Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

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Department of Financial and Professional Regulation
Division of Professional Regulation
Home Birth Maternity Care Crisis Study Committee Meeting

Date:	August 15, 2019
Meeting Convened:	1:25 P.M.
Meeting Adjourned:	3:27 P.M.
Location:	Chicago: JRTC CBD Room 9-040; Springfield: Stratton CBD 376
Roll Call:	Senator Iris Martinez, Chairperson Representative Anna Moeller, Vice Chairperson Elect Senator Neil Anderson (Absent) Barbara Belcore, CPM Douglas Carlson, M.D. (Springfield) Karen Harris, J.D. Debra Lowrance, CNM (Springfield) Maura Quinlan, M.D. (Absent) Nadia N. Sawicki, J.D. Mike Tryon (Absent) Jeanine Valrie-Logan, CNM Carrie Vickery Rachel Wickersham, RN, CPM Hunter Wiggins, J.D. Cheryl Wolfe, M.D.
Staff Present:	Robert Dixon, IDFPR (Springfield) Lucienne Doler, IDFPR Matt Sanchez, IDFPR Richard Schultz, IDFPR Ciara Wagoner, IDFPR (Springfield) Amanda Phelps, IDFPR (Springfield)
Speakers Present:	Patricia Pfeiffer Benjamin Rathert, MD (Springfield) Iris Rose Ida Darragh, CPM, LM
Guests Present:	Karen Bachman, RN, Illinois Council of Certified Professional Midwives ("ICCPM") Becky Coolidge, ICCPM Shaquan DuPort, Illinois Hospital Association

Dan Hohl, Illinois State Medical Society ("ISMS") (Springfield)
Nicole Miles, Chicago Birthworks Collective
Phil Milsk, JD, Illinois State Bar Association
Erin O'Brien, ISMS
Dru O'Rourke, Illinois Chapter of American Academy of Pediatrics
Trisha Rodriguez (Springfield)
Christine Sheets, Illinois Friends of Midwives ("ILFOM")

Topic	Discussion	Action
Opening Statements	• **Senator Martinez:** Thanked everyone for attending the meeting regarding the Home Birth Maternity Care Crisis. She hoped that the meetings could result in legislation that could benefit the home birth community to allow the open licensure of midwives who could assist in home births. She explained that she needed to hear from people who oppose home births so that they could have a conversation about their concerns now rather than after a bill is being considered in Springfield. The hearings are about having a conversation about proposed legislation so that they can submit a recommendation to the General Assembly regarding legislation which will recognize individuals who are currently working in the dark helping people have home births to practice legally in Illinois. She stated that she needed people to step up to explain what can be done to pass a bill to license. She wants women who choose to have births in their homes to be able to legally hire licensed midwives to assist them in that wish. Hopes to have a bill that everyone can support which will license midwives so that they can legally provide that service to the women in Illinois. She also recognized her counterpart in the House of Representatives, Representative Anna Moeller, to carry this message and she wants to have a conversation to move legislation which will pass forward. • **Representative Moeller:** Expressed her gratitude to Senator Martinez for her leadership on this issue. Stated that she was a strong supporter of licensing midwives in Illinois and allowing them to practice. Women are choosing to have babies at home and we need to provide an environment where that is regulated for the safety of mothers and babies. Over thirty states license midwives to allow for home births and she does not see why Illinois cannot join those states. While she has worked on the issue, she has not heard a compelling issue why midwives should not be licensed. She feels for the women who have been working for decades on a bill which would license midwives and applauds Senator Martinez for creating the Committee. Her goal is that next year there can be some movement to draft a bill, licensing midwives, which will pass. She respects that there are stakeholders on both sides who will provide testimony and be part of this process. She is very grateful to be part of the group to provide for the health, safety and wellbeing of women and babies. She thanked everyone for attending and participating in the meetings.	
Call to Order	• The meeting was called to order and a roll call was taken. As there were twelve Committee Members present, in Chicago or Springfield, there was	

	a quorum of the total fifteen Committee Members. All attendees then introduced themselves.	
Old Business	• The draft of the July 18, 2019 minutes was considered. Some Committee members requested that the minutes be modified. As some of the requests to correct the minutes were significant, the Committee determined that all of the corrections to the minutes be forwarded to IDFPR Staff and defer the approval of the draft minutes to the next meeting.	
New Business	**A. <u>Comments from the Chair</u>** • Noted that she had provided comments in Opening Statement. Recommended that Representative Moeller be selected as Vice-Chair. **B. <u>Vote for Vice-Chair</u>** • **Senator Martinez:** Nominated Representative Moeller to serve as Vice-Chair of the Committee. • **Ms. Wickersham:** Seconded the nomination. • As there were no other nominations and no discussion, the matter went to a vote. • **Home Birth Maternity Care Crisis Study Committee votes**: 12 yes votes (Senator Martinez, Representative Moeller, Barbara, Dr. Carlson, Karen, Debra, Nadia, Jeanine, Carrie, Rachel, Dr. Wolfe and Hunter), 0 no votes and 0 abstentions. **C. <u>Witness Testimony</u>** • **Senator Martinez:** Introduced the first speaker and asked if people could keep their comments to a minimum and have a very good discussion and debate in the conversation. **1. <u>Patricia Sherman Pfeiffer</u>** • **Ms. Pfeiffer**: Stated that she is grateful to be permitted to speak regarding this issue. She has worked on this issue for the last 8 or 9 years. She initially was an activist and a mother, and then became a doula, but she felt that she was not making progress to allow licensure of midwives, so she went to 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 referred to a chart showing the number of home births in Illinois, which is attached in the presentation labeled Exhibit A. She explained that home births are happening with the assistance of various types of attendants. As a labor doula, she has attended over 100 births, in all areas. She said that she has observed negligence by midwives and physicians in all settings, and has also seen great care offered by midwives and physicians in all settings. Home births are still happening, and they are not going to stop happening, and there is a crisis for families seeking home births. She said that home births are happening 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.	Representative Moeller Approved as Vice Chair

