



# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

**JB PRITZKER**  
Governor

**DEBORAH HAGAN**  
Secretary

**CECILIA ABUNDIS**  
Acting Director  
Division of Professional Regulation

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

Date: September 19, 2019  
Meeting Convened: 1:10 P.M.  
Meeting Adjourned: 3:26 P.M.  
Location: Chicago: JRTC CBD Room 9-040; Springfield: Stratton CBD 376

Roll Call: Senator Iris Martinez, Chairperson  
Representative Anna Moeller, Vice Chairperson  
Senator Neil Anderson (Absent)  
Barbara Belcore, CPM  
Douglas Carlson, M.D. (Springfield)  
Karen Harris, J.D.  
Debra Lowrance, CNM (Springfield)  
Maura Quinlan, M.D.  
Nadia N. Sawicki, J.D.  
Mike Tryon  
Jeanine Valrie-Logan, CNM  
Carrie Vickery  
Rachel Wickersham, RN, CPM  
Hunter Wiggins, J.D.  
Cheryl Wolfe, M.D. (absent)

Staff Present: Lucienne Doler, IDFPR  
Alex Martell, IDFPR  
Samantha Ortiz, IDFPR  
Amanda Phelps, IDFPR (Springfield)  
Matt Sanchez, IDFPR  
Richard Schultz, IDFPR  
Ciara Wagoner, IDFPR

Speakers Only Present: Erin O'Brien, ISMS  
Tina Wheat, M.D.  
Stephanie Martinez, CNM  
Tayo Mbande  
Melissa Cheyney, PhD, LDM

Guests Present: Destiny Lee, Senate Democrats (Springfield)  
 Trisha Rodriguez, Senate Democrats (Springfield)  
 Gordana Krkic, Illinois Academy of Family Physicians  
 Jennie Pinkwater, ICAAP  
 Angelique Muhammad, Illinois Friends of Midwives  
 Kristen Mantell  
 Becky Coolidge, ICCPM  
 Sonia Collins  
 Rebecca Searles  
 Nora Kropp, ICCPM  
 Antonique Johnson  
 Nicole Miles, CBNC  
 Lina Isabel Rauh, ICCPM  
 Tim McLean, ITLA

Topic	Discussion	Action
<b>Opening Statement</b>	<ul style="list-style-type: none"> <li> <b>Senator Martinez:</b> Thanked everyone for attending the meeting regarding the Home Birth Maternity Care Crisis Study Committee. Mentioned that Representative Moeller was elected as Vice-Chair at the last meeting. Representative Moeller will be stepping in at any time that Senator Martinez needs to leave or is unavailable. Representative Moeller is a great supporter of this legislation and she hopes that through the work of the Committee they can move forward with a piece of legislation.           </li> </ul>	
<b>Call to Order</b>	<ul style="list-style-type: none"> <li>           The meeting was called to order and a roll call was taken. As there were thirteen Committee Members present, in Chicago or Springfield, there was a quorum of the total fifteen Committee Members present. All speakers and attendees then introduced themselves.         </li> </ul>	
<b>Comments from the Chair</b>	<ul style="list-style-type: none"> <li> <b>Senator Martinez:</b> Stated that there are some ground rules that she would like all of the participants to keep in mind during the Committee meeting, because there are speakers that have opposing views. Regarding the speakers, she asked them to be as clear and concise as possible with their testimony and to leave time for questions from the Committee. She also asked the presenters to remember that the Committee Members have copies of the documents which they have provided, so there is no need to read from the documents. In addition, she asked the speakers to focus on the most important facts in their presentations, so that all speakers will be able to make their presentations in the allotted two-hour time. Regarding the Committee Members, she asked that they be respectful of each speaker's opinions and time. She asked to hold all questions until the end of the individual's testimony. She asked that the Committee Members refrain from making comments about the speakers' testimony during the questioning period, and if they would like to contradict a speaker's position, please save those comments for the general discussion period. Also, if Committee Members have long detailed questions, she asked them to submit the questions to attorney Richard Schultz after the meeting. Mr. Schultz will circulate the questions and the responses to the Committee prior to the next Committee Meeting. If you have any articles or studies questioning a speaker's statements, please send those to Mr. Schultz and           </li> </ul>	

	<p>he will distribute the materials to the full Committee prior to the next meeting. For everyone, please remember that we are here to collaborate and talk through this issue and not to debate or argue with each other. We do not have the time for that. From the very beginning, which was a few years ago, the concern has always been about how we can come together because we are seeing births happening outside of hospitals want to always ensure the safety of babies and mothers. Her concern is that there are a lot of great midwives available that are assisting in births and performing these duties. Now we have 35 states that do have certification for midwives and that is where I would like to get at one point. She believes that it is very important to have midwives licensed in Illinois. Now we are going to hear from the other side about why there is an opposition to this. She really believes that somehow, the Committee can arrive at a happy medium and find a way to make sure that no one is operating in the shadows. She wants to ensure that moms who desire to have a baby at home have a data base or something that they can pull from as far as who they want to assist in the delivery of their child at their home, because they are going to deliver them anyway. The most important item is making sure that the midwives are screened, have a license, and are monitored through IDFPR. She is open to any kind of idea, whether it is a pilot program, or they start off small and see how it comes out. Her goal from the Committee meeting is to have some type of legislation to file in the next session that reflects the work that this Committee has done. Thanked the Committee Members again for their participation.</p>	
<b>Old Business</b>	<ul style="list-style-type: none"> <li>The July 18, 2019 and August 15, 2019 minutes were reviewed and approved without any changes.</li> </ul>	Minutes Approved
<b>New Business</b>	<p><b>A. <u>Witness Testimony</u></b></p> <p><b>1. <u>Erin O'Brien Testimony</u></b></p> <ul style="list-style-type: none"> <li><b>Ms. O'Brien:</b> Stated that she is the lobbyist for the Illinois State Medical Society. Thanked the Committee very much for allowing her to be there and for the creation of this task force. Believes that it is leading to very important discussions regarding home births and it has certainly given everyone an opportunity to learn more about basic questions that physicians have moving forward and what they could do about home births. At a minimum, it has provided her a lot more information to bring back to her physician leadership. Dr. Wolfe unfortunately had a patient case that needed her immediate attention, so she was not able to attend the meeting. She wanted to be brief because there are other physicians who will testify about their specific concerns. She intended to touch on three basic issues: adverse events, education, and briefly touch on liability, because she knows that is a "hot button" issue for everyone. She distributed an article that recently was published in Florida about adverse events. She circulated the article for two reason. She believed that it was important to delve more into what actually happens at the home when things go wrong. This gets to the heart of concerns among physicians. We need to know how</li> </ul>	

	<p>to minimize the risks when emergency situations present themselves. Believes that we also need to know how to limit midwives from taking on more risks than they are trained to handle. The other reason that she circulated the article about Florida midwives was that it highlights what has been readily acknowledged, which is that there is no data describing events which occur in home births. Florida has a reporting requirement in their midwifery law that actually had to be strengthened because there was a real failure of reporting on adverse events. The article that was distributed highlights the need to collect data. She acknowledged that adverse events happen everywhere, even in the hospital system. She noted that Senator Martinez has been integral stakeholder in the development of legislation that addresses the maternal health crisis through Senate Bill 1909, and what can be done to fix it. Part of that, which her organization supported, was adequate and full insurance coverage for dual services. Her organization believes that this is very important. However, she desires that there be a greater discussion about what happens when adverse events occur in the home. Florida law also contains a number transfer and consultation protocols, as those contained in the previous Illinois bills, but somehow the protocols continues to get lost. As we move forward, we need to make sure that when risky situations present themselves, that those risks are dealt with by the most highly trained individuals 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 certified professional midwives (“CPMs”). People need to know what is happening with home births and where it is happening. Regarding training, physicians have had a lot of questions about what training the midwives receive. She admitted that she has 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 as it is not in line 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 makes sure that all individuals within a profession are equally trained to deal with events that are presented. Finally, concerning medical liability, she 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, if the parties could come to a resolution, it would be great, although she acknowledged that it would be slightly 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. Thanked Senator Martinez, Representative Moeller and the other Committee Members for their time. She explained that there was a large amount of information that she will take back to her organization and a lot of</p>	
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discussion will take place after the hearing. She stated that she was open to respond to questions or to let the physicians testify.

