



# 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: November 21, 2019  
Meeting Convened: 1:22 P.M.  
Meeting Adjourned: 4:41 P.M.  
Location: Chicago: JRTC CBD Room 2-025; Springfield: Stratton CBD 376

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

Staff Present: Samantha Ortiz, IDFPR  
Richard Schultz, IDFPR  
Robert Dixon, IDFPR (Springfield)  
Ciara Wagoner, IDFPR (Springfield)

Speakers Only Present: Darren Covington, Esq. (by WebEx)  
Theresa Hubka, MD  
Mary C. Sommers, CPM

Guests Present: Nora Kropp, ICCPM  
Katie Davis, Illinois Trial Lawyers Association ("TLA")  
Sarah Farwick, TLA  
Tim McLean, TLA  
Sue Clark, Capitol Edge Consulting (Springfield)  
Debbie Broadfield, Capitol Edge Consulting (Springfield)  
Kristin Rubbelke, Capitol Edge Consulting (Springfield)

Dan Hohl, Illinois State Medical Society (Springfield)  
Destiny Lee, Senate Democrats (Springfield)

Topic	Discussion	Action
<b>Call to Order</b>	<ul style="list-style-type: none"> <li>• The meeting was called to order and an initial roll call was taken. As there were ten Members of the Home Birth Maternity Care Crisis Committee (the “Committee”) present, in Chicago or and none in Springfield, there was a quorum of the total fifteen Committee Members present. All speakers and attendees then introduced themselves. Ms. Lowrance and Ms. Sawicki connected via WebEx at an off-site location. Senator Martinez then stated that a quorum of Committee Members was physically present, and Ms. Lowrance and Ms. Sawicki had previously requested to attend this meeting by phone or video conference. A motion was made and seconded to allow Ms. Lowrance and Ms. Sawicki to attend the meeting by video conference.</li> <li>• As there was no further discussion, the matter was called for a vote.</li> <li>• <b>Home Birth Maternity Care Crisis Study Committee votes:</b> Ten yes votes (Senator Martinez, Senator Anderson, Ms. Belcore, Ms. Harris, Mr. Tryon, Dr. Quinlan, Ms. Vickery, Ms. Wickersham, Ms. Valrie-Logan and Mr. Wiggins), zero no votes, zero abstentions, and three Committee Members absent (Representative Moeller, Dr. Wolfe and Dr. Carlson.)</li> </ul>	<p>Ms. Lowrance and Ms. Sawicki are permitted to participate by phone or video conference.</p>
<b>Old Business</b>	<ul style="list-style-type: none"> <li>• The October 17, 2019 minutes were reviewed and unanimously approved by the Committee as corrected.</li> </ul>	<p>Approved</p>
<b>New Business</b>	<p><b>A. <u>Witness Testimony</u></b></p> <p><b>1. <u>Darren Covington, Esq.</u></b></p> <ul style="list-style-type: none"> <li>• <b>Senator Martinez:</b> Welcomed Darren Covington, the Director of the Medical Licensing Board for the State of Indiana. Asked Mr. Covington to talk about how the licensing and regulating of Certified Direct Entry Midwives (“CDEMs”) has progressed in Indiana.</li> <li>• <b>Mr. Covington:</b> Gave some history and background on how midwives became licensed in Indiana. He explained that since the 1980s, midwives sought licensure, but their efforts were met with strong opposition from physicians and others within the general assembly. It was not until 2013, after about 20 years of lobbying, that a bill was finally introduced that allowed CDEMs to become licensed. He explained that the Chair of the Senate Health Committee was a Registered Nurse (“RN”), who strongly opposed the licensure of midwives for many years, but eventually agreed to allow them to become licensed.</li> <li>• Dr. Wolfe joined the meeting.</li> <li>• <b>Mr. Covington:</b> Explained that the bill as drafted imposed a number of limits and restrictions. If you compare Indiana to other states, you probably noticed that Indiana is stricter in their requirements for midwives than other states’ laws and regulations. The bill was passed and signed by the Governor in 2013, but CDEMs quickly realized a snag because the law required that CDEMs reach a collaboration agreement with physicians to become licensed. CDEMs were having trouble finding any physicians willing to collaborate with them. The primary reasons for this related to malpractice issue, since physicians were being told by their malpractice</li> </ul>	