	• **Dr. Wolfe:** Questioned the differences shown within the columns on chart, which listed the numbers of Illinois Home Births that were both entitled "% Change from 2007." She noted that one column showed an increasing percentage of and the other showed a declining percentage. • **Ms. Pfeiffer**: Explained that one column showed that overall birthrates in Illinois have been declining since 2007. She also noted that the number of home births have been increasing since 2007, which is shown on the other column on the chart. She further explained that in 2015, we opened two birth centers in Illinois, which were located in Bloomington and Chicago, so those births are out-of-hospital births that are counted as hospital births. • **Senator Martinez:** Stated that the births are counted by the hospital because they were put there by the hospital. • **Ms. Valrie-Logan:** On birth certificate there are only two options, which are hospital or home. • **Dr. Wolfe:** Stated that the data she has seen from the vital statistics that show home births include a birth facility, a residence or a physician's office. So, the data does not show all indented home births. • **Ms. Pfeiffer:** Stated that unfortunately, Illinois does not have the same categories which are used by other states in the country. • **Senator Martinez:** Stated that was because the State of Illinois does not license certified midwives. • **Ms. Pfeiffer:** Added that Illinois does not have integrated care and only has two birth centers in the State, which are new. This is also an issue. Stated that the Illinois Legislature and IDFPR have been aware that home births have been happening in the State for some time. She also stated that it is the duty of the State and IDFPR to protect consumers' rights and offer an avenue for reasonable persons to make reasonable medical decisions. She said that denying licensure to a body of individuals who are seeking to be regulated approaches negligence. • **Representative Moeller:** Noted that the chart showed the number of home births remaining relatively stable over the last ten years, with increases during the years 2013, 2014 and 2015. Asked how the information was obtained. • **Ms. Pfeiffer:** Responded that information was obtained through vital statistics, and had a statistician report the information back to them. She added that the numbers are a little bit "fuzzy," because people provide misinformation about where they are having babies. • **Senator Martinez:** Asked how many people would actually admit that they had a home birth especially knowing that these individuals are not recognized by the State. • **Ms. Pfeiffer:** Responded that the fact that the question exists shows the problem, in that they question cannot be accurately be answered. • **Senator Martinez:** Noted that the numbers of home births could actually be higher than shown by the chart on the second slide, because	

	individuals are not admitting that they are having births at home. Asked whether mothers are even providing information about the births. • **Ms. Pfeiffer:** Responded that often mothers will choose to give birth at home and then transfer into the hospital afterwards 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 home birth. They do this to protect their midwives. • **Ms. Vickery**: Noted that the chart on the third slide of the presentation mentions MDs and Doctors of Osteopathic Medicine ("DOs"), but we do not know of any MDs or DOs who are delivering babies at homes, so those would be deliveries during the transportation of mothers to hospitals. Some of them would be legal transports by nurse midwives who assist in the birth, and some are parents who birthed unassisted who needed to be transported to the hospital. • **Ms. Pfeiffer:** The MD and DO births listed in the chart contained on the third slide are births occurring during transportation to the hospital and are not physicians delivering babies at home. That is not happening very often any longer, if at all. • **Ms. Vickery:** Stated that we cannot tell what percentage of home births are with midwives. • **Ms. Pfeiffer:** Responded that this is correct, and that the way that births are recorded is dependent on the way that the physician or nurse midwife decided to classify the birth in that moment at the hospital. Stated that the numbers are "fuzzy." • **Senator Martinez:** In saying that it is important that the Department hears exactly what is happening in the State. There are babies being born and they are continuing to be born at home, and as insurance is becoming less and less affordable, especially in the rural areas, there are going to be a lot more home births. Wants to have the Department to put their arms around the home birth issue. Women feel that they cannot afford to have a birth in the hospital, so home births will continue to happen. Again, like Ms. Pfeiffer said, this could be negligence by the Department for not recognizing people, who are certified to assist with home births, but cannot get licensed in the State. Have to have a conversation with the Department to determine how this licensing can be incorporated because it is the responsibility of the State to recognize those individuals that are providing a service. • **Ms. Pfeiffer:** Agreed that it is the duty of the State to recognize that not licensing midwives is "perpetuating a black market which is dangerous." The statistics provides a window into that market. 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. This is from an American Academy of Pediatrics ("AAP") publication or the medical community, for whom she has a deep respect. Home birth is a reasonable option for families. When people request information from their pediatrician about home births, the AAP recommends they tell the families that this is an option. Nothing about home births is unreasonable. 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 expected management over active management in the births and want home births. It is an evidenced based practice. Based on information from ACOG, planned home births are associated with fewer maternal interventions, such as fewer: labor augmentations; regional analgesia; electronic fetal heart monitoring; episiotomies; operative vaginal delivery, by forceps or vacuum; and cesarean deliveries. The chart on the seventh slide, from an ACOG fact sheet regarding home births, shows that home births have: fewer vaginal perineal and third or fourth-degree lacerations; and less maternal infectious morbidity. Both AAP and ACOG maintain that out-of-hospital births are not as safe as hospital births or birth center births. At the same time, they very much agree that fewer interventions are happening with home births. Again, this shows that home births are a reasonable option. There are evidenced based reasons that people are choosing to give births at home. • **Ms. Wickersham**: Asked if she knew the window of time that the information in the charts was collected. • **Ms. Pfeiffer**: The information in the chart on the seventh slide came from 2015. The Fact Sheet is from 2017, and renewed in 2018. The data that they use is from a study in 2015. • **Ms. Wickersham**: Asked if the number of states that had not licensed midwives at the time of the study which reported on the hemorrhage rate could have been larger than it is today. Mentioned that women living in the states where midwives were not licensed, may not have a provider who had access to medications or other tools to assist in the birth. Said that could affect the numbers of hemorrhaging events in the birthing process. • **Ms. Pfeiffer:** Agreed that in those States, there are providers assisting in births who do not have access to these tools. Said that integration with a hospital is very important for home births. She could not explain the increase of blood transfusions and hemorrhages for planned out-of-hospital births but noted that it was very small. Said difficulty to explain every reason why blood transfusions would be required. • **Dr. Wolfe:** Noted that the data is from a study in a New England Journal of Medicine article published in 2015, so it is not really from the ACOG.	