- **Senator Martinez:** Stated that questions will be held until all of the panelists have completed their presentation to allow for clarifications after the completion of the testimony.

**2. Tina Wheat, M.D.**

- **Dr. Wheat:** Stated that she was representing the Illinois Academy of Family Physicians as a board member and that 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 in delivering babies. Since many obstetrical complications cannot be anticipated, in most cases, 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: there could be maternal or fetal hemorrhage; prolapsed umbilical cord; shoulder dystocia, making it difficult to properly deliver the infant and can result in paralysis; and there could be 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. Just two weeks ago, 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 had no problem with this current pregnancy. So, she is someone who 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. This was one of the emergencies that she mentioned as shoulder dystocia. This complication if not successfully managed can 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, which was about the longest minute ever when one was going through the emergency. 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. 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. 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 39<sup>th</sup> Annual Pregnancy Meeting in Nevada. While planned home births in Illinois are lawful, currently the only people legally allowed to deliver babies are medical doctors and certified nurse midwives. 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 medical doctors and certified nurse midwives' teams in performing home births.

**3. Maura Quinlan, M.D., MPH**

- **Dr. Quinlan:** Thanked the Committee for the opportunity to speak. She is an OBGYN physician practicing at Northwestern, and the Legislative Chair of the Illinois Section of the American College of Obstetricians and Gynecologists (“ACOG”), which represents about 1,500 OBGYNs 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 focus on 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. Clearly, we have resources now to make it 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. As was mentioned, there have been a number of studies written about the risks of home birth. 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. Again, very few babies die during or immediately after labor, but according to this study, this risk is doubled when the mother plans a home birth. 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 believed that the central requirement is that families choosing this alternative are very well informed about the risks of home birth. 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. In 2011, ACOG always opposed legislation to license home birth providers, but as the interest has increased in home births, the position of ACOG has evolved and there is a Committee Opinion from the professional group which reflects the change in the position. (This Committee Opinion has been provided to the Committee.) The basic statement is 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. So, that was a huge policy shift for ACOG moving forward. She was happy that the Illinois Section of ACOG has adopted that same policy change. In 2011, ACOG had opposed home birth legislation presented at that time because the organization felt that there were no requirements: for minimum educational standards for providers; that mothers needed to be low risk; to establish criteria for when women and infant needed to be transferred to a hospital; and to report complications during home births. At that time the State of 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. She was happy to report however that legislation on home birth licensing last year was quite different. Illinois ACOG was delighted when it was asked to participate in the writing of the legislation and had a great relationship with the midwives who spearheaded the bill. This bill included all the details that ACOG had outlined to make home births as safe as possible. She briefly reviewed what ACOG thought was essential. One component was the appropriate selection of candidates for home birth, in that only low risk women could deliver at home based on that proposed legislation. In addition, the bill included clinical details of events during prenatal care, labor, postpartum, or the infant that would require transfer to the hospital. OBGYNs believe that it is not safe for women who are considered being at high risk of complications to deliver at home. These risks include for example women with diabetes, hypertension, twins, history of a c-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 Certified Nurse Midwives ("CNMs"), Certified Midwives ("CMs"), or Certified Professional Midwives ("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 that was in last year's bill, which her organization supported was that there would be clear reporting requirements for complications and a review board of CPM's, CM's, and physicians who would 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 her 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. She believes that the growing interest is a wake-up call for physicians in obstetrics, that we 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 safe as possible if she chooses to deliver at home.

**Questions of Witnesses**

- **Senator Martinez:** Thanked speakers and noted that this was time that was available for questions and asked the Committee Members to wait to be recognized for questions. She noted that many of the things that the speakers discussed were the reason why the Committee was formed. Home births are going to continue to happen, whether people accept it them or not. There are financial reasons for home births, in that there are people in rural areas who cannot afford giving birth in a hospital. Other women simply just want to have their baby at their home rather than a hospital setting. She thought that the different associations requesting this legislation, realize that the safety of the mother and the infant are important. In rural areas where hospitals are not close, even establishing birthing centers near these areas would be very challenging. The information provided shows why this issue is

important, and is why working in a collaborative way with hospitals and physicians really helps achieve what the Committee is trying to do, which is to provide a safe environment for the births, because not all births are the same. But we also know that many children already have been born in the home with the assistance of midwives with no traumatic results. The data is very important in crafting a bill that has safety measures in place to ensure the safety of the mother and the baby. Also, they should work with the physicians that could be nearby. Agreed that home births are going to continue to happen and the Committee has to determine how to address home births to make sure that the individuals who are performing home births are people who are highly qualified, certified and that they follow every rule that applies to home births to be licensed. Thanked the panel for their testimony. Stated that they have one thing in common, which is to ensure that the babies and mothers are safe, and that whoever is providing that service is in connection with everyone that needs to be part of that woman's care, from prenatal to postnatal. That is very important. Also, has heard how involved midwives are from day one to the very end, and it is important that the Committee keep an open mind to that. Needs to ensure that the liability component, the reporting, and the data are all a part of this discussion. That will contribute to making a good bill, because it will include measures that will address these issues.

- **Ms. Sawicki:** Noted that both Dr. Wheat and Dr. Quinlan, talked about the importance of women making informed choices. She agreed that as with all patients, people should be allowed to make informed choices even to do things that are high risk. She asked whether there was any data on women who choose home births regarding their interactions with the healthcare system after they find out they are pregnant. She provided an example of whether women who seek home births see a doctor or have an opportunity to receive information before they make the choice of home birth. She thought that it was important in discussions about making sure women are informed of risks. She wondered where women receive information about home births. She did not know if the speakers were aware of any data about interactions with the medical system during pregnancy prior to delivery, or if they had any other thoughts or comments about how women would obtain the information that they need to make an informed choice about where to deliver their baby.
- **Dr. Quinlan:** Stated that there is nothing that she knew of that would answer the question. She knows there are some communities, where if the homebirth midwives do not have prescriptive abilities, they might be able to have a single visit with a physician to obtain medication. If there are complications and mothers need to communicate with the medical system, then they might be informed of risks through that communication. She did not know that there is any data about that. It is her understanding that most of the women spend the entirety of their

