that the plan of action would not just to call the EMS at the last minute to send the patient to the ER, but something much more detailed. She thought that the best care for the patients was when there is close collaboration between the midwife and the physician, because the process seems to work better.

Dr. Hubka explained that she would not be able to collaborate with midwives for various reasons. Liability issues are one barrier to entering into a collaboration agreement, because Illinois is a very litigious state. She explained that she knows that births can be the non-risk, low-risk, but also unpredictable. Another reason is that she has a solo practice, so she would not be able to take on CPMs' births because she would want to be there at the delivery.

Regarding potentially risky pregnancies, Dr. Hubka stated that she believed ACOG had put together risk profiles for patients, with areas that doctors think a home birth is on average common standard births. She noted that presumably the mothers with risky births would “risk out,” in that the mothers would not be allowed to have a home birth. She said that low-risk births are often someone that has previously had a child in a hospital, therefore they know what birth is about and they have a proven pelvis. For those patients there are no risks for shoulder dystocia or something unpredictable. Also, the patients need to have no prior caesarean section. However, the mothers who are experiencing their first birth are the tough patients to determine if they could have a risky delivery. Someone might be healthy during pregnancy, but still experience a postpartum hemorrhage. As far as a written collaboration, if there is going to be a one-on-one CPM and physician collaboration she also felt that the nearest hospital should be notified about the birth. If a CPM had to transfer a patient, then the hospital would know that the patient might have to be transferred.

She understood that everyone wants the patients to have the ability to have access to good and safe care for both babies and mothers, but she believes that those performing home deliveries and hospitals have to have an agreement that safety of the mother and baby is the most important consideration. However, she believes that they have two patients who they are treating, the mother and child. While she acknowledged that a mother has a choice about the location of the delivery of her child, she believes that a mother’s “risking out” is an important factor to require that the birth occur in a hospital. However, she thinks that as Illinois is such a litigious state, it makes it difficult because doctors are asked to perform treatment after the mother started labor at home with a midwife.

Mary Sommers, CPM

Mary Sommers stated that she is the Director of Birth Center Operations and the Maternal Child Health Program at PCC Wellness (“Birth Center”), the site of the first free standing birth center in the State. She was not representing the Birth Center, but only representing herself. She is a CPM, and has been an urban midwife, so she did not address the issues facing rural mothers. She is also licensed as a CPM in Wisconsin, where she worked at the first accredited birth center in Wisconsin. She was a World Health Organization (“WHO”) fellow and has an app on maternity care that is accessible in every country of the world, but Greenland, and has worked with programs in Mexico. She has been part of about 1,800 births and she also has conducted mother and maternity programs.

She wanted to explain to the Committee that there is actually a lot of common ground regarding midwives and other medical professionals. Her focus was on Medicaid and urban health. She explained that if the State took advantage of the great structures that are available in Illinois and Chicago, it could provide very positive results. In fact, the Birth Center has been called “a positive deviant,” by a Boston University doctorate student. When talking about the future of health care, she suggested that the Committee look to people who are doing things that seem impossible.

She maintained that the reason that licensure has not been approved for CPMs is that they have been marginalized for so long that they do not know the players and the inside game. In her case, it was not hard to find collaborative care because people know her, and she is part of the health system. When a person is in the system, they can make bridges for more within the system. Her first plea was that part of the problem is that CPMs are not regulated or licensed. There are always going to be renegade midwives,

and her observations have shown her that over time, renegade midwives disappear because the average consumer does not want to use them.

Ms. Sommers stated that even though she is a CPM, she cannot act as a primary midwife. However, she is fine with that because she gets to participate in Morbidity and Mortality Reviews, Grand Rounds teaching and all of the regulatory learning processes. If you just license midwives and did not consider a system of collaboration, the State would be like Indiana with few home births. Also, because approximately 50% of the people who give births are on Medicaid, it shows that CPMs have not championed that fact to support licensure across the nation. Even in states like Florida with 35 birth centers do not have relationships with Federal Qualified Health Centers (“FQHCs”), because they were not set up that way. Where FQHCs are structured with CPMs, it resolves issues involving collaboration, malpractice, the community base. In addition, there are 500 FQHCs across the nation. She explained that she was not saying this was the only way to structure health care, but her point was that there are other ways to consider problems involving health care.