carriers that their premiums would increase (in some cases quadrupling) if they collaborated with CDEMs. Also, the State's largest health system told its physicians that they were not permitted to collaborate with midwives. This was a huge challenge for CDEMs. Therefore, they went back to the legislature and the legislature added specific language that stated physicians who collaborated with midwives were immune from certain civil suits in order to alleviate physicians' concerns about collaborating with midwives, which passed in 2015. After that issue was resolved, the Medical Licensing Board began work on rules. These were completed in 2017 and licensing began shortly thereafter. Indiana currently has fourteen CDEMs who hold an active license in the state. The key barrier to CDEMs getting a license is the collaboration requirement due to a reluctance of physicians to enter into the agreements and geographical limitations of those physicians who are willing to collaborate. Even with protections from liability, there are not enough physicians who are willing to collaborate in Indiana. Also, many doctors were not geographically close enough to collaborate with CDEMs. He explained that was why there were so few CDEMs who are licensed in Indiana. He suspected that there are many midwives still practicing without a license. He noted that Indiana has a large Amish population who use unlicensed midwives, both within and outside of the Amish community to assist home births. There are others who do not believe that licensure is necessary, and they continue to provide those services. Typically, his office does not pursue action against unlicensed midwifery practice, unless there is a bad outcome or death from a home birth. The Medical Licensing Board has so far issued one cease and desist order against an unlicensed midwife in northwest Indiana. He welcomed questions about Indiana's requirements or what they saw in this area.

- **Mr. Tryon:** Asked how Indiana handles the liability issue with the CDEMs.
- **Mr. Covington:** Responded that this was not something the Medical Licensing Board has direct control over. He explained that is an issue between the physicians and their malpractice carriers. Indiana's General Assembly amended the statute in 2015, to expressly state that except in cases of willful misconduct or gross negligence, the physicians could not be liable for the collaboration with CDEMs. He stated that the issue is more with the malpractice carriers and the health systems in Indiana. Indiana University ("IU") is the largest health care system in Indiana and they have informed their many providers that they are not permitted to collaborate with a CDEM.
- **Dr. Wolfe:** Asked how many deliveries in the state of Indiana are assisted by licensed CDEMs.
- **Mr. Covington:** Responded that the State's server had been down all week, so he did not have those numbers, but it has not been that many, and speculated that it was less than 50 home births. (A report provided after the meeting showed that in 2018, there were 300 total live births, and no still births or maternal deaths.)
- **Dr. Wolfe:** Asked how many home births occurred in Indiana, which would include planned home births.