	<p>care outside physician care. She presumed that these discussions about risks are exclusively with the midwife.</p> <ul style="list-style-type: none"><li>• Dr. Carlson left the meeting.</li><li>• <b>Dr. Wheat:</b> Stated that she was not aware of any data on that issue either. She thought that the closest analogy that she could make is literature about the mother’s interactions with doulas, and how positive having a doula as an advocate in improving the experience. She believed that this would lead family physicians to be very open and receptive to having women have their own choice regarding the location of their birth. She acknowledged that physicians are not always talking to patients the way that they should. She thought that they have to change this to improve the experience, knowing that when there is a better advocate presenting information in a way that is more meaningful it can lead to a better experience. That is the closest example of sharing information with expectant mothers.</li><li>• <b>Ms. Sawicki:</b> Asked if legislation is moved forward, to ensure that women are making informed choices, whether there was a system in place for making an informed choice, or whether there are expectations regarding how women would secure information to make an informed choice.</li><li>• <b>Dr. Quinlan:</b> Responded that in the U.K. and the Netherlands systems, the first pre-natal visit is with a physician or a certified nurse midwife, and there is a determination that if the patient is low-risk they can deliver at home and if high-risk they will deliver in the hospital. She thought that the clear risks are discussed at that time. She believes that she heard about a midwife consent form in the discussion of last year’s bill, to allow patients to understand the risks and benefits, but she did not think there is data on how that risk is discussed. She also thought that legislation could require the closure of risks in a clear and understandable format.</li><li>• <b>Ms. Wickersham:</b> Thought that the groups could possibly collaborate on an information pamphlet regarding risks that midwives may provide to patients. Also questioned Erin about her statement that ISMS considers that the Bridge Certificate is a loophole. She asked how ISMS arrived at this judgement despite the fact that the ACOG had gone on record encouraging the Bridge Certificate.</li><li>• <b>Ms. Brien:</b> Responded that it was a matter of understanding who was getting what education. About two years ago, when she was involved in a discussion regarding this issue, one of the questions that arose was if the MEAC program was three years, how is the material involved in that program covered in a 50-hour program. The question regarding the differences between the 50-hour program, which was not accredited, and the accredited three-year program. The physicians are looking for a better understanding of what the Bridge Certificate education entails and how it is consistent with a three-year program. She noted that if the MEAC program is going to be touted as comprehensive education that can adequately train professional</li></ul>	
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	<p>midwives, then her organization wants to make sure everyone is obtaining that same comprehensive education. Last year, the bill's language stated that anyone seeking licensure before 2020 can apply for and receive licensure if they received the 50-hour program, but then after 2020 all applicants had to meet the MEAC program. Her organization questioned why the Bridge Certificate process was permitted. The organization did not understand why all applicants would not be required to qualify under the MEAC program. Another concern was that the proposed language stated that if someone from another state who had been practicing for a certain length of time, yet they had not become certified under the MEAC program, could apply for licensure too. She believed that the physicians were looking for consistency, and consistency for us is assurance that the education and training is adequate. She stated that was an issue her organization had moving forward.</p> <ul style="list-style-type: none"> <li>• <b>Ms. Wickersham:</b> Asked whether these physicians who have these questions are members of ACOG.</li> <li>• <b>Ms. O'Brien:</b> Responded that they were not all members of ACOG, but she thought that some may have been members. She noted that physicians disagree amongst each other all the time. There are physicians who are members of ACOG and ISMS, who have raised their concerns.</li> <li>• <b>Ms. Wickersham:</b> Asked Dr. Quinlan, who had mentioned the Oregon study, whether she had a chance to review the Caughey study, which was a more recent study that concluded that outcomes were equal for women and infants if the midwifery is carried out in a well-integrated setting.</li> <li>• <b>Dr. Quinlan:</b> She agreed with that study but noted that Illinois would not have a well-integrated setting and Illinois is far from that setting unfortunately. The Danish system is very impressive, and she has seen what labor and delivery looks like there. There is a board of review like they have at Northwestern for women in labor at a hospital, and a separate board for women in labor at their homes. The board has updates and people know who is working at each of the boards and how to communicate between these systems. That country has a well-integrated system. In Illinois, women would arrive at the emergency room, which is a disaster, and the physicians attempt to do the best that they can without much discussion. She agreed that in a well-integrated system, the mortality numbers would probably be better and thought that these mortality numbers could get close to hospital rates if there is an attempt.</li> <li>• <b>Ms. Wickersham:</b> Asked if Dr. Quinlan would agree that licensure of CPMs would be a step towards achieving a better integrated system.</li> <li>• <b>Dr. Quinlan:</b> Stated that it was a little step on a big ladder. Mentioned that other components for safety are necessary.</li> </ul>	
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- **Ms. O'Brien:** Added that it required the resolution of the major question about how to reform the health care system in the United States.
- **Ms. Belcore:** Mentioned that the first step for licensure would be initialed by creating a bill, but beyond that are the development of rules and regulations which come after a bill is approved. She stated that it was similar to the Birth Center Bill, where the bill itself will provide a very basic framework, and the rules and regulation will involve all of the details. Asked if Dr. Quinlan sees a potential for licensing CPMs as a first step in developing a well-integrated system, and that the implementation of the well-integrated system would come from the adoption of rules and regulations and oversight by a board to address the integration problems. Asked if she could see CPM licensure as a first step in a potential path toward developing a well-integrated system as well, because on behalf of CPM's, that would be their goal.
- **Dr. Quinlan:** Responded that the question was more appropriate for a legislator. In last year's bill there were talks about having as much detail as possible in the bill and not leave things up for discussion. However, she would leave this discussion for someone in Springfield who knows the legislative process.
- **Senator Martinez:** Responded that as a member of the Legislature, we can present a bill as detailed as we can, but during the rule making process things always get fine-tuned.
- **Dr. Quinlan:** Stated that her worry was that a bill would not include something important. She provided an example of whether a woman would be considered a low-risk or high-risk patient. If a woman has a prior C-Section, they would be considered high risk, but the rules may not include that classification. Stated that her worry about safety would be to have any part of a bill not be discussed in public manner.
- **Ms. Sawicki:** Commented that from the legal side, that one of the risks in having a lot of medical detail of what it means to be low-risk in the legislation itself, is that standards of care change and it is very hard to change legislation to reflect current standards of care. This is why very often there are terms in legislation that end up being defined by regulations, which are much easier and quicker to amend. She absolutely understands the concerns about making sure that everyone understands what low-risk means. From a legal perspective, it is not a great idea to define the medical details in legislation, as opposed to the more flexible process as rules.
- **Ms. Harris:** Added that from a legal perspective, the other way other states have dealt with this is by adopting existing guidelines from organizations that define those standards, like ACOG. So as those standards change, they also automatically change for the legislation. She noted that was another way to address this issue. She then stated that regarding the informed consent issue, one of the things she has noticed while looking at other state statutes was that the majority of