She also noted there are a large number of CPMs in Chicago, where there are high rates of women on Medicaid. The Birth Center assists women from 42 different neighborhoods in Chicago and 54 municipalities, which shows that a lot of people want out-of-hospital births. These women drive from all over to come to the Birth Center. What she likes about the Birth Center’s structure is that they transport into themselves when problems arise. That is very much how all systems should work. There are problems when you are spreading yourself thin, but if you have these collaborations all around these problems do not arise.

Her past experiences have shown that there can be an effective collaborative model between CPMs and other health care providers. She explained that if there is a collaborative model, the parties will risk better and have better outcomes. She described her experience while she worked at Mercy Hospital with Dr. Wolfe. The patients received their care at the clinic, but the care was no different from woman having a hospital birth. The protocols were the same for the clinic and the hospital. She said that the physicians had final say on who the midwives could accept or not, but that was how it should have been because the patient may have to be transferred to a physician if an event occurred. Then, if a patient chose a home birth, she would be seen by the midwives. The teams at the clinic were made up of a CNM with a CPM, which was very common for community health. While CNMs who served in private hospitals did not care about Medicaid patients, CNMs who served in community health centers did care about women on Medicaid. That was the model of care. If the midwives saw a mother was deviating from the normal birth process, then the patient would be taken to the hospital. However, the hospital would already know the mother and have her medical records. Moreover, the CNM would be collaborating with the obstetrician/gynecologist on call. She felt that this system is most effective in producing good outcomes. While the transfer birth can be difficult, if you can trust your colleagues to follow a protocol then it is easier. Also, she noted that if someone did not follow a protocol, the committee would learn out about that. This way there was no one who did not know what was occurring. She explained that there were also discussions about how the process could be improved, in that quality control was always raised. Ms. Sommers believed that this process made her a better midwife, because of the access to the information and the feedback that she received. She explained that for the safety of patients, collaborative care was necessary. However, the first requirement is to license CPMs, because the biggest obstacle to collaboration is not having licensure.

Ms. Sommers further explained that if there is no licensure, CPMs are excluded from education and process opportunities. She explained that failing to provide licensure for CPMs honors the renegade midwife because the renegade midwife never wants to be regulated. Without licensure CPMs also do not know others in the health care professions, so they will not know how to ask for help which hurts patient safety.

She thought that there are a lot of jobs performed by nurses that CPMs would be better qualified. For example, the Mayor has expressed a desire to start postpartum home visit and will be hiring a lot of brand-new graduates for those positions. She asked whether it would be better if CPMs or community doulas could move up to a CPMs role to make these visits. That is part of the health care structure, and she is looking at home births to find better ways to practicing by embedding them into the systems. It is a win-win.

Regarding medication, Ms. Sommers stated that there is a scope of practice that would need to be written and there are standing orders than could exists if considering education levels, risks, and so forth. If you consider a patient that has diabetes you would likely need a CNM. However, if you consider a normal home birth, there is a possibility of a hemorrhage. It would be better if the CPM would have the medicines to administered in the appropriate manner which is no different from the standard National Resuscitation Program (“NRP”). The Birth Center is regulated by the state, as a national birth center, as a FQHC, the joint commission and a number of examiners ensure that it is properly doing its job. Something that CPMs need to give up is that they need to agree to some regulation. She thought that the good CPMs would welcome the regulation. However, when people are marginalized, and she sees this all across the world, they are afraid to pass over that bridge. She explained that barriers have to be broken down and the first step would be the licensure of CPMs with the MECA accreditation with the scope of practice.

Ms. Sommers also argued that CNMs alone could not solve the home birth maternity care crisis. She explained CNMs are not knocking on her Birth Center’s doors to work there because hospitals can be more accommodating with CNMs work schedules. CNMs can also retreat to academia by working for a doctorate, but she said that some of those getting in the school for doctorates are entering the school with never assisting any deliveries. These CNMs are looking at birth very academically, whereas some CPMs will graduate with over 100 births under their belt. She then discussed an analogy involving a friend who was the Chief of a Fire Department. She explained that he told her that the Department started hiring applicants with Bachelors and Masters Degrees, and they understood the science of fire, but at the end of the day the Fire Department needed people who were willing to run into the fire. Physicians keep thinking the answer is CNMs and the truth is there is a limited amount of people willing to go to work in the needy communities or in an out-of-hospital setting. She stated that CPMs need to build that desire in the people who are from those poor communities and are willing to run into the fire and help the mothers and babies in those communities. It is not a glamorous job, because they have to go into the community in the middle of the night and assist in the births. While some CNMs are willing to do more, many of them are not willing to make these kinds of sacrifices. Again, this all starts with the licensure of CPMs.