	<ul style="list-style-type: none"><li>• <b>Mr. Covington:</b> Responded that he did not know the answer to that question but mentioned that Indiana’s Department of Health may have that information.</li><li>• <b>Dr. Wolfe:</b> Asked why IU Health would discourage their employees from collaborating with CDEMs.</li><li>• <b>Mr. Covington:</b> Responded that he did not want to speak for IU Health, but he believe that it goes back to liability concerns.</li><li>• <b>Senator Martinez:</b> Noted that Mr. Covington mentioned that there are many midwives who are practicing without a license. Asked if there was a reason they were not becoming licensed.</li><li>• <b>Mr. Covington:</b> Responded that there was probably a number of reasons. Some midwives philosophically oppose licensure and do not believe licensure is necessary. They believe that the arrangement is an agreement between the midwife and the mother, and the State should not be involved. There also is a large Amish population in Indiana who operate within their own system and do not want involvement from the State. Other midwives would like to be licensed but cannot find a collaborating physician. In addition, there are midwives who have been performing midwifery services, but do not meet the education requirements. He noted that when the law was first enacted there was a grandfathering provision that allowed an applicant to substitute experience for education, but that provision was opened only for about a year and is now closed, so now applicants must have at least an associate degree in Midwifery, but a lot of midwives do not meet that educational requirement and did not apply for a license based upon experience.</li><li>• <b>Senator Martinez:</b> Asked if Indiana was stepping up its enforcement of unlicensed practice for midwives since a law has been passed which permitted licensure. Especially if the reason that the midwives do not become licensed is caused by their inability to locate a collaborating doctor. Also, she asked Mr. Covington to confirm the fact that in Indiana, if a midwife does not have a collaborating doctor, then she cannot become a licensed CDEM.</li><li>• <b>Mr. Covington:</b> Responded that a midwife has to have a collaborating physician in order to obtain a license and practice as a CDEM in Indiana. Practicing without a license can subject a person to both civil and criminal action. He stated that generally, county prosecutors will not a pursue a criminal case unless there has been some harmful event, such as a death of a mother or infant. He also cautioned that largely his Department will not know who is practicing as a midwife without a license until someone complains, because the Department does not have any investigators or people on the ground searching for unlicensed midwives. Enforcement actions are all complaint driven. If something goes wrong, that is when they hear about the unlicensed midwife. If the Department receives a complaint about unlicensed practice, then it will send a cease and desist order, but the Board does not have the resources to search for unlicensed midwives.</li><li>• <b>Senator Martinez:</b> Asked whether he is seeing more physicians who are willing to collaborate with midwives, or unlicensed midwives who are still looking for physicians to collaborate with.</li></ul>	
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- **Mr. Covington:** Responded that he is not seeing an increase in physicians willing to collaborate. He said that just a handful of physicians are willing to collaborate and utilize midwives as a part of their practice.
- **Senator Martinez:** Stated that the Amish community practices midwifery as a part of their culture and community. Also stated that sometimes members of the Amish community practice unlicensed midwifery. Asked how Indiana dealt with any catastrophic events which occurred during a birth with an unlicensed midwife in the Amish community.
- **Mr. Covington:** Responded that this could be said about all of humanity for thousands of years before licensure laws. At this point the Medical Licensing Board has not had anyone who came forward from the Amish community to complain about an unlicensed midwife. If a complaint were received, they would apply the same standard for the treatment of unlicensed midwives. He explained that there is no exception in the law. If a person is practicing midwifery, regardless of the context, then the midwife is required to have a license.
- **Ms. Wickersham:** Noted that Mr. Covington mentioned a few barriers to the licensure of CDEMs and asked whether the requirement for midwives to maintain professional insurance liability coverage was also a barrier to licensure.
- **Mr. Covington:** Responded that there was quite a bit of discussion about midwife’s malpractice insurance while the rules were being drafting. He noted that they agreed that there are policies available to midwives for purchase, and they settled on the insurance policy amounts which were the most accessible for midwives to obtain.
- **Ms. Wickersham:** Asked for the amounts of the minimum required insurance coverage.
- **Mr. Covington:** Responded that the minimum required was \$100,000 per incident and \$300,000 aggregate.
- **Ms. Lowrance:** Asked if other professionals in the state of Indiana were also required to carry malpractice insurance, or if this requirement was unique to CDEMs.
- **Mr. Covington:** Responded that the only other health professions that are required to carry malpractice insurance by law were podiatrists and massage therapists.
- **Ms. Wickersham:** Stated that rather than requiring Certified Professional Midwives (“CPMs”) to have a collaboration agreement with physicians, the Committee has discussed the possibility of establishing a list of medical conditions of the expectant mothers which would be used to exclude the mothers from home births or require CPMs to consult with a physician regarding only those cases, rather than maintain a collaboration agreement. Asked if this were an option to physicians in Indiana, would more physicians be willing to engage with midwives and there would be fewer barriers to CDEM licensure.
- **Mr. Covington:** Responded that the requirement for collaboration with physicians is pretty common, in that physicians are already collaborate with other nurse practitioners, physician assistants and health professionals, so he did not believe that the required collaboration agreement as a barrier to licensure.

- **Ms. Wickersham:** Followed up by stated that she thought he said that physicians were not willing to sign a collaborative agreement because their malpractice coverage would not allow them to do so.
  - **Mr. Covington:** Responded that he misunderstood the question and stated that he did not believe that the fact that physicians would have to have a collaborative agreement would disincentivize them from collaborating. He explained that he believed that the barriers to entering into collaborative agreements was based on doctors' inability to obtain liability insurance and the distance requirements that the Board has established.
  - **Ms. Wickersham:** Made the point that in Illinois midwives want licensure as opposed to some of the midwives in Indiana.
  - **Ms. Sawicki:** Regarding the difficulty in securing collaborative agreements between physicians and midwives, questioned whether that difficulty also existed for collaboration for births that are not home births, such as births in birthing centers or hospitals.
  - **Mr. Covington:** Responded that CDEMs are prohibited from having privileges in hospitals, so that they would not be having any births in a hospital. He continued that there are some birthing centers around the state, one of which is in northeastern Indiana and there is a physician who collaborates with CDEMs at that location. Also, noted that there are few birthing centers in Indiana. As a follow-up to the previous comment, he noted that there was a vein in the midwife community that does not want licensure, but as he previously stated, there is a larger vein of the midwife community that has sought licensure for over 20 years. That group wanted to be considered as professionals and to distinguish themselves from untrained midwives. Both currents of thought regarding licensure are held by midwives in Indiana.
  - **Senator Martinez:** Noted that there were no additional questions of Mr. Covington and that it is an important issue in Illinois. She explained that the Committee was looking for ways to ensure that the babies and mothers are kept safe. Also, want to ensure that midwives can be licensed in Illinois, because the Committee knows that expectant mothers are having their babies in Illinois and other states now with midwives who cannot become licensed. Many legislatures are looking at this topic as well and enacting legislation. She thanked Mr. Covington for discussing Indiana's experiences licensing CDEMs with the Committee and stated that it was vital to learn what Indiana has done to license midwives.
2. **Theresa Hubka, MD**
- **Senator Martinez:** Introduced Dr. Hubka and noted that she will be discussing patient safety and treating adverse events that occur at the home under the care of a CPM.
  - **Dr. Hubka:** Explained that she was speaking on behalf of herself and the Illinois Osteopathic Medical Society ("IOMS"). She is an obstetrician/gynecologist, and has received 12 years of training with college, medical school, and four years of residency. She has also taken licensing boards and state medical exams to keep her training up to date. She has had 25 years of experience in obstetrics and gynecology as a sole private practitioner in Chicago. She is also on the Board of Trustees in the American Osteopathic Association, IOMS, as well as the board of the