	<p>them do say somewhere in there that the risks need to be disclosed. She did not see other states defining what the risks were involved in home birth. She suggested that Illinois can be at the forefront of defining what these risks were by providing a brochure that must be given to expectant mothers so that they understand the full risks of home births. She added that reading a brochure that is published by the state is one option and having someone explain the risks is another. She posited that sitting down with a physician or other health care provider who would explain the risks is probably the best. Those are some of the things that she has seen in other state's statutes.</p> <ul style="list-style-type: none"><li>• <b>Ms. O'Brien:</b> Added that informed consent is an informative process. She stated that her organization has resisted bills that mandate a physician provide a written informed consent because it is a very informative process, as opposed to simply providing a pamphlet. In previous conversations she has talked about CPMs providing that informed consent and she urged that it definitely has to be part of the process moving forward.</li><li>• <b>Senator Martinez:</b> Asked whether an expectant mother who arrives at a hospital does the doctor provide informed consent forms, or would this requirement just apply to CPMs.</li><li>• <b>Ms. O'Brien:</b> Responded that as she understood the process, when doctors talk about any procedure, whether it is pregnancy or a medical condition, the physician reviews the risks and benefits, including what can go wrong or what can go great, which is all part of the informed consent.</li><li>• <b>Senator Martinez:</b> Asked the midwives, whether they provide the risks when someone approaches them about home birth. Noted that many mothers have heard about home birth from other sources, and she asked what midwives tell expectant mothers about home birth.</li><li>• <b>Ms. Belcore:</b> Responded that in order to receive your certification as a CPM, the applicant must create and submit an informed consent document that would be included in the paperwork for patients. This informed consent document must be approved by MEAC before CPM applicants are approved to take their board exams. Most midwives that she knows in Wisconsin are required to present their informed consent forms to their clients with documents regarding their services. The consent form is read and signed, along with a Transport Agreement, which outlines the usual reasons for a transfer to a hospital.</li><li>• <b>Senator Martinez:</b> Asked if patient is informed of risks from the first day that they agree to retain her services to assist in the home birth.</li><li>• <b>Ms. Belcore:</b> Agreed that the patients are informed of the risks from day one or the interview process.</li><li>• <b>Ms. Harris:</b> Mentioned that the consent form sounds like an individual document and asked whether there are specific guidelines that must be followed for the informed consent form.</li></ul>	
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	<ul style="list-style-type: none"> <li>• <b>Ms. Belcore:</b> Responded that there are no specific guideline or standards for the informed consent form, but the informed consent form must be approved by NARM before applicants can take the boards for CPMs. Also, different states will have different regulations regarding an informed consent form, so there is no standard form for what is expected or would be required. But, there are basic standards that NARM insures are included and NARM has the right to reject midwives informed consent documents in the process of CPMs application review.</li> <li>• <b>Ms. Harris:</b> Stated that if CPMs are licensed to practice in Illinois, should there be a document that has at least the minimum level of standardized disclosures, so that everyone in the state gets some basic information that is standard.</li> <li>• <b>Ms. Belcore:</b> Responded that the legislation that Dr. Quinlan was talking about, which was with the collaboration of ACOG, was very good at explaining the risks that needed to be disclosed. This would be a basic standard for informed consent forms. Assured Ms. Harris that her organization would be very open to creating a standard informed consent document for the state. If that is a requirement to get licensure, her organization would be happy to work with doctors, hospitals and others to create a basic form. Also, mentioned that the organization would be happy to participate in a collaborative committee regarding a basic informed risk form.</li> <li>• <b>Senator Martinez:</b> Added that when there are 35 states already licensing midwives, she was sure that there are so many documents can be reviewed to see what other states are doing to inform about risks and to ensure that mothers are protected where ever the mother wants to deliver her baby. Said that was good to know.</li> <li>• <b>Ms. Wickersham:</b> Mentioned that earlier there was a concern about record keeping, and a concern about arriving at the hospital without any records. However, that is not true because many nurse midwives and CPMs use electronic medical record keeping. She mentioned that there are computer programs for record keeping, and paper forms for record keeping. Laboratory reports and records of the labor are all available, but the lack of licensing is what prevents these records from getting into the hands of the receiving hospitals or physicians. This is because many midwives are afraid to turn these documents over because it incriminates them. So, licensure is the way to have transports arriving with good records about the expectant mother.</li> <li>• <b>Ms. Harris:</b> Responded that of the 35 states that license midwives, only ten of those laws specifically state that upon an emergency for a transport, the records must be provided to emergency personnel at the hospital. A few of those ten states also provide that when possible, the midwife travel with the transport to provide the hospital received full information about the mother and the pregnancy. It would be very important to include in proposed legislation that these records need to</li> </ul>	
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	<p>be transferred to the hospital and if possible, the presence of the midwives with the mother to provide additional information.</p> <ul style="list-style-type: none"> <li>• <b>Senator Martinez:</b> Responded that as discussions have proceeded, she had heard that as a possible requirement. Explained that midwives want to be able to do this, but they have concerns about doing this when they are not licensed by the State because they can get into trouble by accompanying the mother. That is why it was so important to protect the population performing these homebirths. They have to also have protections by licensing them through IDFPR and that the license is monitored by the State.</li> <li>• <b>Representative Moeller:</b> Noted that there were discussions about legislation in other states and asked whether it would be possible to have IDFPR staff to put together something with the different states which license midwifery for the 35 states. She believed that it should give some ideas about the larger elements of what other states are including in their statutes which license midwives. Mentioned that the chart should include some of the larger issues, such as liability, informed consent, and education, so the Committee Members can see how other states are handling these issues.</li> <li>• <b>Ms. Wickersham:</b> Responded that those documents already exist. There is existing comparison documentation of the various state laws which would help IDFPR in the right direction.</li> <li>• <b>Mr. Schultz:</b> Requested that those documents be sent to him so that he could circulate them to the Committee.</li> <li>• <b>Ms. Wickersham:</b> Believed that they would be helpful as the Committee moves forward. Noted that some laws were enacted in the 1990s, which occurred at a time when the laws did not need to address things that currently need to be addressed.</li> <li>• <b>Representative Moeller:</b> Responded that perhaps the Committee should be given statutes that were enacted more recently rather than those which were enacted a long time ago. It would permit the Committee look at the best practices among the states.</li> <li>• <b>Ms. Wickersham:</b> Noted that one of the witnesses will address some of these issues as well.</li> <li>• <b>Ms. Valrie-Logan:</b> Questioned Dr. Wheat, about her reference to statistics that mothers who have home births were three times more likely to die. Requested that she provide that study to Mr. Schultz, so that they can be circulated to the Committee. Also, asked whether there was any documentation in that study that talks about the likelihood of maternal and child morbidity and mortality in the hospitals.</li> <li>• <b>Dr. Quinlan:</b> Responded that the Oregon data stated that there was a two-fold increase in neo-natal death for home births compared to hospital births, and information about that data is generally available. She said that they could send it to the Committee.</li> <li>• <b>Representative Moeller:</b> Stated that in discussing the incidents of harm or death in home birth, like mentioned in the article about the</li> </ul>	
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experience in Florida, which stated that there were 972 injuries or problems in a hospital setting. However, they could not break out in terms of whether it was related to birth or not compared to the 6 home birth problems that happened in the same period. Noted that the Committee needs to be able to ensure that they are presented with accurate comparisons as much as possible.

- **Ms. O'Brien:** Noted that one of the reasons for the difficulty in presenting data is this lack of data. She knows there is some very good adverse reporting from Illinois medical professionals. She also stated that the Illinois Department of Public Health published an excellent report on maternal mortality rates and we can look at that as well.
- **Ms. Belcore:** Questioned Ms. O'Brien about her statement that the doctors were concerned about risks which the doctors don't believe CPM's are trained to manage.
- **Ms. O'Brien:** Responded that she believed physicians historically have wanted to know what happens in the home when emergency situations arise during labor.
- **Ms. Belcore:** Asked whether the Committee could receive a list of those concerns, so the Committee members can determine whether they are related to low-risk births. She explained that the proposed legislation focused on low-risk birth mothers, and CPMs are able to address the concerns that arise during low-risk births. She would love to be able to demonstrate that CPMs are trained to address the concerns that may arise in low-risk births. As an example, she mentioned Dr. Wheat's testimony about shoulder dystocia, and pointed out that CPM's are very well trained about how to address shoulder dystocia. The training includes how to manage it, and things that CPMs would do to address shoulder dystocia. There are things that can definitely happen at home, but things like shoulder dystocia are all hand maneuvers, it does not require specific to medication, pharmaceutical or something that only hospital trained providers have available. That is all experience with one's hands, which is something that midwives have. Assuming they cannot manage those is the problem, not the shoulder dystocia itself. Of course, you cannot always predict when the event will happen. Just wanted to mention that the midwives can address these concerns point-by-point, and explain how the midwife training addresses these events. This would help doctors become more comfortable with the midwife licensure process.
- **Ms. O'Brien:** Responded that the Committee will be hearing from physicians in the coming months and she encouraged more questions from them as well. Her organization was part of the larger group four years ago where the professionals had time to sit down and discuss these issues. Her organization is definitely trying to work through the issues involving the licensure of midwives. The Committee will be hearing from more physicians in the coming months and she would encourage that questions be raised about their concerns. Thanked Senator Martinez again because she believed that it was a good forum.