	• **Ms. Pfeiffer:** Agreed that was the source of the information on the chart. Stated that there was a review of studies contained in an article from a 2019 edition of Elsevier Ltd., which searched five data bases from 1990 onward, with a data set that included 500,000 intended home births. This is the largest and most comprehensive data analysis to date. It the only one that takes jurisdictional support into account. Found that there is no statistical difference between neonatal and maternal mortality for intended home births and hospital births under a few categories. • **Ms. Sawicki:** Asked how the review defined a "well integrated setting?" • **Ms. Pfeiffer:** Explained that the "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 are absent. • **Ms. Sawicki:** Asked whether the article discusses mortality and morbidity rates when births take place in a non-well integrated setting. • **Ms. Pfeiffer:** Responded that it did, but she did not have those numbers available at the moment. • **Ms. Sawicki:** Those numbers would be helpful to the Committee. • **Dr. Wolfe:** Noted that this relevant for rural areas where emergency transportation is not readily available, which can be a concern. • **Ms. Pfeiffer:** Mentioned that Dr. Rathert will speak to that issue. Safety is obviously the highest priority. Right now, home births are not safe anywhere in Illinois, which is important to keep in mind. Said that the rate of cesarean delivery, which are 31.1% in Illinois, is one of the reasons that women are choosing home birth. Stated that the World Health Organization recommends a rate of between 10% to 15% as an ideal rate. However, Illinois' rate is about on the national average. Noted that labor and delivery units are closing across the state, including one in the region where she lives. Therefore, there is less access to maternal care in the State. Illinois has very high costs of medical malpractice rates. They are the highest in the region, if not the country. Questioned whether the State was attracting the best individuals when the medical malpractice rates were that high. The State has many good physicians, whom she works with and they are wonderful. However, women in Illinois are not always receiving the best care and they are looking for care in other states, which is part of the picture. • **Dr. Wolfe:** Asked if Patricia believed that the physicians in Illinois are not the best because of malpractice costs. • **Ms. Pfeiffer:** Believes that the cost of malpractice adds to Illinois' problem retaining physicians, but there are other factors as well.	

	• **Dr. Wolfe:** Asked if Patricia had data to suggest that physicians in Illinois were not sufficiently trained or not as good as physicians in other states because of malpractice insurance rates. • **Ms. Pfeiffer:** Stated that she did not have any such data, and she understood the basis for her question. She said that she appreciated Dr. Wolfe's comment. Stated that home birth is a reasonable choice for reasonable persons, and that home births in the United States and in Illinois are increasing. In discussing the thirteenth slide, 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. • **Representative Moeller:** Stated that it would be appreciated if Patricia could supply other demographic information about out-of-hospital births. • **Ms. Pfeiffer:** Agreed to provide that information. • **Senator Martinez:** Commented that it would be helpful to determine the populations that are choosing out-of-hospital births. • **Ms. Wickersham:** Stated that she plans to have two additional witnesses who will be addressing the issues specifically related to home births by women of color. • **Senator Martinez:** Wants to make sure that the Committee covers every aspect of the groups of women who choose to have an out-of-hospital birth. • **Ms. Pfeiffer:** Stated that 35 other states have found solutions to the problem of the home birth crisis. Illinois has been lagging in that regard. There is an answer to this issue, which is not going away. 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. It is a valid reasonable option that has been implemented by other States. 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. Illinois women are crossing borders to give birth so that they can have licensed providers. There is a CPM in southern Illinois who is unbelievable, in that she has great statistics, but she does not practice in Illinois, but Missouri where she is licensed. Her clients are from Illinois, but they both cross the border to give birth in Missouri. 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 to which they are entitled, also cross the borders to have out-of-hospital births that are regulated. Most of Illinois does not have access to coverage for out-of-hospital births. The only access that Illinois residents have is through ten Certified Nurse Midwives ("CNM") practices which assist out-of-hospital births for all 102 counties in Illinois. While she was aware that there were a number of physicians who provided	

	collaborative care with CPMs, she did not have an exact number of these physicians. 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. 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, and Illinois women are traveling to other states to have babies in hotel rooms. • **Senator Martinez:** She is aware of an instance where an Illinois woman who had a baby in a hotel room in another state and it was a disaster. • **Ms. Pfeiffer:** Noted that people are also having unassisted births when they cannot locate a midwife. While it is not safe, it is legal. There are births with CPMs and other direct entry midwives, who may be good at providing care, or they may not have gone through the rigorous training of a CPM to be able to provide care. Believes that failing to license CPMs is perpetuating a "Black Market," and may be attracting midwives who may not be the best providers. • **Senator Martinez:** Noted that it is important to regulate midwives because then the Department can pursue midwives who should not be providing the service. Without regulation, the Department cannot pursue individuals who are not certified and providing services which they should not be providing. That is happening now. The issue to be resolved is how midwives can be regulated in Illinois. • **Ms. Pfeiffer:** Added that as a doula, she represented a number of families in a hospital setting for their births. She developed great relations with doctors in those hospitals. She noted that the biggest difference between the families who chose home births and those who chose hospital births was not their education, or research, but it was that if a home birth did not proceed correctly, they did not have an avenue to make a complaint, which was not fair. • **Senator Martinez:** Added that the Committee has heard that some CPMs want to be licensed so that they can have a collaboration agreement with a nearby hospital or doctor. But, with a state that does not license midwives, the hospitals are not going to agree to such arrangements. We need to talk about this to make sure that there is a connection between CPMs and hospitals. CPMs have said that they want to be part of a network to have access to a hospital or doctor if something happens. She believes that is very important. CPMs do not want to be in the shadows any longer. • **Ms. Pfeiffer:** There are a body of professionals who are recognized by other States and are pleading to be regulated. There are also families in Illinois who want to have them regulated.	