American Osteopathic College of Obstetricians and Gynecologists. She has had many deliveries all in the hospital throughout the years, because that is how she has practiced medicine. She has wonderful friends in the midwifery community. She has experienced some sad cases that were handed off to her without collaboration, where home births were attempted, and she received the expectant mother, who had been in labor, because she was the doctor on call at the time. There is one particular instance that comes to mind where she was at lunch with her sister who was visiting from California. She got a call and the person who called her had not provided her name or information, but asked Dr. Hubka to take over a case where the mother had been in labor for two days at home. The person stated that the birth mother had meconium and had to be taken to the hospital. She asked for the collaborating physician and the back-up hospital and was told that the expectant mother did not have one. Dr. Hubka told the woman that she was sorry, but that she could not help the mother because she did not know the situation. She explained that the midwife must take the mother to the nearest emergency room and take care of things that way. Instead, the woman handed off the patient at the hospital with a sheet that was supposed to be the pre-natal record, with Dr. Hubka's name but was misspelled. The residents at the hospital admitted the patient and called Dr. Hubka to say that her patient was there. They relied on the prenatal record with Dr. Hubka's misspelled name. Dr. Hubka explained that the expectant mother was not her patient. Due to the expectant mother's dire situation, Dr. Hubka decided to go to the hospital and she thought that she knew who the midwife involved. She did an ultrasound on the patient and there was certainly meconium, heart tones were down, and the baby had been breeched. This was the mother's first pregnancy and she was delivering a breeched baby at home. The ultrasound also showed that there was something odd about the sacral area. It happened that this baby had spina bifida and five segments of cord were outside of the body. Dr. Hubka had to perform a caesarean section the mother. The baby had to be transferred to a children's hospital. This is one of many stories involving failed home births. She had another situation involving a home birth where the baby was fine, but the mother had an undiagnosed placenta accreta and was delivering the placenta. Placenta accreta is where the placenta is embedded too deeply in the uterine wall and fails to detach after childbirth which causes an inverted uterus. Dr. Hubka believed that this occurred because a standard ultrasound was not performed on the mother. The mother's husband called her saying his wife did not look well, in that she was not responding. Also, there was hemorrhaging without any blood, which is a sign of real danger. In that instance, Dr. Hubka happened to be at the hospital helping the unit that night and she instructed the father to bring the mother to the emergence room as soon as possible and provided some instruction regarding how to assist the birth mother. She noted that there have been other similar situations involving home births. We know here in Illinois, for maternal safety, some of the biggest safety issues are: postpartum hemorrhage; infection; and cardiovascular disease, which is often unknown until women are treated at a hospital. Some of the most significant issues are that there is no collaboration between the midwife and physician and that there is a distinct difference in the educational backgrounds of doctors and

midwives. Dr. Hubka also trains students and considered what the students do in their six-week rotation. The students work approximately 80 hours a week, just like physicians. They are there for a four to six weeks of training, and there is about 480 hours where they attend five to ten deliveries. Dr. Hubka asks all of them if they would be willing to do a home birth. They all respond no, because they are nervous. She understands some of the needs, and everyone certainly wants safety. Everyone also wants the patients to have the ability to have access to good and safe care for both babies and mothers. She believes that they have two patients who they are treating. She also understands a mother's choice, and so "risking out" is an important factor. However, she thinks that as Illinois is such a litigious state, it makes it difficult because doctors are asked to perform treatment after the mother was at home with a midwife.