	<ul style="list-style-type: none"> <li>• <b>Mr. Tryon:</b> Questioned the assignment of risk and having risk categories. Asked that just because a person is in a high-risk category, whether that would mean that they are totally eliminated from the option of a home delivery. He provided an example, where a person with type-2 diabetes, which is under control, their A1c was 6, and the person is fit. He asked why that would place the person in a high-risk category, which would deny the person the right to have a home birth.</li> <li>• <b>Dr. Quinlan:</b> Responded that the example involved a more complicated medical discussion. A1c 6 or coupling factor 6 (“CF 6”) would be high for a pregnant woman, even a 5 or 4 ½, there are still complications in child birth. She expressed concerns about splitting hairs about defining risk. Her default would be making sure patients are low-risk. She said that she could not sleep at night knowing that she had supported something that seemed at all compromising to the mother’s care. Her colleagues and ACOG national would not support defining a mother as low-risk with those conditions.</li> <li>• <b>Mr. Tyron:</b> Pointed out that if a person did not have an A1c of over 6 and one-half, the person would not be considered to have diabetes.</li> <li>• <b>Dr. Quinlan:</b> Responded that obstetrics is totally different considering diabetes. She stated that an A1c of 5.2 would similarly raise concerns for a woman giving birth. She explained that for pregnancy, the cut-off is totally different, and it has to be much tighter controlled with diabetes.</li> <li>• <b>Ms. Lowrance:</b> Noted that she appreciated the short discussion on risk. She believed that sometimes in the medical field we do not have a clear understanding of risk. For instance, she stated that one of the doctors quoted in a new article cites that home birth risks are 3 times higher, but if you look at that, it is still low-risk. She added that the same thing is true for some of the risk factors, for example, for a vaginal birth after a C-section, the biggest concern for physicians is the risk of a uterine rupture. That risk is very low risk. She agreed that there is a predictability factor with that, but it is very low-risk considering the total risks. Another issue is when talking about risk factors there has to be a discussion about who determines these risks and how many risk factors are considered when someone is designated high-risk or low-risk. She just wanted to mention the point that when discussing risks, the risks are relatively very low. Also, when reviewing the article, they have to not just look at the position that the risk is two or three times higher, but what is the overall risk. If the risk is less than 1%, it means that 99 out of 100 are going to be fine. Questioned whether that was high-risk or low-risk.</li> <li>• <b>Ms. Sawicki:</b> Asked Dr. Quinlan about her comment that ACOG states that they believe that a hospital or delivery center is the safest location for a woman to give birth, but still respects women’s right to choose the delivery location. Noted that they could discuss what constitutes high and low risks, but asked if a woman who falls into a</li> </ul>	
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	<p>category of high-risk, would the position of OBGYNs be that the woman could not make the choice to birth at home with a midwife.</p> <ul style="list-style-type: none"><li>• <b>Dr. Quinlan:</b> Responded, “Yes.” She then explained that she believed that most midwives would agree that delivering twins would just not be safe. Certainly, a woman could deliver alone, or could locate a midwife who does not practice under licensure rules and would assist in a home birth. But her organization would never support legislation that places lives at risk. She explained that the voice that is lost in this conversation is the baby, so if someone wants a vaginal delivery at home after having a cesarean section and the uterus ruptures and the baby does not survive, the risk is not just to the mother but to the infant. She added that the risk is low, but it is still present.</li><li>• <b>Representative Moeller:</b> Asked whether there a defined standard of care within ACOG or the industry on what defines high-risk and low-risk births.</li><li>• <b>Dr. Quinlan:</b> Responded, “Yes.”</li><li>• <b>Representative Moeller:</b> Asked to confirm that there are already definitions that establish whether a birth is considered high-risk or low-risk, for the Committee to use either for the rule making process or legislation.</li><li>• <b>Dr. Quinlan:</b> Agreed.</li><li>• <b>Ms. Wickersham:</b> Asked for a clarification. Stated that at her organization, we agree with ACOG on many of these things and we disagree on some but are willing to concede on those disagreements. Stated that while there are states which allow midwives to help with the birth of twins, but her organization does not want to assist those births. There are some births that the midwives do not want to take care of because they agree that the patients are high-risk. Most of what we do agree on is people we do not want to take care of at all.</li><li>• <b>Ms. Vickey:</b> Noted that there was discussion about integration and how lack of integration increases the risk overall for people. Based on the discussions she wondered about the steps that the medical societies in Illinois are taking to increase integration. She noted that as a consumer, it has been her personal experience that hospitals have not contributed to integration.</li><li>• <b>Dr. Quinlan:</b> Responded that from her practice, she did not know the decisions that hospitals make.</li><li>• <b>Ms. Vickey:</b> Added that it was not just a hospital’s decision, but a physician’s decision as well. She said that she wondered if there are any active working groups in any of your societies which are specifically considering how to integrate hospitals with home births. She explained that she was not just talking CPM’s, but CNM’s, so that there would be statewide expectations or standards available to consumers, so they know that hospitals and physicians across Illinois are developing standards for integration. She explained that these standards would involve current deliveries that arrive at the emergency</li></ul>	
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rooms or are transferred to the hospital before labor begins to ensure a transfer process that is safe and smooth. She asked whether the organizations were working on anything now to improve integration, which could also improve outcomes.

- **Dr. Quinlan:** Responded that she believed that just being here is something that they are doing, because hospitals cannot really do any collaboration because midwives are not licensed. Noted that there are some CNM practices that work a physician, OBGYN or family medicine, that are part of the group. However, hospitals and physicians cannot work together and collaborate because midwives are non-licensed providers. She also stated that she was at the meeting to work on this to become integrated.
- **Ms. Vickey:** Noted that the data and articles sometimes talk about transfers being presented as somehow a negative event. Asked whether a decision to transfer delivery to a hospital is seen as a failure or negative by the receiving hospital or physicians. She explained that if the decision to transfer is viewed as a negative, then when transfer numbers were increased, midwives could be criticized for the increased transfer rate.
- **Dr. Quinlan:** Responded that she did not think of a transfer as a failure. She said that a transfer is necessary to get a healthy outcome, so as long as the transfers are clinically appropriate and not too late, she did not believe that it would be considered a failure.
- **Ms. O'Brien:** Added that a large part of the discussion on maternal mortality in the hospital setting, has been about how we can integrate the system so that it focuses on the health of the baby and the mom, and by establishing transfer protocols as appropriate. She did not believe that physicians view transfers as a negative.
- **Ms. Vickey:** Commented that that position has not been her experience as a mother.
- **Dr. Wheat:** Added that as a family physician, she has to transfer her patients to someone else a lot of the time. She noted that any time that there has to be an operative delivery, or someone becomes high-risk, because she is also primarily doing low-risk deliveries. She experiences that as well. This is very much viewed as a correct decision in that something was identified before this could go wrong. She noted that it is very collaborative and works very closely with her team. She added that her group trains for emergencies that can happen in any setting, but primarily focus on the team and making sure that every member of the team is heard and part of the system. Her group values the team work, and noted that all the information that they can get, and conversations are very important. They train for how to handle those things that come in to the hospital.
- **Senator Martinez:** Thanked the speakers again for their testimony and invited the next set of speakers to the floor.