- **Ms. Valrie-Logan:** Asked if the data was obtained CDC Vital Statistics or Illinois.
- **Ms. Pfeiffer:** Responded that the data came from CDC Vital Statistics, but it was not contained in an official report. They have someone who works with CDC that compiled the data for the organization.
- **Mr. Dixon**: Requested that Ms. Pfeiffer provide a list of reports or studies, upon which the data that was cited in the PowerPoint presentation, was obtained.
- **Ms. Pfeiffer:** Said that she would be happy to provide the list.
- **Senator Martinez:** Asked that everyone who was a stakeholder or Committee Member in Springfield get a copy of everything that is being presented to the Committee in Chicago. It is important that everyone sees the information.
- **Ms. Pfeiffer:** Thanked the Committee for the opportunity to speak.

2. Benjamin Rathert, MD

- **Dr. Rathert:** Stated that he is a family practice doctor from southern Illinois, and currently practices in Du Quoin, Illinois. He was testifying on behalf of the Illinois Friends of Midwives, but noted that no one paid him to provide testimony. He has a full range family practice, including pediatrics and about one hospital obstetric delivery every month. He also does addiction medicine and other types of medicine depending on his patients' needs. He has a traditional rural practice and sees about 30 patients a day. He has been practicing for about six years, and currently works with the Du Quoin practice. 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 he is having a regular and routine pregnancy. He does not manage high-risk pregnancies, which may require a C-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 C-Section. In his practice, he tries to intervene, by inductions, augmentations, introducing medicines to make the labor progress faster, only when necessary. For the most part he believes that a woman's body will do what it naturally does, and he tries not to get in the way of that process. He noted that there is excellent data showing that doctors getting involved results in more C-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 that it should. He explained that it is very

routine and not very complicated. For the vast majority of the deliveries with which he has been involved, his involvement is to manage when the baby is crowning and deliver the shoulders. That is the very little portion that he covers to ensure that the mother and baby are fine. Specifically, he became interested in studies which showed that the "standard of care" for hospital births was not as straightforward as it sounded. While there is a "standard of care" for births in hospitals, there is really limited data to show if that care is effective. For example, it is extremely routine 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. However, the standard of care for a pregnancy is to start the woman on IV fluids. Plus, a woman cannot be permitted to eat anything because she may need a C-Section and could aspirate and die during surgery. 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 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 abnormal for the birth process. Have a good way of getting between a woman and the natural pregnancy process, which is the care that is offered to the mother. 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 could slow the labor process. Patricia raised a very interesting point by showing data that the C-Section rate is five times higher for hospital deliveries than home deliveries. Stated that this was not surprising because we are living in a day where lawsuits are very common, and no one ever gets sued for having a C-Section rather than natural birth, even if it was not necessary. There is such a thing as being "too careful," which causes doctors to perform surgeries that did not need to happen. We do not have evidence that the natural birth would have been dangerous, yet the OBGYN managing the birth thinks what if I get sued. That concern is in his mind as well, but he attempts to give a woman every chance to have a normal vaginal delivery. 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. As such, they are very savvy about 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. He found from his conversations with CPMs and

national studies that home deliveries are as safe as births in hospitals. So, he has built a relationship with as least three professional midwives in the southern Illinois area, who will consult him not about the obstetric issues, but neo-natal questions. He is in favor of home births and his stance to CPMs is call me anytime they have a question or concern. He has occasionally received such phone calls. 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 a hospital emergency room, 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 pregnancy, where the mothers are screened to ensure that they are appropriate for home births and make sure that it is safe for the mother and baby, but it is a safe option for births. The CPMs job is basically 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. This training went deeper than his obstetric training. Yet, because he is Board certified, he can legally practice in the eyes of the State. So, the idea of creating licensure and an oversight board, is a "tide that lifts all ships." It is not just to ensure that bad midwives are not permitted to practice, but it 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. Provides an alternative to requiring women to go to a hospital and be strapped to a hospital bed and wait for the 24 hours it takes for the baby to be delivered. That is currently the legal way to have a birth. Home births with a CPM also needs to be legal.

- **Senator Martinez:** Thanked Dr. Rathert for his statement and believed that it was on target.
- **Ms. Sawicki:** Noted that Dr. Rathert mentioned that more healthcare providers engaged in higher intervention, like limiting movement of birth mothers, despite the fact that there is insufficient evidence for those practices and suggested that one of the things that may be motivating healthcare providers to take that approach is the fear of litigation. Asked whether he had a sense of what change could prompt doctors who deliver babies in hospitals to reduce their level of intervention and ensure that the treatment that they provide more appropriate.

	• **Dr. Rathert:** Responded that he truly wished that he had a good answer to the question. Felt that the issue is such a thicket, because a patient's right to take legal action cannot be suspended if something goes wrong, yet at the same time the culture of this is if anything should go wrong in the birth, we need to blame the provider or nurse. He could not even develop a list of things that would change the system that resulted in the care of mothers in the hospital setting. Person's actions and judgments can be second guessed in litigation. That is the culture that we live in. Apologized for not being able to provide a good answer to the question. • **Senator Martinez:** Mentioned that when she had the bill in Committee, the trial lawyers were in attendance. They questioned who would be liable and how is liability going to be determined. She said that is a question that the Committee has to consider as well, and another topic for the Committee to hear testimony. That group was one of the groups opposing the bill. Their concern at the time was who is liable if something goes wrong. That is another component about what the Committee needs to discuss as the meetings move forward. • **Ms. Harris:** As a counsel representing hospitals, she wanted to clarify one point of information regarding the expense of hospitals, that most hospitals do have charity care plans which provide financial assistance. She also noted that regarding liability, it is a very important topic and should be discussed thoroughly. • **Senator Martinez:** Responded that the Committee will have that discussion because the trial lawyers initially opposed the bill, but later agreed to its passage. Something that has to be brought to the table is the liability issue and the trial lawyers are seeing this opportunity. If there is a bill authorizing the Department to issue licenses, the liability is an issue to be considered. • **Dr. Carlson:** Stated that he appreciated the thoughtfulness of the presentation and the opportunity to be on the Committee. He explained that he is a pediatrician and has made observations in his career. He is a Medical Director of a hospital that has a large OB service. He is also a father who made the decision with his wife to have his babies at home 29 years ago. The decision was based on much of the data available at the time which showed that a home birth was safe if there was a well supervised birth, with a well-trained nurse midwife; and most importantly, within the systems and connections in the medical community, in case there were unforeseen complications. He made the decision willingly and he is happy with that decision. People are surprised that he made the decision, but it was a reasonable decision. He also sees this as a hospital and emergency physician who sees the end product of wayward decisions that are made in situations where better care could be provided. You can rely on regulation to address this, but you should consider evidenced-based medicine. While it is true that more C-Sections are done in the hospital, because that is where C-Sections are performed. Their outcomes on average are worse	