- **Senator Martinez:** Thanked Dr. Hubka for her statement, and asked what Dr. Hubka felt about CPMs, some of who are her friends who are trained and doing great things in mothers' homes. Also asked how she felt about the CPMs who deliver births in mothers' homes.
- **Dr. Hubka:** Responded that Certified Nurse Midwives ("CNMs") who train in university settings or in educational programs and then are licensed, as well as work in the hospitals or birth centers, do a very good job. However, they follow protocol and guidelines.
- **Senator Martinez:** You believe that for only CNMs, as opposed to a CPM.
- **Dr. Hubka:** She responded that she has a dear friend who is a CPM who has worked all over the world doing home births. In areas that have no access, it is better than nothing. She is very skilled and trained and has experience, which is lacking with a CPM. The Committee really needs to look at that and make sure they think of safety of the patients. Most of the CPMs that her organizations have looked at in the State of Illinois practice in Chicagoland area. She did not feel the issue was a lack of access to assisting in birthing, but more so an act of the mother's choice to have a home birth. If it was an issue about access to safe births in Chicago hospitals, she would understand the need for CPMs.
- **Senator Martinez:** Asked about the deep rural areas in Illinois where a mother does not have access to a safe hospital birth and CPM are vital.
- **Dr Hubka:** Responded that she understands that mothers in rural area have less access and less backup, which is a concern. If you want to compare no birth assistance to a CPMs birth assistance, she would absolutely say an expectant mother needs some assistance to have a safe birth. It is not just one individual, there should be one individual aiding the mom and one individual aiding the baby, at a minimum. She also had a concern about the Amish community, in that home births are common in that community, as it is a low access area. If the State was going to begin, it needs to provide support for the mothers in that community to assist in their births. She stated that the State would have to do more education and training with CPMs, so they can effectively respond to events. Some of the issues that can arise are postpartum hemorrhage, and CPMs must know how to treat that issue. Other issues that may arise could be resolved with medications, but the CPMs do not have a license to dispense medications. Stated that was a problem.



	<ul style="list-style-type: none"> <li>• <b>Senator Martinez:</b> Asked whether she had looked at the curriculum for CPMs.</li> <li>• <b>Ms. Wickersham:</b> There are Midwifery Education and Accreditation Council (“MEAC”) accredited schools that have specific curriculum, which meets the approved by the Department of Education.</li> <li>• <b>Dr. Hubka:</b> Responded that her concern is that CPMs do not have a Drug Enforcement Authority license to prescribe and administer necessary medications.</li> <li>• <b>Ms. Wickersham:</b> Regarding the transport stories, asked whether she was aware if those midwives were CPMs with a national certification or possibly lay midwives without certification.</li> <li>• <b>Dr. Hubka:</b> Responded that often times she does not know who was assisting the mothers. She explained that she received calls, and usually are not given the midwife’s name. Also, she did not receive the mothers’ health records of the previous care to let her know if the mothers have received any standardized Group B Strep testing, an ultra sound or other testing.</li> <li>• <b>Ms. Wickersham:</b> Asked whether she could imagine a situation in which CPMs were licensed, they would be able inform hospitals of their certification and provide the records of tests and ultra sounds conducted for the mother. In addition, she would be informed whether the midwife was unlicensed.</li> <li>• <b>Dr. Hubka:</b> Admitted that both of those would be beneficial.</li> <li>• <b>Ms. Wickersham:</b> Asked whether Dr. Hubka would be willing to sign a written collaboration agreement with a CPM.</li> <li>• <b>Dr. Hubka:</b> Responded that she has collaborated with midwives in the past. While she never delivered for the midwife, she has been collaborative with them in communication and have reviewed their charts when they worked in hospital system. She explained that for her, medical liability is a barrier.</li> <li>• <b>Ms. Wickersham:</b> Asked whether Dr. Hubka would be a collaborating physician for her.</li> <li>• <b>Dr. Hubka:</b> Responded that she might not be able to collaborate for various reasons. One reason is that she conducts a solo practice, so she would not be able to take on a CPMs births because if she is collaborating she would want to be there at the delivery. That was her limitation.</li> <li>• <b>Ms. Wickersham:</b> Asked that for someone who might not have time limitations, or if Dr. Hubka had more time, if Ms. Wickersham came to her with a list of things she had to call someone about, but there was no written collaboration agreement, whether that would be a concern or barrier.</li> <li>• <b>Dr. Hubka:</b> Responded that there would be a barrier if she could be liable for the patient later. That would remain her concern or a barrier, because Illinois is a pretty litigious state and while birth is natural it is not what we can expect. She explained that she knows that births can be the non-risk, low-risk as well as the unpredictable.</li> <li>• <b>Ms. Wickersham:</b> Asked whether without a license, she could see any way that CPMs could participate in things such as the Illinois annual certification of obstetric hemorrhage prevention and treatment, so that CPMs did not have to estimate blood loss but count blood loss.</li> </ul>	
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we do not know whether a patient actually has a low risk. Explained that she is happy that there are so many wonderful and healthy births but worry about the ones where you do not know the risks. The midwife may have done a wonderful job, but a mother can still hemorrhage. Those are the things that you cannot predict. So that is why you need to know where the nearest hospital is located, and the hospital may have been notified that the birth occurred with no occurrences.