**4. Stephanie Martinez, CNM**

- **Stephanie Martinez:** Stated that Stephanie is a CNM practicing in the largest and oldest home birth practice in the state of Illinois. Stephanie is the proud daughter of a Mexican immigrant, a lifelong resident of Chicago’s southside, and on Stephanie’s father’s side, the fourth generation of Stephanie’s family to grow up in the southside. Along with being a nurse practitioner, Stephanie holds a bachelor’s degree in Latin American studies and Latinx studies from UIC. Stephanie is proud to say that Stephanie is one of only four certified nurse midwives of color in Illinois who practice out of hospital birth. Stephanie is all too familiar with the limitations faced by patients who share Stephanie’s own life experiences. Stephanie’s decision to become a midwife was partly formed by the story of Stephanie’s own birth, which Stephanie’s mother describes as traumatic. Stephanie was born in a well-known southside hospital where sterilization abuse, one of the most well know eugenic abuses that occurred in the U.S. targeting women of color, was practiced until the 1990s. Stephanie’s mother was a recent Mexican immigrant knowing limited English and had no health insurance, when Stephanie was born. She described a birth where she remembered being threatened and bullied, and where vaginal exams occurred so frequently and without her consent that she developed a fever. Stephanie’s mother’s fever led to Stephanie being taken to the neonatal intensive care unit (“NICU”), and Stephanie’s mother not being able to see Stephanie on the day of Stephanie’s birth. Stephanie wanted everyone present, especially the OBGYNs and doctors, to ask themselves an important question, “what is a vaginal exam without consent?” 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. More people around the globe are recognizing the devastating impact of racism and white supremacy on black and brown families during pregnancy and childbirth, especially in the U.S. While babies of Hispanic origin made up 23.3% of births in the U.S., in 2017, and 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. Stephanie’s education and personal experience have also led Stephanie to believe there are actually more Hispanic babies being born than actually reported. Since the U.S. Census began using the term Hispanic, people who are ethnically Hispanic are notoriously underreported and

	<p>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 Trump was elected President in 2016, rates of pre-term births, low birth weight, and birth by caesarian 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. Likewise, in spite of Trump labeling immigrants as being criminals and rapists, more immigrants in Illinois have a college degree or more, than do immigrants in Illinois with less than a high school diploma. Immigrants make up one in seven people in Illinois and own over 20% of businesses in the Chicago area. One in eight people in Illinois is a child of immigrants. 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. Stephanie has noticed more of a desire and need for home birth to be available for healthy low-risk Latino parents. 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 Stephanie would be an anomaly in Stephanie’s career, becoming a nurse midwife in the U.S. is an expensive and time-consuming process, which is unavailable and inaccessible to many birth workers of color. Stephanie would like to gently remind the Committee that 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 are dedicated birth workers and who hunger for more education and training, but have young families to support and a minimum of seven years of school is simply out of the question. Legalizing certified professional midwives 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 should be ashamed of itself for holding 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</p>	
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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 families of color. Giving CPMs licenses to practice in Illinois will save lives. Stephanie begged the Committee to end the archaic belief that home birth is unsafe, that midwives are ill-prepared, and that home birth is not desired by communities of color. Stephanie asked that Illinois be given the opportunity to catch up with the rest of the country and world by allowing CPMs to practice legally. Everyone deserves the option to be born in a safe and loving home environment with trained professionals. Stephanie asked the Committee Members to do what they could to: prevent mothers and babies from dying; protect the most vulnerable residents of Illinois; and make homebirth safe and accessible to everyone in Illinois by legalizing CPMs and mandating insurance companies cover out of hospital births.

**5. Tayo Mbande Testimony**

- **Ms. Mbande:** Stated that she 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 said that she has given birth twice in a hospital, and once at home, without a midwife and around family. She explained that the home birth was the best experience she has ever had. She has a son and two daughters. 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. Although she gave birth to a full-term baby at over 39-weeks, during those 10 days she was completely 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 married, a college graduate, but this still did not place her in any greater category to not experience these types of abuses. She spent 10 days in the hospital against her will, while repeatedly asking 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. It was very tough. She was very educated on what should happen with a physiological birth, as well as the risk factors involved with home birth and potential giving birth to a pre-term baby. She decided to educate herself as much as she could, 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 thought that her

	<p>obstetrician, who was identified as the most skilled and prepared person to deliver her child, was not present, and the nurses were not comfortable with her giving birth without an obstetrician present; yet, her baby was born safely on the toilet in the bathroom (he did not fall into the toilet), and without a problem and is very healthy. Her birth went great, because her family was present, and they took the lead, not because an obstetrician told her the required position and not because of the nurses and medical staff, who took no other actions other than pulling the red emergency cord. For her third child, she made sure to take all 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 and past birthing experiences. At 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, all of her risks, and the conversation turned to her being asked why she did not want to be tested for HIV, as mandated by the state, instead of asking how her father had affected her pregnancy and the types of outcomes she hoped to achieve with the pregnancy. None of those things were discussed. So, she decided to go to a person who she thought and hoped would help her, which was a CNM. She went to the only free-standing birth center in Illinois and got the exact same care as a hospital. The midwife there, who was not black, told her that they could not acknowledge or would not acknowledge a pregnancy loss of mine because she did not take a pregnancy test. She was told that if she had not taken a pregnancy test, they could not confirm that she has lost the baby. That is when she knew that she could not receive care with that nurse midwife and 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 10 minutes. Tayo had to bring her two other children to appointments, but the black midwife was extremely accommodating and even though she was anxious taking her two toddlers to the appointments, the black midwife made sure she felt comfortable and safe. Tayo was able to feed her children lunch during our visits, she talked about her father with the black midwife, and the black midwife helped her talk about things that she was experiencing physically and emotionally. The black midwife helped her work through her physical and emotional issues. Towards the end of her pregnancy, the black midwife transitioned out of the practice, and Tayo was left with only white midwives. Then, the exact same thing happened again, with the white midwives. The white midwife told her that she had not seen her in a long time and this cannot happen. The white midwife emphasized to Tayo that that in order for them to remain in compliance, she was</p>	
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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. The white midwife told her what would happen postpartum, which Tayo was well aware of as she had previously given birth twice. She 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. Tayo told the white midwife that she appreciated that the information was shared, but that she wanted to decline these things; however, the white midwife continued. Tayo decided that she did not want to give birth at that location because she would not be respected. Tayo wanted to be respected as an adult who was pregnant and be most authoritative on how her child should be brought into this world and the manner of her care. She emailed the entire staff of the birth center to let them know that she would be birthing at home. She had a very uneventful labor. Her baby was born at home and full-term, one-day before her due date. When she was seen at the birth center, Tayo had to argue with the CNMs about her actual due date. Tayo asked the midwives how much her experience knowing her body meant to them, and how much it meant that she had been in her body longer than the midwives had known her, and that she had given birth twice before. The midwives said that they understood her point, but they had to follow protocols. These protocols would have shifted the type of care that she received because her daughter would have been considered premature, when she was born one day prior to her due date. Tayo 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 believed that she would have gotten a better continuity of care under the supervision of a CPM, who was a person of color. Tayo wanted to give birth with a black midwife that looked like her, because she understood the stress and the trauma from a birth at a hospital, which was a huge detriment to her health and her child's health. When home births are talked about as not being the safest place to deliver a child, and hospital being the safest place to give birth, people should understand that for some people hospitals are not considered safe. Anytime a member of her family is not 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 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. This is what led me to choose a home birth. She hoped that the information is helpful for the decision that the Committee will make.

- **Senator Martinez:** Thanked Tayo for her testimony.