because that is where we all agree that high-risk deliveries should be held. So, if there is a high-risk delivery, such as malformations or premature births, should be in a hospital. The best studies considering this issue try to case match those that are carefully called purposeful home deliveries verses those that occur in a hospital. A survey in the New England Journal of Medicine said that home births are safe, while an ACOG and AAP studies which say that it has some risks to be considered. Studies from Oregon and New Zealand show that when you match those decisions to have home birth or hospital births for low risk pregnancies the mortality is about one-third higher for home births. He worries about that fact. Also, it is the medical system around the births that is important. His concern is that we have this established accreditation for nurse midwives, which come from rigorous accredited undergraduate and graduate programs, standardized certification testing of those individuals and ongoing continuing education. He believes that those have been the gaps which have not been completed for certified midwives. The pushback is not based simply on home birth, but making sure that home birth practice is regulated so that the midwives meet the standards of education and accreditation. Another study showed that 40% of intended home births are not low risk, they are high risk. Whether that is because of the practitioner not knowing it or they are taking chances. That is encapsulating his very pro-home birth personal attitude verses his worry about broadly expanding home births without meeting all of those other criteria. That encapsulates his concerns about home births.

- **Senator Martinez:** Responded that others on the Committee share his concerns. Also, she heard those comments at the hearing on the bill by the hospital association and the medical society. It is the conversation that is necessary for the Committee. She said that we cannot keep saying that this is not happening, because it is going on right now and it will keep on happening. It is occurring in Illinois right now and the Committee has to find a regulatory solution because the number of home births is going to continue to rise.
- **Ms. Valrie-Logan:** Requested the cites to the studies that were mentioned by Dr. Carlson.
- **Dr. Carlson:** Stated that he would make sure that he provides those studies to the Committee Members.
- **Mr. Dixon:** Requested that any studies which contain data that the Committee Members refer to be provided to the Department. Also, if there is geographic data about availability of hospital care and home births for the people in Illinois, that should also be provided. In addition, any studies about gaps in access to hospital care would be helpful.
- **Ms. Lowrance:** Illinois Department of Public Health has information on its website regarding the locations of hospitals in Illinois. The information is divided into regional areas and they show which

	hospitals are currently providing obstetrical services and other information. • **Mr. Schultz:** Requested that these studies be sent to Richard.Schultz@illinois.gov, and they would be circulated to the Committee. • **Ms. Wickersham:** Mentioned that during the time period that the Oregon study, which Dr. Carlson quoted, was conducted, Oregon permitted midwives who were uncertified to legally assist in deliveries. Thus, the births in that study were delivered by certified and uncertified, licensed and unlicensed midwives. She noted that a study in Canada at about the same time showed that babies born at home with licensed and certified midwives were just as healthy as those born in a hospital. She also stated that Canada had an integrated midwife system which is something that other speakers will discuss. Asked Dr. Rathert whether it was true in general interventions that are implemented to avoid being sued sometimes create other complications. • **Dr. Rathert:** Responded yes, as far as he knows. He explained an example, a physician decides to move to a C-Section because the heart rate is not reassuring, and the C-Section goes well, and the baby is well. However, the mother could then have complications from the surgery. Doctors intervening more can create more problems in the future that would not have arisen otherwise. • **Dr. Wolfe:** Noted that she has been an OBGYN physician for 20 years and that she has seen the progression of treatment from woman about to give birth. She recalled a time when the doctors had the patients flat on their backs when she was trained. She said that at that time the patients were told not to move, and just sit and take their punishment. She stated that currently she is in a university setting and she noted that she has seen changes, such as providing epidurals, walking epidural treatments, nitric oxide and IVs. Also, they have nurses who are great and provide whatever assistance that the birth mother requests. She believes that the practice is changing, so one should not make the global statements that giving birth in a hospital means that the mother has to be flat on her back and not doing anything. • **Dr. Rathert:** Responded that he is envious of Dr. Wolfe. • **Dr. Wolfe:** Stated that she works in Chicago and does not believe that Rush is unique in providing treatment. She just wanted to let the audience and other Committee Members know that things have changed and progressed. She stated that she works with midwives. She also pointed out that mothers are permitted to eat during delivery. She added that most of the time that she does a C-Section, the mothers do not have a wound infection and they are very conscious of decreasing the rate of C-Sections. She also pointed out that Illinois and Rush have a lower percentage of C-Sections than the country as a whole. Rush's C-Section rate is 25%, which is excellent. She said that she just wanted to dispel some of those myths.	

- **Senator Martinez:** Stated that the important thing is that any woman who wants to have a hospital birth should be permitted to have one. Believed that most people want to give birth in a location where they feel is safe to have a child. We are discussing the women who choose not to have a hospital birth, but want to have a baby at home, for economic, religious or other reasons. That is the population that she wants to focus on. It is always going to be the woman's choice for her and her baby. Those who for financial or other reasons do not want to have the baby in a hospital. They are interested in ensuring that if someone has a mindset that they want a home birth, they know that they are going to find that certified highly-trained midwife, who will be less costly, to be able to have their baby at home. This would be a less costly alternative and the mother would receive the same type of attention during those difficult time which they would receive if they were in a hospital setting. Everyone wants to be treated well during that difficult time when we are not the nicest people. We are headed to protect the woman who chose not to have a hospital birth for all of the reasons that were mentioned. We want to ensure that these mothers are entitled to a good, responsible certified person to assist them in their births. Agreed that the hospitals have changed so much from when she had her daughter 37 years ago to what it is like today. It is currently very different setting from that time. She applauds the women who can choose but knows that there are also women who don't have any other choice but to have the baby at home. Those are the women who she is worried about.
- **Ms. Lowrance:** She applauded Rush Hospital and believed that it has always been a trend setter, but unfortunately many of the small community hospitals still practice the way they have always been doing things are not evidenced based. Evidence takes about 15 years to become common practice. So, there are many pockets in the State that have not progressed. She knows of at least two community hospitals that still have VBAC bans in place, which goes against the evidence. We are struggling because not all hospitals are up to par and that is sad.
- **Ms. Valrie-Logan:** Added that specifically home birth needs to be an option for women who, if they go to the hospital, are having disproportionate rates of morbidity and mortality. Wants to make sure that stays part of the conversation because national statistics for morbidity and mortality for black women are statistics from hospital births in big cities and rural communities, not home births. Wants to make sure that home birth is an option for everyone.
- **Senator Martinez:** Agreed and stated that the Committee should move on to the next speaker.