- **Ms. Harris:** Raised the scenario if a midwife is located in Chicago but travels up to two hours to see a patient and that the problem with having a collaborative agreement is because the patient is two hours away with the midwife having an agreement or affiliation with a hospital in Chicago. Asked why not get an agreement with a physician close to the patient.
- **Ms. Valrie-Logan:** In response explained that she had a home birth when she lived on the northside of Chicago. Her midwife's office was in the northside, and her collaborative hospital was at the University of Illinois in Chicago. She saw a physician there because that was in their agreement. But if something happened to her, she would go to Swedish Hospital because that was a block away from her house. Her midwife did not have a collaborative agreement at Swedish Hospital and other hospitals because that would be very costly.
- **Ms. Harris:** Then asked whether the way to approach your practice is for midwives to select an area and only accept patients within a certain radius because that is where they have collaborative agreements. Suggested that midwives not take patients who are two hours away from their locations.
- **Ms. Belcore:** Noted that this illustrates the crisis for those areas which are not served by licensed professionals right now. People are not choosing midwives that are two hours away because they want to, but because the midwives are too far away.
- **Ms. Harris:** Asked whether licensure would increase the number of available CPMs, then won't some CPMs choose to practice in a rural area because that will be a good base for them with plenty of patients.
- **Ms. Belcore:** Responded that that is the hope, but some rural areas have fewer people who are having babies, so it will be hard for the midwives to maintain a practice on the income from a small rural practice and pay their bills. Midwives would quickly decide that they cannot afford to serve those few families in rural areas.
- **Ms. Lowrance:** Addressed the rural community issues, as she is the lone CNM south of Peoria. There are no other licensed midwives south of Peoria. Almost two-thirds of Illinois is not covered by midwives. The State needs more people to offer the services because there is such a need to offer alternatives for women. In her area alone, she is on average driving close to 300 miles a day making prenatal visits and getting women access to care, even if the women choose not to do a home birth. There are no physicians in her area that are willing to work with midwives, so she has to reach out to hospitals and try to make connections. She reaches out to anyone that she can so that she can provide safe prenatal, antepartum and postpartum care for these women. It is a real issue down south because of the spatial issues, and there are few hospitals that even provide obstetric services in southern Illinois. Two hospitals recently closed their obstetric services in southern Illinois. Some of the hospitals are critical

access hospitals. There are limited services and the availability of services for women in southern Illinois.

- **Ms. Valrie-Logan:** Noted for clarification, that there is a substantial difference between a lay midwife and a CPM. A CPM attends a brick and mortar school education and are educated. Second, regarding the lack of access issue, even in Chicago, this is not just a problem that will be eliminated once licensure is approved. People still need to decide that they will practice in these areas because on the south side of Chicago or other placed down south, there are still not enough resources or access to safe and good care. She would love to talk further about the idea that safe care is in a building, like a hospital, because she knows women who are desperately afraid, due to their race and economic situation, to enter a hospital. This is caused by the existing inequities of birth outcomes for black and brown children and women are in hospitals. These are statistics from out-of-hospital births, because they are in hospital births. Having someone who would be licensed, who could come to women's homes and provide care would be more of a service, than a disservice, since they are not receiving that safe unbiased care within a hospital.
- **Senator Anderson:** Believed that he is bring a unique perspective because he is a fireman and paramedic by trade as well and have helped deliver two babies not including his own. Asked whether it was more important to include as a requirement in legislation, a collaborative agreement between a CPMs and a physician or hospital, or a set of rules or requirements for education of CPMs.
- **Dr. Hubka:** Responded that it was a really hard to say one way or the other. To her, education and experience is critical because of all of the training medical students receive. She reviewed the educational process and knows that it is still different. She noted that birth is fantastic when it is right, perfect, and the outcome is perfect for mom and baby. The problem is when it is not perfect and can go wrong anywhere. Education and experience, although she cannot place one over the other, is critical because you can think on your feet and respond and react appropriately. Also, to include medication and knowledge and the risks and benefits of those medications that could be administered. She still said that even though she understood what he was saying about hospitals, they go through so many regulatory steps. She would love to work at more hospitals herself, but she cannot have privileges at all of those hospitals and cannot comply with the regulations for all the hospitals. It is too many births for one person to do. That is why there are physician groups. Also, it is feasible to get to the various locations. She still thinks that some type of collaboration with a hospital or a knowledgeable person, so that when someone is doing a home birth the nearest hospital would have emergency care services would be available and could be alerted once a birth has occurred and everyone is fine. It is really hard receiving the call that she may have to take on a patient she knows nothing about.
- **Senator Anderson:** Added that the issue that Senator Martinez and he have been working with for a few years and it seems that education, as far as requiring certain curriculum requirements is on the table. But as the Committee has heard from Mr. Covington and yourself, collaborative agreements are not something that doctors are very willing to do because