She believes that everyone would agree that midwives want education and collaboration. She noted that in the past there has been a polarization among the parties, but also thinks that everyone is now at the same table. There may be a plan that people can agree with, but all of the parties should review the structures that Illinois has and use these to work toward everyone’s benefit. She said the State should focus on the urban Medicaid woman who wants to stay in her community. The State should actually educate and train

more midwives of color, which is something that both CNMs and CPMs have failed to accomplish. That is because a number of them have been outside the system for so long they do not care about Medicaid, and it is not on their priority list. She said that she has been in community health and a CPM in a State that does not recognize her licensure, which is alright if it means that she is moving forward. However, she wants to make more types of her that are licensed and legal and use existing structures to provide more assistance to the people of Illinois.

Ms. Sommers summarized that the first step is to license CPMs so that they can help in a number of ways to Illinois' mothers. For example, they can not only help with home births, but they can also be part of FQHC systems, provide additional care to high-risk births and aid mothers, by providing nutritional counseling or home visits. She also emphasized that it is impossible to know the other ways that CPMs could provide assistance until they can be licensed.

Report by the Illinois Department of Financial and Professional Regulation

In response to questions raised by Committee Members, the Department presented a memorandum to the Committee. The Memorandum informed the Committee that the search of its records showed that the Department has received only a single complaint involving unlicensed midwives since January 1, 2016. This complaint involved an individual holding herself out as a midwife without being licensed and possibly without receiving a certification as a professional midwife.

The Department was also asked to estimate the number of individuals who may become licensed as CPMs in Illinois, if the State permitted licensure. In this regard Rachel Wickersham informed the Department that there are currently 22 CPMs who live in Illinois, and another 10 individuals who will likely finish school and pass the credentialing exam in the next two to three years. She also added that the surrounding states of Wisconsin, Indiana, Iowa, Missouri and Kentucky currently license CPMs and some of these CPMs will seek licensure in Illinois. Ms. Wickersham estimated that there would be two to three individuals from these states who choose to become licensed in Illinois. Based on this information, the Department estimated that over the next three to five years there would be approximately 40 to 50 CPMs who would become licensed to practice in Illinois, if licensure became available. For comparison purposes, as of October 18, 2019, there were 523 Certified Nurse Midwives licensed in Illinois, and the number of CPMs that were licensed in other states ranged from one in Delaware to 483 in California.

The Department was also requested to estimate the expected costs for the licensure and regulation of midwives in Illinois. As way of background, the cost to the State for licensure and regulation is passed on to licensees as their license fees. To an extent, the costs to the State would depend on whether any proposed legislation would establish a new board for the regulation of CPMs, or if the CPMs would be regulated under the existing Nursing Board, with a CPM providing advice to the Nursing Board. In addition, the license fee assessed on CPMs would depend on the population of licensees. To address this variable, the estimated license fee per CPM was calculated on the basis of 50 licensees, and then on the basis of 100 licensees. The calculations, which are attached, show that the estimated annual fee for 50 CPMs with a CPM Board would be \$3,842.14, while the estimated annual fee for 50 CPMs using the Nursing Board would be \$3,442.14. Calculations based on the assumption that there would be 100 CPMs, show that the estimated annual fee with a CPM Board would be \$1,921.07, and the annual fee using the Nursing Board would be \$1,721.07.