**6. Barbara Belcore Testimony**

- **Ms. Belcore:** Stated that she 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 plans to discuss the very practical challenges that working CPMs face in Illinois today. She 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 lot of territory that is simply 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 want to choose to be assisted by a midwife, or choose midwives that look like them, deserve that option. Secondly, 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 will have no legal responsibility for that choice. Parents have the right to do this. There are compelling religious, philosophical, and personal reasons to choose homebirth. In addition, some choices are driven as a result of prior birth trauma and these families may no longer trust the medical establishment, as we have heard from other witnesses. 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. There can be a great deal of hostility that can occur. 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 and those they may transport to a hospital should work to maximize the chances of good outcomes for the mother, baby and family in whatever way that they can. Right now, CPMs' efforts to do that 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 and still have a good outcome. Oxygen may also help a new born immediately after birth. Currently, CPM's carry oxygen tanks and are certified in neo-natal resuscitation. She referred to a book, which is 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

	<p>during a birth. However, in order to fill their O2 tanks, CPMs in Illinois must cross the border and go into a legal state in order to obtain that oxygen or find someone who is sympathetic to them and is willing to fill the tank 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. Asked how that made home birth safer. All births also 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 that will save lives. These are medications which CPMs are trained to use and administer. 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 and hope that the medications work. 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. 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. Right now, CPMs face hostility, refusal to take reports by providers, 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 attempting 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. Midwives need to be accepted as a part of this team, and this 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 CPM's having access to RhoGAM, then a mother's reproductive</p>	
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future may be at stake. Twenty-four hours after 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. Those involve test cards provided by the State and that the midwife must perform the tests and send results to the Illinois screening unit. Midwives are not doing this because they are afraid of putting their name on paper work that 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. A baby needs a properly filed birth certificate and once again this requires a CPM to interact with the State of Illinois to report the live birth. Many CPM's hesitate to sign birth certificates, which leaves parents to 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 our State, 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. This is not discovered while the children are young because many of these children are also homeschooled. Because of CPMs illegal status, there are difficulties with smooth transport in emergency situations, difficulty obtaining necessary lifesaving medications, difficulty performing potentially lifesaving newborn screening, and difficulty filing proper birth certificates. All of these could be remedied simply with licensure. To fail to remedy these things shows a disregard for the health and wellbeing of the babies whose families will choose home birth no matter what the Committee thinks of it. Providing CPMs with legitimacy and the tools needed to safely carry out the job is the only ethical choice. Home birth is not made safer by limiting the number of trained providers. By limiting the number of trained providers, we are making home births less safe.

- **Senator Martinez:** Thanked Ms. Belcore for her testimony.

## **7. Melissa Cheyney Testimony**

- **Dr. Cheyney:** Stated that she is a Medical Anthropologist at Oregon State University and served for 6 years as the Chair of the Board that oversees the practice of midwifery for Oregon. Stated that in Oregon there were similar conversations about midwives in the early-nineties. Midwives have been licensed in Oregon since 1993. Currently, the Committee on which she was serving are discussing the issues, which were raised by the two other speakers, involving the inherent injustice of allowing only white college educated women to have access to a full range of birthing options. The Task Force in Oregon is tasked with determining how they could expand the home birth option to all people in their state. She 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 that report until it is released. She wanted to let the Committee know that the report should be released in the next couple of 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 is based only on her opinion and not on the NASSCBS. She will not disclose anything from the NASSCBS in her presentation.
- **Senator Martinez:** Asked when the NASSCBS report would be issued.
- **Dr. Cheyney:** Responded that it will be issued over the next several months. Explained that the NASSCBS will first present it to Congress as that study was Congressionally mandated by the Maternal Health Caucus. After they see the report there will be a lot of publicity around it, and she will make sure that a copy is provided to the Committee. As part of the NASSCBS, she just recently published an article with Erin Koy, who is the head of the Documents Committee that issued the most recent ACOG opinion. They together wrote an article on Home and Birth Center Birth, it is in the Green Journal, and the Journal of Obstetrics and Gynecology, which is the journal for ACOG. The article is an expert’s opinion about home and birth centers births, and much of the information in her presentation is also in that article. She said that when the very large body of literature is reviewed, there are a few things that really come to the surface 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 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 integration. There must also be complex care planning, which is the reality and it speaks to the point that there are occasions when someone is higher risk, yet they still would like to have a home birth. You need to be able to state how that can work out in practice. Of all of these things that make birth

safer, the inherent and first step for all of them is regulation and licensure. She said that she would demonstrate that during her presentation. Regarding training and preparation for practice, she stated that she understood that there was some discussion about this, but she wanted to say one thing about “MEAC vs. PEP” routes to certification. There are two ways to become a CPM in the U.S. One through a MEAC accredited school, which are 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 for obvious reasons. The second route for certification is the PEP process, or the portfolio evaluation process, which is an approach that is focused on experiential learning. It is where a midwife practices as a student midwife apprentice to a more senior midwife and she learns through the process of going to births with the senior midwife and through self-study. At the end of the PEP training process, both forms of training to become certified midwives must take the same exam. Wanted to clarify that the Bridge Certification is not a replacement for a MEAC accredited school, it is 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. So, it is not the only training that they have, but additional training that they received with the training on the other pathway to certification. Another important thing about licensure and regulation is that it allows you to set standards for continuing education. So, you have preliminary education, but education and training are ongoing. Without licensure and regulation, the State has no ability to require re-licensure or evidence of continuing education, so this is a critical piece for training and preparation. In addition, when you have regulation data collection can be required, as well as quality improvement programming through the 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 cautioned 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 opposes home birth, they stand behind CPMs, CNMs and CMs. Also, ACOG states specifically about CPMs is that they either gone through an accredited program or they have done the PEP process and the Bridge Certification pathway. She did not want to overlook the years of dialogue and discourse between these eight organizations that met for years 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. She encouraged the Committee to look very closely at all of the USMERA materials that document that process. There is a lack of agreement in the literature about what constitutes

	<p>low-risk pregnancies. She stated that when you look across the nation at the 35 other states that currently license midwives, the other states 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. This illustrates some of the ambiguity that the Committee previous discussed. 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 that the patient could be appropriate for a home birth. She encouraged the Committee to consider ways that they can produce 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 look at the legislation in states which have the highest level of integration, because these states also have the best outcomes in the United States. She also stated that over the last year, the NASSCBS has considered the safety of births in the home setting. There are a total of 70 studies on safety of home birth and 24 of these studies have reviewed home birth safety in the United States. There are some take away conclusions from the entire body of studies. One of the first conclusions that can be drawn is that there is something in common across all 70 studies, which is that in the home setting morbidity is reduced for the mother. All of the studies show lower rates for cesarean section, lower rates of post-partum hemorrhage, lower rates of perineal tearing, and higher rates of breast feeding. A lot 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 place of birth is that there is a delicate balance of maternal and fetal harm and benefits, and that there is not one choice of birth setting that is "risk free." What woman are actually negotiating is a complex set of social, cultural and clinical factors when they make their choice of delivery location. So, it is not as simple as saying that the risk is two times higher to the baby. Regarding the previous speaker, she wanted to say that there is a name for the kind of risks that she is discussing. One of the risks is called relative risk and the majority of studies from the U.S. show that there is a slightly elevated risk to the baby when they are born outside of a hospital setting. That risk is as high as two-fold. What we are talking about is an increase of .6 out of 1,000 verses 1.2 out of 1,000 on average. She wants the Committee to understand that for many mothers considering where they are choosing to give birth, the difference of between .6 and 1.2 out of 1,000 is not as meaningful as two-fold. That is referred to as the absolute risk. She believed that it is very important in providing information to clients to provide both</p>	
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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. Both of those pieces of information must be conveyed to consumers. In addition, all of these studies must be considered for the population levels in the studies and any one individual person has mitigating or complexifying risk factors that either make them more at risk or less at risk than these large national levels. This can only be negotiated through a close relationship. She provided an example of how risk is considered in Oregon, which is contained on the ninth page of her PowerPoint. The risk factors that are in yellow or not shaded would mean "caution," which means that the rules state that these factors require that providers reach out to a collaborating physician or someone with hospital admitting privileges and have consultation, since they are not absolute risk factors. The risk factors in red or shaded, would be considered absolute risk factors. Noted that the Committee should keep in mind that low risk factors have blurry boundaries, and that this method is one way to keep that in mind going forward because it more easily conveys the complexity of assessing risks of out of hospital delivery. The other thing that must be stressed is that it is necessary to support midwives who work in the community setting because they are the nearest provider to manage first line complications. An enormous amount has been written about a midwife's support of physiologic birth, in fact this does seem to be the case in very large data sets that she manages, 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 things that have been discussed. Midwives are trained to address these complications and can provide relatively safe support in the home birth setting. Also, mentioned that in Oregon, part of the way that they ensure that midwives can address complications is that midwives have a formulary. Once a person becomes licensed by the state, it allows CPMs to carry certain medications. CPMs in Oregon renew licensure every year and take additional training to demonstrate that they still understand how to use drugs and devices because they are uncommonly used in the home setting. 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; metabolic screening; and CPMs also manage hearing screening hubs for hearing screenings for the new born. In Oregon, CPMs are seen as highly valuable maternity care extenders. Oregon is similar to in Illinois in that there are major population densities along the I-5 corridor, and everyone else is disbursed within the state. It is