of various reasons. It would be foolish not to consider that hospitals want people coming into hospitals to make money, and he was not saying people here believe that. Regarding the issue, he believes that education is much more important than a collaborative agreement. From his perspective, coming to a house where something went wrong during a home birth, he wants to be able to have somebody who knows what they are doing, is licensed, and willing to go through the process rather than someone who is an illicit home birther untrained midwife. He would rather walk into that house as a medic, and have that person be able to tell him exactly what happened, so he could take the proper emergency measures as a medic and get that patient going to a hospital. The issue here is that there are going to be home births for whatever reasons, whether legislation is passed or not, but everybody in this room wants the safety of the mother and the child at the forefront. So, if it is not going to be with a collaborative agreement then the Committee must find another way to go and he thinks education is at the top of that.

- **Dr. Hubka:** Responded that she supported that, which was why she explained that she supported more education and experience, so that they would be able to respond appropriately in emergencies. She would like to have a hospital made aware that a home birth was taking place. It is not just because of hospital finances, but also safety concerns. She understood though that women may have had bad experiences with their first births at a hospital. At the same time patients need to be educated and expectations need to be discussed, so that women may feel more empowered to discuss their concerns and needs.
- **Mr. Tryon:** Stated that if the State were to have a CPM program with adequate training, so that someone received a certification as a midwife, and had what was considered a standard of licensed midwives. Asked whether there should only be a collaborative agreement required in situations where the patient was more at risk, or in some form that person was considered high-risk, such as a mother with some sorts of diabetes.
- **Dr. Hubka:** Responded that she believed that the high-risk mothers should “risk out” the patient, so they would not be permitted to have a home birth.
- **Mr. Tryon:** Explained that there was different level of risk, he believed that someone who has managed Type II diabetes is at the same risk as someone with Type I diabetes and should not be precluded from having a home birth if everything else is fine. But believes that previously there was support to require that CPMs have a collaborative agreement with a physician who could help monitor the pregnancy to determine if it is unsafe to have a home birth.
- **Dr. Hubka:** Responded that she believed that any high-risk or any risk should have a collaborative agreement, and usually call it “risk out” of a home birth.
- **Tryon:** Noted that Dr. Hubka stated that in rural areas CPMs are better than no assistance, which is an access to health care issue. Also, stated that when tort reform was considered by the legislature a few years ago, a rural obstetrician/gynecologist stated she ceased her obstetrics practice because she could not afford the insurance, in that she did not deliver enough babies to cover the cost of providing care. She told him that the

cost of insurance was \$80,000 or \$90,000 a year, or more than that. She explained that she had to deliver 110 babies a year to break even and not make any money for herself. So, she stopped delivering babies over a six-county area. He continued that there is also an access issue involved in this review, especially if a patient does not have insurance or Medicaid. He guessed that if he called a hospital in Chicago and asked how much it would cost to have a baby delivered there, they will not tell him. A person should not have to risk their livelihood or house to have a baby, if she can have an option that is safe with a CPM, who can tell her how much it will cost to have a baby with a normal delivery. He also stated that the model that the country is operating under today will be much different in the future. He explained that community hospitals cannot survive unless they are part of a big system of hospitals. Big systems can absorb some of the losses. He explained that some individuals would like to have a home birth because of the setting and it would be better for the family financially. He then stated that given that he believed education was the only way to achieve a safe home birth delivery. He said that CPMs who deliver home births can be regulated, while the State cannot outlaw home births, cannot outlaw people who do not have money or insurance from delivering at their homes. He believes that where the State is today is a discussion about where it needs to be in the future, because when doctors cannot afford the costs to deliver babies in certain areas, the State has a problem. He believed that \$100,000 a year for insurance is obscene. Explained that it sounded to him like Dr. Hubka was saying that if there are hospitals in the area there is no need for home birth deliveries.

- **Dr. Hubka:** Responded that she was saying that there needs to be an understanding between those performing the home deliveries and the hospitals about safety. There has to be an agreement that safety is the most important consideration. The safety of a birth cannot be predicted. Also, there can be a discussion about an inadequate number of providers down state verses Chicago, but she believed that more CPMs will be practicing or are practicing Chicago, where there is much more access to care. She also acknowledged that some CPMs would practice in south Chicago or southern Illinois, but CPMs are not always where they need to be. Regarding the financial costs, she mentioned the Spina Bifida baby patient that she helped, the mother payed \$2,000 to her midwife at the first meeting to establish a contract, and at the midpoint of her care the mother she gave the last payment of \$2,000. She acknowledged that she did not know whether the midwife was a CPM or if she had received any training. Noted that physicians receive about \$1,800 when they deliver a Medicaid patient, but added that Illinois has not paid independent physicians in three years. When discussing how many deliveries a doctor has to make, she explained that she does it because she loves doing it. Also, it is not always about the money, but she has had patients, who do not have insurance, where she negotiated pricing with the hospital and accepted Medicaid for her time. While the standard cost for an uninsured birth at the hospital would be about \$20,000, she was able to negotiate the price for patient of \$5,000 for both the hospital and the Medicaid rate for her time. So, the patient's large bill was reasonable, and she had a safe delivery.
- **Senator Martinez:** Noted that her example was a rare circumstance.