Committee's Recommendations

The Committee, by a unanimous vote of the persons who were present (with two abstentions),¹⁵ agreed that from 2007 to 2017, during which the total number of births in Illinois had decreased substantially, the number of home births has remained relatively constant, being between 703 and 880 per year. The Committee noted that the number of births in Illinois was at a high of 180,530 in 2007 according to evidence presented by Ms. Pfeiffer, but decreased every year to 2017, when the total births were 149,390. During this time the estimated number of home births remained relatively constant, in that during 2007, there were 703 estimated home births, which was the lowest number, and during 2014, there were 880 estimated home births, which was the highest number. The Committee also considered that the actual number of planned home births was likely higher because during this time home births which required transportation to a hospital would have been counted as hospital births. In addition, in 2015 two birth centers opened in Illinois and even though the births at those locations were out-of-hospital births, they were still considered hospital births. Moreover, the Committee believed the witness testimony that expectant mothers in Illinois were continuing to have planned births in their homes, rather than at a birth center or hospital.

Similarly, by a unanimous vote of the persons who were present (with two abstentions),¹⁶ the Committee agreed that approximately 40% of the 703 to 880 planned home births per year, which were noted above took place with an unlicensed CPM or other unlicensed individuals. Ms. Pfeiffer provided evidence showing that from the years 2013 to 2017, approximately 36% to 39.9% of known planned home births were assisted by no licensed provider. Again, these percentages were based on numbers that were likely lower than the actual numbers because of the undercounting described above. The Committee also heard numerous witnesses recount the current dangers that women face by delivering at home without having the assistance of licensed and regulated health care providers who have the ability to provide immediate necessary assistance and prescription drugs that could treat the mother and child during and after birth. Therefore, the Committee concluded that a planned home birth with an unlicensed and unregulated individual, which is currently occurring in Illinois, threatens the health, safety and welfare of both Illinois' expectant mothers and their babies.

Regarding the best solution to increase the safety of home births in Illinois, a majority of the Committee believed that the best solution is to license and regulate CPMs, with certain requirements for the licensing of the CPMs. Three members of the Committee determined that the best solution would be both the licensing of CPMs and providing incentives to CNMs to assist home births in Illinois.¹⁷ A Committee Member, who voted with the majority, noted that in the last few months the law regarding CNMs has changed to allow them to have full practice authority, which may permit more CNMs to become active in providing home births. In addition, it was mentioned that the Committee has not heard any meaningful testimony from representatives of the Illinois Society of Advanced Practice Nursing ("ISAPN") regarding what they think would be useful to increase CNMs participation at home births, or the disadvantages of

¹⁵ The vote was eleven Committee Members in favor and two Committee Members abstaining, with two Committee Members absent.

¹⁶ The vote was eleven Committee Members in favor and two Committee Members abstaining, with two Committee Members absent.

¹⁷ The vote was: seven Committee Members in favor of the licensing and regulation of CPMs as the way to increase the safety of home births; two Committee Members who were in favor of the licensing and regulation of CPMs and providing incentives to CNMs to participate in home births, as the way to increase the safety of home births; and three Committee Members abstaining, with three Committee Members absent.

placing additional requirements on the curriculum of CNM schools. In addition, CNMs have separate and different licensing and regulatory requirements. Therefore, the Committee Members in the majority stated that the focus of the Committee's recommendations should be exclusively involved with the licensure of CPMs, which they believed was the intention of the Resolution creating the Committee. A different Committee Member, who supported the position that the best way to increase the safety of home births would be to promote both CPMs and CNMs, stated that the Committee's task was to find solutions for the home birth safety crisis generally, and it would be best to look for both types of midwives to promote the safety of home births.

The Committee, by a unanimous vote of the persons who were present (with two abstentions),¹⁸ agreed that CPMs should be licensed and regulated in Illinois, so long as certain requirements are placed on their licensure, such as necessary education, testing, continuing education, an established permissible scope of practice, and other regulations. The Committee recognized that expectant mothers in Illinois should have the right to safely deliver their children in their homes, rather than in a hospital setting. Moreover, the Committee recognized that some of these mothers will have a home birth for various reasons, including religious, monetary and safety concerns. The Committee believes that CPMs can and should play a role in ensuring the safety of expectant mothers who desire to have their children at home. Licensed and regulated CPMs can play a significant role in protecting the health, safety and welfare of both the mothers and babies during home delivery.