with the everyone else that the state can get creative regarding how to extend services. Credentialing is the first step in being able to use CPMs as health care extenders to those most in need. System integration is measurable, and it has been measured. She would be happy to help to improve the systems integration in Illinois. 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 that home and hospital are equivalent. Only in the U.S. with all of the additional problems that exist around access, around quality of care, around legalization of all practitioners is when 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 provides a guide for regulations that Illinois could emulate. She and her group met with experts around the country, went through the entire body of literature on what makes home birth safe and identified numerous factors that contributed to safety and to integration. They created an index which could go up to 100, as being highly integrated. The lowest level was 0, which meant that the state was not integrated at all. The data about each state was quantified, tested with experts from all 50 states and 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 9<sup>th</sup> from the last in the rankings with a score of 25. No state had achieved the score of 100 as would likely be achieved by the Netherlands. They then created complex statistical models that seeks 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, she is not going to have a good birth outcome in the U.S. The second-best predictor of birth outcomes was an integrated delivery system. It 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. Integration predicts 12% of the difference in outcomes across the states. She 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 center and hospital options, including midwives in a unit within the hospital. Midwives and mothers see their collaborators 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. This

occurs only 5.8% of the time. She stated 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. The group came up with 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 describes the literature basis for interprofessional communication and collaboration just at the time when it is most important that providers be able to speak across difference and that is 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 that:

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.

She also noted that there is an article entitled *Too Much Too Soon and Too Little Too Late Systems*, in which the author states that across the world there are two kinds of systems: too much too soon systems, and too little too late systems. She stated that because of rampant inequality both of these can exist in one country. She said that predominately in the U.S. we suffer from this. She quoted a position statement from ACOG on preventing primary cesarean as well as an article by Miller and colleagues 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 setting it can because there has been too little too late, because there are barriers to getting 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 in a way that respects maternal autonomy for all people, not just for white women. She 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 showed the impact of place of birth on mistreatment. The study showed that 28.1% of women who have a birth in a hospital setting feels that they experienced some form of mistreatment. She stated that she did not think that it was the hospitals’ intention to mistreat women, but there may be systems in place which unintendedly impact women

negatively. Based on the percentage of women who feel that they were mistreated, it should be reviewed to determine why the women feel that way. Those feeling mistreated in a birth center in a hospital was 24%, in a freestanding birth center it was 7% and a home birth it was 5.1%. She understands from the response that people have provided is that they often choose home or birth center births because they want to have continuity of care 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 you do not know from the dozens of people who interact with your care what kind of treatment that you are going to receive, that will often shade their perception about where the safest place is 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, there are higher rates in the hospital setting compared to freestanding birth centers or home birth. She is showing this information to help the Committee understand why people are choosing to have home births, even though it is uncommon with only 2% of people choosing to give birth outside of a hospital setting in the U.S. She also presented charts showing 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. She also noted 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. She believes that the U.S. has a “home-hospital” divide, which can be divisive, but 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. Midwives working in the hospitals can work to bring down the C-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.

- **Senator Martinez:** Thanked Dr. Cheyney for her presentation. Opened the floor to questions from Committee Members.
- **Ms. Wickersham:** Asked Ms. Mbande to clarify her statement that in the end she chose to give birth completely unassisted?
- **Ms. Mbande:** Responded that she did not like to say unassisted because she had a lot of assistance from her family, but she chose to give birth without a licensed or unlicensed medical professional.
- **Ms. Wickersham:** Asked whether there was any evidence that making or keeping the practice of midwives illegal anywhere in any setting has ever resulted in making it safer?
- **Dr. Cheyney:** Responded that there was no evidence that making something illegal or keeping it illegal makes it safer. In fact, there is quite a lot of evidence to the contrary. As in Illinois, women will find

	<p>ways to have the birth that works for them. Her recommendation would be that legislation and regulation of midwives is the way to go to make home birth safer.</p> <ul style="list-style-type: none"> <li>• <b>Ms. Wickersham:</b> Noted that Dr. Cheyney mentioned a twelve percent integration outcome. Asked whether she was talking about an entire state having better perinatal outcomes.</li> <li>• <b>Dr. Cheyney:</b> Responded that when midwives are integrated in the system, both home and hospital outcomes are better. The survey covered midwifery in general, and the states that have the greatest integration, the most open and supportive practice for all midwives. Now, the states that do not have regulation for a whole group of midwives will have 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.</li> <li>• <b>Ms. Wickersham:</b> Asked to confirm that Oregon’s C-Section rate was 5% C-Section rate in comparison of a higher national rate.</li> <li>• <b>Dr. Cheyney:</b> Agreed that the national rate was 32%. Added that this percentage rate was for everyone, but for low-risk women, the percentage of woman having C-Sections was 16%. As you all know, the world health organization says the rate should never exceed 10-15%. She is working hard to get that percentage down.</li> <li>• <b>Senator Martinez:</b> As there were no additional questions, thanked everyone for their input. She said that moving forward she wants to hear from additional parties. She wanted to hear from the Department regarding its position on home birth, any capacity issues and any plans for enforcement regarding home birth. She also wanted to hear about the legal and liability component of this issue. In addition, she wanted to hear about insurance and medical malpractice and how they could work with midwives. There is no doubt that everyone here has a concern for the safety of the baby and the mother, and to have a collaborative environment to discuss these issues. Also, she wanted to hear from midwives about how they can collaborate to assist in the safety of the mother and baby and provide transport to hospitals when necessary. In addition, she wanted to hear from the trial lawyers who assisted with the bill in the past.</li> <li>• <b>Representative Moeller:</b> Stated that it would be interesting to hear from the regulating body for one of our neighboring states that license CPMs and hear about their history and experience of licensing. Stated that she attended a conference last week in Utah about professions and midwifery came up. She was able to get some information and for other states’ experiences with midwifery. She wanted people with the state who could explain their experiences with midwifery.</li> <li>• <b>Ms. Wickersham:</b> Do we want to discuss public health and disasters like Katrina as well and how midwives could assist with those situations.</li> </ul>	
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<b>Adjournment</b>	<ul style="list-style-type: none"><li>• Adjourned 3:27 p.m.</li></ul>	