3. <u>Isis Rose</u>

- **Ms. Rose:** Thanked the Committee for allowing her to be there and to speak to the Committee. She had the full text of her testimony but provided only an outline of her statement to the Committee.

	• **Senator Martinez:** Requested that Isis provide her full testimony to the Department, so that can be distributed to the Committee. She also asked Isis to highlight the important portions which she would like the Committee to consider. • **Ms. Rose:** The outline that they have focuses on articles from other writers and provides fact-based information. Her testimony is more about her personal experience, which is more anecdotal and based on her studies as a cultural anthropologist and PhD student at the University of Illinois. She talked about this issue in her position as a black woman. She is a 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 birthing people. 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 professor in statistics at the University of Illinois, in Urbana-Champaign. Her daughter was born on January 15, 2018. She was an 8 pound, 9 ounce baby. She was born in her living room. It was an unmedicated water birth, and it was one of the greatest defining moments of her life. She knew at the time that this was not only a beautiful experience, but one that unfortunately a lot of people cannot have because midwives are not licensed in Illinois. She 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 said that she thought that this was something that Jeanine just spoke to as well. Stated 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, medical related causes of these deaths were due to 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. She 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. It is now widely understood that black women are 3 to 4 times more likely than white women to die from childbirth. In Illinois, this disparity is much greater. In Illinois, black women are 6 times more likely to die from pregnancy related causes than white women. This figure is directly from the Illinois 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 as was said, 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. So, anthropologist Dána-Ain Davis calls this phenomenon "obstetric racism." Medicalized child birth is a phrase that describes how birth is treated as a medical event. 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. When she was planning her home birth, 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. The 2018 report on maternal mortality and morbidity even lists racism as a critical social determinant of health. So, when she was seeking care in her rural college town, she was very nervous about birthing in the hospital with few providers of color, which eradicated their water birth program and had high rates of C-Section surgeries in Champaign-Urbana. One of the recommendations offered by the 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 also expand efforts to provide universal home visiting to all mothers within three weeks of giving birth. She believes that is great and notes that doulas are awesome. Studies have shown that doulas improve birth outcomes for mothers representing all levels of risk. However, doulas are not medical providers and they do have little power to address these structural inequalities that allow these disparities to persist in hospital settings. Her recommendation is 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 the original home visitors and are capable of proving pre-natal care, attending births and providing post-partum medical attention to families in their homes. 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. She also believes that the integration of home birth midwives is important for positive outcomes. The midwife who served her family last year did have the necessary credentials to provide competent care. She has an excellent reputation and great birth outcomes. Most importantly, she felt safe under her care, which she did experience pre-natally, at birth and post-partum. Unfortunately, in Illinois non-nurse midwives, like the one that assisted her family, work under the 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 midwives in Illinois are practicing in Cook County, and the remaining are servicing the surrounding areas. So, her choice to give birth at home was completely legal, 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." What ever 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. That is why everyone is at the meeting, and she feels "fed up." Meanwhile, midwives continue to operate outside of the law. While her midwife is competent and has 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 engage in what Adelle Dora Monteblanco called "identity substitution," by representing that she was 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 effects black and brown women. Also, the legacy of midwifery stems from African-American midwives. 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.

- **Senator Martinez:** Thanked Isis for her testimony and asked if there were any questions of the witness. Being none, the next witness was called to provide testimony.

4. Ida Darragh, CPM, IM, Executive Director, North American registry of Midwives

- **Senator Martinez:** Thanked Ms. Darragh for appearing and requested that she limit her testimony because of the lateness of the day. She also mentioned to the Committee that she would like to hear from those stakeholders who oppose the licensing of midwives to understand their perspectives. She also stated that she wants to hear from Ms. Darragh.
- **Ms. Darragh:** She is the Executive Director of the North American Registry of Midwives, 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 CPM, 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 intended to give an overview of the education of CPMs, how it compares to the CNM, the national standards for CPMs, a description of the US MERA and the national accreditation process. Her organization has been accredited to issue the CPM credential since 2002, and they maintain that on a regular basis. Stated that the CPM credential requires didactic education. Even programs representing apprenticeships are required to include didactic education and clinical education. To get the CPM, a student must be instructed about specific content areas which must be part of the education. It can be obtained through accredited schools. In addition, there can be one-on-one educational periods with other practicing registered preceptors who are require to provide extensive period of clinical supervision. There is a minimum requirement of two years training, but the average is three to five years of training. So, there is extensive time of getting experience under the practice of registered preceptors who are with the student 100 percent of the time, covering everything that they are doing. The last step in certification is passing the North American Registry of Midwives ("NARM")

examination. Their 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. These are part of the certification process. CMPs are also required to have 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 personnel certification, and it accredits the CNM credential, the CM credential and many health care related credentials, including the CPM credential. To obtain 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 the CNM credentials. The NARM has met these criteria and received this accreditation. This accreditation process is required every five years. Also, every year the organization completes an annual report, which is reviewed by a third party to keep accreditation current. She stated that her specialty is test development, and she works closely with the States which use the CPM for licensure. She explained that 34 states license CPMs and one state that does not license CPMs but has statutory permission to permit CPMs to practice. States have all different ways to recognize or legalize CPMs with a great deal of regulation or minimum 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. The methods of CPM regulation are not standard, but CPMs are always regulated by the states. The regulation 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. Schools for CPMs and CNMs are both accredited by the Department of Education. 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 Department of