Regarding the education requirements for CPMs, a majority of the Committee Members recommended that CPMs must receive didactic formal education in Illinois or another state at a MEAC accredited school or, if they obtain certification through a non-accredited path, have separately obtained the Midwifery Bridge Certificate.¹⁹ It was noted that this option was recommended because it was the only one that complied with current US MERA standards, and provided a balance between classroom and PEP training with the additional training and testing through the Midwifery Bridge Certificate. Two Committee Members recommended that CPMs must receive didactic formal education in Illinois or another state at a school which has been accredited by the MEAC. This recommendation was based on the belief that only didactic formal education that was accredited by MEAC is the best way to ensure that the CPMs are properly trained to protect the public.

The Committee, by a unanimous vote of the persons who were present (with two abstentions),²⁰ agreed that CPMs can be licensed in Illinois only if they are required to receive at least 20 hours of continuing education, if there is a 2-year license renewal cycle, or at least 30 hours of continuing education, if there is a 3-year license renewal cycle. The Committee Members pointed out that NARM already requires that CPMs complete 32 hours of continuing education every three years, so that there may be unnecessary duplication of continuing education requirements. However, it was noted that CNMs currently can use continuing education earned for the American Midwifery Certification Board ("AMCB") as continuing education for licensing with the Department. Therefore, the continuing education hours completed by

¹⁸ The vote was ten Committee Members in favor and two Committee Members abstaining, with three Committee Members absent.

¹⁹ Eight Committee Members voted in favor of this recommendation, and two Committee Members voted to require only a didactic formal education which has been accredited by MEAC, two Committee Members abstained, and three Committee Members were absent.

²⁰ The vote was ten Committee Members in favor and two Committee Members abstaining, with three Committee Members absent.

CPMs for the requirements of NARM can also be used for the continuing education requirements by the State, and it would not be additional requirement for continuing education. In addition, there would be a benefit of having the State require continuing education, and there are some continuing education topics required by State law that are not required by NARM, such as sexual harassment training.

The Committee, by a unanimous vote of the persons who were present (with one abstention),²¹ agreed that CPMs should be licensed in Illinois without requiring them to obtain professional liability insurance, but a disclosure of their insurance status should be mandatory. The Committee Members considered that neither physicians, nurses, advanced practice nurses nor CNMs practicing in Illinois are required to purchase professional liability insurance, and therefore they did not believe that CPMs should be required to maintain professional liability insurance of any amount. The Committee Members believed that the requirement that CPMs disclose their insurance status would be sufficient to permit an expectant mother and her family to make an informed decision whether to have a CPM assist them in a home birth.

The Committee, by a unanimous vote of the persons who were present (with two abstentions),²² agreed that CPMs can be licensed in Illinois only if the law licensing CPMs states that CPMs are prevented from caring for patients as a primary midwife if a patient is not considered “low-risk,” as defined by the presence or absence of certain medical conditions on a separate list included in rules. The Committee Members recognized that CPMs may help with delivery by some birth mothers that have medium or high-risk pregnancies, but to be the primary midwife for a birth, the mother’s pregnancy would have to be considered low-risk to ensure the safety of the mother and the baby.

In addition, the Committee, by a unanimous vote of the persons who were present (with two abstentions),²³ agreed that CPMs can be licensed in Illinois and can carry and administer the following drugs, which would be listed in rules: postpartum antihemorrhagic drugs, for use in emergency situations; oxygen; local anesthetics, only for postpartum repair of lacerations, tears and episiotomy; Rhogam; IV fluids; Sterile H2O papules; sutures; vitamin K injections; erythromycin ointment; ibuprofen; and prophylactic antibiotics for Group B Strep (also known as Beta Strep). The Committee considered that the training that CPMs receive includes instruction regarding the safe and proper use of these drugs and that the drugs are necessary to effectively and promptly treat a mother or baby during or shortly after birth. Therefore, it is essential that licensed CPMs be permitted to carry and administer these drugs for the safety and welfare of the mothers and babies in Illinois. The Committee also noted that the drugs that CPMs would be permitted to carry and administer should be listed in rules rather than the statute because the required medications could change in the future.

Regarding a reporting requirement, the Committee, by a unanimous vote of the persons who were present (with one abstention),²⁴ agreed that CPMs can be licensed in Illinois but are required to report any injury or mortality events in connection with the births on an annual basis. The Committee considered that it

²¹ The vote was eleven Committee Members in favor and one Committee Member abstaining, with three Committee Members absent.

²² The vote was nine Committee Members in favor and two Committee Members abstaining, with four Committee Members absent.