	Education to accredit schools. Upon completion, 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. Most CNMs across the country work in hospitals. Illinois has one of the largest numbers of home birth CNMs in the country, but in many states CNMs do not assist in home births. There are not enough CNMs in Illinois who do home births to meet the need of Illinois residents. CPMs have required training in an out of hospital birth, which is not required for any other profession that permits people to deliver babies. All of the training for the usual CPM candidate is for out of hospital births, with a required minimum number of participations with home births. A chart in the materials provided shows the minimum number of clinical maternity care requirements, which must be completed under supervision as the student works through the process of obtaining clinical training. 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 to work in all settings like they do in Canada, but it is not required in the United States. The CPM education 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. CPM education encompasses only those time periods in a woman's life span, as opposed to a CNM, which encompasses all aspects of the woman's entire life span. We are the only country that divides its midwives into nurses and non-nurses, in that 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. The international confederation sets the criteria for competencies, education, regulation, and for associations of midwives, which is called the Midwifery Education, Regulation and Association ("MERA") standards. The United States established the US Midwifery Education, Regulation and Association ("US MERA"), which was established because of the differences in the US system so it could create its own standards for CPMs and CNMs. This organization assisted in the determination that the US needed more midwives in the various states. The US MERA organization took position supporting licensure of CPMs, but one of the organizations opposing CPM licensure were the CNMs. This was frustrating because CPMs had the same goals as CNMs. Obstetricians also opposed the licensure of	

	CPMs for a long time. CPMs worked with CNMs and obstetricians to learn why they opposed licensure, and worked out language to permit licensure. In large part, CNMs opposed licensure because of the lack of accredited education. This was addressed with the accredited school and also brought in ACOG and family physicians to discuss how to overcome the lack of understanding about the competencies of CPMs and how to come to a standard which would be acceptable. That language is in the documents she provided to the Committee entitled "US MERA Professional Regulation Committee." The document included two standard statements for legislative language for states developing licensure statutes for CPMs. The language required that all CPMs certified after January 1, 2020 must go to an accredited school to be licensed. The language also required that for CPMs that had been practicing for a long time, if they were apprentice trained then they needed to get this accredited educational component which became known as the Midwifery Bridge Certificate ("MBC"). The MBC is continuing education which is accredited hours regarding maternal emergencies and complications, newborn emergencies and complications, and another list of professional issues. When this language is included in licensure bills, they have passed in almost every state attempting to establish licensure requirements in the past three years. There were two states, in each year from 2016 to 2018, for a total of six states which passed bills approving licensure of midwives, and Illinois is going to be next. Now there is support from the American College of Nurse-Midwives ("ACNM") and ACOG for CPM licensure, because this additional language assures every one of the competencies of CPMs. The language requiring certain CPMs to obtain an MBC must be included in the licensure bill to gain support from ACNM, and so ACOG will not oppose the legislation. 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 her materials included a statement from ACOG regarding the organization's support of the requirement of the MBC for CPMs who lacked accredited education and 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. NARM addressed this concern in a very competent way and she recommends that the language be included in a bill presented in Illinois. While individual CNMs or obstetricians may oppose a bill with this language, ACNM and ACOG would not oppose the bill because they feel that NARM has addressed their concerns about licensure. The last part of the document packet which she provided is entitled "Principles for Model U.S. Midwifery Legislation & Regulation." It is a guidance document approved by US MERA regarding regulation standards for midwives in a manner that midwives are regulated in this country. This is a US MERA regulation document which describes who should be on the	

boards, how those boards should function, how decisions should be made, and how regulations should be written. The documents submitted also include the Curriculum Checklist of Essential Competencies describing core competencies for midwives compiled by MEAC. These competencies are derived from competencies described by ICMs, so that they are very similar to international standards. She also provided a document prepared by the ICM, which is entitled "Global Standards for Midwifery Education," to show the international standards for midwifery education. This was the basis for US MERA's determinations about core competencies, standards and education accreditation regarding midwifery schools.

- **Senator Martinez:** Thanked Ms. Darragh and noted that there is a great deal of material to review.
- **Ms. Sawicki:** Asked about the proposed language regarding the MBC. Said that Section 1 involves CPMs who obtain certification after a selected date with new licensure laws requiring one to have completed an educational program accredited by MEAC and had no problem with that portion. Section 2 involved a pathway other then an accredited MEAC program. Subpart b of that section applies to a CPM who is licensed in another state which did not require an accredited education to be licensed. However, this subsection states that these individuals "may" obtain the MBC regardless of the date of their certification in order to apply for licensure in a state that includes the US MERA language. Questioned whether the language should be "may" or "must." She asked whether a CPM, who is licensed in a state other than Illinois but did not receive his or her education through an accredited school, would be required to go through the MBC program.
- **Ms. Darragh:** Responded that if the state's law required CPMs to complete the MBC process, the person would have to complete the process. Said that she would be required to go through the MBC program, but not the full educational process. Acknowledged that the language in the statement is "may," and noted that a lot of states permit licensure without a MEAC accredited educational requirement. Explained that the purpose of the language was to permit a pathway to licensure for very experienced CPMs without requiring them to complete a full educational program accredited by MEAC. There are six states that recently adopted the requirement for such individuals to obtain the MBC.
- **Senator Martinez:** Noted that after the conclusion of the hearings and when legislation is considered, they are going to see how midwives feel about this requirement. They will make sure that it is not too restrictive, but they want to make sure that they take the fear of unsafe home births in proposed legislation regarding midwives. Legislators want the assurance that those individuals who would be assisting with home births are as qualified as possible to make sure that such births are safe. She said the need to make sure that the language in a proposed bill is as strong as possible to assure that legislators who are still

	undecided about the bill can come to the table and feel comfortable voting for a bill so that legislation licensing midwives can pass. • **Ms. Belcore:** Thanked Ms. Darragh for traveling so far to provide testimony. She had a question about the tests and certifications and her statement that NARM and AMCB both have a certifying exam for their scope of practice. Asked for clarification about the extent of questions or details regarding the NARM test with the AMCB test. • **Ms. Darragh:** Responded that she could not compare the exams, because they must reflect the blueprint that is set by the job analysis. Questions must be written by teams of trained item writers. The questions are then reviewed by more teams of trained item writers. Then, they are subject to a process of test committee review and have a cut score process, which again uses practitioners to determine the difficulty level of the questions and how many questions the test takers have to correctly answer. The NARM examination contains 300 questions and is a six-hour examination, with a break in the middle. It is a computerized test given at university testing centers around the country, so it can be taken after becoming qualified to take the exam. • **Ms. Belcore:** Asked about the length of the CNM examination. • **Ms. Valrie-Logan:** Responded that the CNM examination lasts four hours and contains 175 questions. Also, the questions are not just child bearing years but questions about other parts of women's lives. • **Ms. Darragh:** Responded that the NARM exam has always been much longer than the CNM exam because NARM felt that they had more that they had to prove. It used to be 350 questions, but it was dropped to 300 because computer testing centers were not staying open for the extra two hours that were allotted. They had two three-hour sessions with a break in the middle. • **Ms. Wickersham:** Questioned what textbook were used in the classes for CPMs. • **Ms. Darragh:** Responded that CPM schools use the same textbooks as CNM schools. Noted that the textbooks were listed in the candidate information bulletin. They have to be recent editions, and easily available. Textbooks costs close to $200 each, but they are the same texts that are used CNMs, but related to the child bearing years. • **Ms. Valrie-Logan:** Noted that the textbooks that she used for her CNM certification were the same as used for CPMs. She also thanked Ms. Darragh for providing the breakdown in classes that CPMs and CNMs are required to take in their schooling. She noted that CNMs were not required to participate in out of hospital births, and that only CPMs receive training in out of hospital births. She added that her school was actually moving to add a requirement that they attend a minimum amount of out of hospital births. • **Ms. Darragh:** Stated that that was amazing. • **Ms. Valrie-Logan:** Agreed that it was amazing, and that she was the only person in her class that attended an out of hospital birth. Asked if	

Ms. Darragh was aware of any other medical or nursing schools that are leaning towards requiring that students attend out of hospital births.

- **Ms. Darragh:** Knew that it has not been a requirement to attend out of hospital births, but does not know if any schools are leaning toward making it a requirement. Noted that it probably will not be a requirement for the CNM credential, but it will be something offered by the school as they try to have more out of hospital clinical sites. It is not prohibited for a CNM to go to out of hospital sites, it is just hard to find them.
- **Senator Martinez:** Noted that it will be important to provide input because the CNMs are the ones that are really vested in this issue, and know the opposition to the licensing of midwives. When drafting legislation, want to make sure that it is crafted in a way that everyone is as comfortable as possible. These are the things that they are going to need to work on when it comes to language. Thanked Ms. Darragh for her testimony and the documents that she provided. Noted that they contain the facts that the Committee needs in front of them so that they can see that there is data available and that there is something that is happening that is only going to result in an increase in the number of home births. It is important that all this information comes to the Committee. She wants this conversation to go on because we value the opinions of our doctors and nurses on this topic.
- **Ms. Darragh:** There are a number of nurses who are CPMs, but not CNMs.

D. <u>General discussion</u>

- **Mr. Dixon:** Requested that for the next meeting the Department would like to reach out to all of the members of the Committee again and ask for topics that they would like to discuss, witnesses that they would like to testify or information that would be circulated to the Committee Members. The Department would do its best to maximize the Committee's time to collect information.
- **Senator Martinez:** Important to talk to the medical society and the hospital association. She wants to make sure that they have the opportunity to provide information to the Committee at the next meeting, if possible. Believes that the Committee should also hear from the Trial Lawyers, as well. Also, anyone else that they may know that do have issues with this concept should testify. Need to hear from groups that are opposed to the licensing of midwives to determine if something can be worked out with these groups. Next time she wants to hear from the medical society, the Illinois Hospital Association, a trial lawyer, possible Tim McClean, and anyone else opposing the licensure of midwives.
- **Ms. Wickersham:** Mentioned that her organization has already arranged for a speaker for the September meeting to discuss patient safety issues.

	• **Ms. Belcore:** Asked if Ms. Darragh or any other witnesses had any suggestions as to model legislation that she has reviewed or could recommend. • **Ms. Darragh:** Stated that there is only one model legislation and that is the one that will pass. The legislation needs to say who is the licensing authority, who is going to oversee the licensed midwives and needs to authorize the use of a specific formulary. • **Senator Martinez:** Requested that she provide sample legislative language that she thinks would be helpful to the Committee. • **Ms. Darragh:** Stated that there is no model legislation. • **Senator Martinez:** Stated that she wants to make sure that the Committee has the best practices from other states. Wanted to make sure that Illinois' legislation is not extremely different from other states. There is a large amount of caution in considering legislation, which has to be addressed. • **Ms. Sawicki:** Asked the groups representing midwives, or any other groups, has any suggestions of someone who can speak to the Committee about malpractice insurance implications and the economic impact that it would have on midwives. The topic would include the impact on midwives if malpractice insurance is required, legally, encouraged or necessary. • **Ms. Darragh:** Commented that of all the states that license midwives, only three require them to secure malpractice insurance. The three states have new legislation to license midwives. Washington state requires that midwives purchase malpractice insurance if they are permitted to receive Medicaid reimbursement, but not just for licensure. So, it is not normally associated with the licensing of CPMs. All of the states that have been licensing for many years have not found a need to require CPMs to secure malpractice insurance. • **Ms. Sawicki:** Explained that she only raised that because the attorneys raised this concern. • **Senator Martinez:** Hearing no other questions, a motion to adjourn was made by Ms. Sawicki and seconded by Ms. Harris. • Meeting was adjourned by unanimous consent.	
Adjournment	• Adjourned 3:27 p.m.	