²³ The vote was nine Committee Members in favor and two Committee Members abstaining, with four Committee Members absent.

²⁴ The vote was ten Committee Members in favor and one Committee Member one abstaining, with four Committee Members absent.

was important to have accurate information regarding the numbers of planned home births which occur in Illinois and any injury or mortalities that occur during home birth. This is important for the requirements of licensure of CPMs and can be evaluated on an on-going basis by the General Assembly and the Department.

The Committee was divided regarding the issue of the makeup of a professional board to participate in the regulation of CPMs. Three Committee Member recommended that a board established to recommend disciplinary actions and other matters regarding CPMs should be made up of a combination of physicians, CNMs, and CPMs, the majority of which are not CPMs.²⁵ Three other Committee Members recommended that such a board be made up of a majority of CPMs. The Committee Members who favored the composition of the board to include physicians and CNMs expressed that there was a benefit to have other complementary health care professionals on the board even if there would not be a majority of CPMs on the board and it was important to have a physician on the board. While the Committee Members who sought a board with a majority of CPMs noted that this recommendation was the only option which complied with the ICM standards. The ICM standards state that CPMs should be self-governed, so a board should consist of a majority of CPMs. In addition, the ICM standards contain the educational standards for CPMs, with which ACOG agrees. It was also noted that professional boards in Illinois do not directly govern their professions, as professions are directly governed by the Department.

The Committee also discussed the issue of whether there should be a requirement for CPMs to submit patient medical records to the ER of a hospital that is geographically near the location of a home birth before the patient goes into labor. Some Committee Members took the position that the requirement would increase the safety of home births because if there is an event that would necessitate transport to a hospital, the onsite physician and staff would have the records available to review while they are awaiting the patient. Other Committee Members questioned whether the submission of an expectant mother's medical records to a designated hospital or hospitals before the mother goes into labor would be beneficial, and noted that even at birthing centers, when a mother is transported to a hospital, the records are only taken to the hospital with the mother. In addition, they maintained that the birth family might not agree to share the mother's medical records with a hospital when there is not anticipation that the mother would need to go there. The Committee was unable to reach a consensus involving this issue.

The Committee also could not reach a consensus regarding whether there should be a limitation on the liability of health care practitioners other than CPMs, in any civil action which seeks recovery of damages for an injury during delivery. The Committee Members agreed that a significant issue is whether a CPM could be determined to be an agent of a doctor or hospital, thereby causing the doctor or hospital to be liable in a civil action, even in the absence of an employment relationship. Some Committee Members stated that if CPMs could be considered agents of doctors or hospitals without an employment arrangement, then no doctors or hospitals will agree to collaborate with a CPM because they could be held responsible for injuries caused by the CPM. Other Committee Members stated that there must be some type of clause in any proposed bill that would make it clear that doctors and hospitals are not responsible for actions taken by CPMs unless the CPM is an employee of the doctor or hospital. A representative of the ITLA stated that their concern is that when mistakes are made by the CPM, the doctor, hospital staff or the hospital, or by any or all of them, the proposed regulation would not erode the rights of someone

²⁵ In addition, five Committee Members abstained regarding this topic of discussion and four Committee Members were absent.

who chooses to use a midwife. The legal protections should be the same for someone who chooses to use a midwife for home birth or uses a hospital. Another Committee Member stated that the hospital should not be responsible unless they do something wrong after a transfer, so the hospital should not be involved for anything that happens prior to the transfer. Therefore, hospitals would need very clear language in a bill which states that the hospital is not responsible for anything that occurs prior to the patient arriving at the hospital or any of the actions of the CPM, unless the hospital employed the CPM. There was also discussion about whether a consultation between the doctor and a midwife could create a relationship, which could form the basis of a lawsuit.

Finally, the Committee Members discussed whether to consider making any recommendations regarding CNMs assisting in home births. The Committee Members noted that they would like to encourage CNMs to assist home births through some sort of legislation, such as recommending scholarships for potential providers. However, there was insufficient time to hear evidence regarding various ways that the health care professionals, including CNMs, can be trained and encouraged to assist mothers in planned home births. Therefore, the Committee declined to make any recommendations regarding the issues involving CNMs or other health care professionals who could participate in home births.