- **Dr. Hubka:** Responded that not every midwife would negotiate a lower fee as well. She stated that when you state that it is not financially feasible for a CPM to go to all of the locations with a couple of deliveries and that they cannot keep their practice going, she said that it was more important that they are not seeing enough deliveries to keep their skills up to date.
- **Ms. Vickery:** Asked where Dr. Hubka obtained her numbers about more CPMs who practice or will practice in Chicago than would be practice in southern Illinois.
- **Dr. Hubka:** Responded that the information came from a data base through another physician. They found that CPMs are more likely to be in or near Chicago rather than in southern Illinois.
- **Ms. Vickery:** Explained that she was a consumer, not a midwife, and she has a lot of interaction with midwives throughout Illinois. When she counts the CPMs that she expects may be serving in different areas she, her count says that there are none with a practice based in Chicago, and more in the areas outside of Chicago. She stated that there is a lack of access of care through CPMs in Chicago itself and in the Chicagoland area, based on information that she has collected. Asked whether she distinguished between formal and informal collaboration and whether that is a meaningful distinction for her.
- **Dr. Hubka:** Responded that formal would mean you know the person and their practice style and comfortable with what they do in their practice. Informal would mean to go by the guidelines of a what a collaborative agreement would be and that it would be at a greater distance. She thought that the best care for the patient is when there is close collaboration, because it seems to work better. However, she understood that there might not be that possibility.
- **Ms. Vickery:** Stated that Dr. Hubka was not necessarily talking about a written collaboration, but people interacting with each other which may not include a written collaboration agreement for a midwife naming a particular physician as someone with which they have the agreement.
- **Dr. Hubka:** Responded that the physician would be involved in oversight over the midwife, so that if something goes wrong, there would be someone who could help with whom the midwife is already familiar.
- **Ms. Vickery:** Asked when midwives become licensed, whether other collaborative networking situations work. She used an example of mutual training, where EMS, physicians, and midwives are training together and becoming familiar with the systems. She noted that would afford the midwives to become familiar with the hospital personnel, EMS or doctors in the areas. Asked whether that was something that could be part of the collaboration which improves the safety while not necessarily requiring a midwife to have a written collaboration agreement.
- **Dr. Hubka:** Responded that she would think of the collaboration is a plan of action that if you were to do the home birth and something went wrong, the next steps are described with safety being the number one issue for both the mother and the baby. She explained that the plan of action would not just to call the EMS at the last minute to send the patient to the emergency room.
- **Senator Martinez:** Thanked Dr. Hubka for speaking with the committee. She believed that her and Senator Anderson sole issue was to have these

individuals come from out of the dark. She also noted that many of the midwives want to be licensed by Illinois and visible. It would also create more comfort for mothers who choose to have their babies at home, in that there can be a database the mothers can review to determine who is certified or licensed, rather than the way a mother locates a midwife today. She noted that CPMs want to practice out in the open, but that Illinois will not recognize them, which is what she has been trying to get for the past three years. Also, once the physicians realize that CPMs are licensed it is hoped that they would be more willing to collaborate with CPMs. In addition, there are many families who cannot afford to have a baby at a hospital and are looking for a lower cost safe alternative to a hospital birth. She explained that there are a lot of components to this issue and the biggest is making sure that the State knows who the midwives are and that they are educated and regulated.

3. **Mary Sommers, CPM**

- **Senator Martinez:** Welcomed and Introduced Mary Sommers.
- **Ms. Sommers:** She is the Director of Birth Center Operations and the Maternal Child Health Program at PCC Wellness (“Birth Center”), site of the first free standing birth center in the State, which is heavily regulated. She was not representing the Birth Center, but only representing herself. She is a CPM who has lived in Illinois very collaboratively for the last 35 years. She is an urban midwife, so she did not address the issues facing rural mothers, although she is also licensed in Wisconsin, where she worked at the first accredited birth center in Wisconsin. She was a World Health Organization (“WHO”) fellow and has an app on maternity care that is every country of the world, but Greenland. She has worked in programs in Mexico. She knows a great deal about births and has been part of about 1,800 births, and she also runs mother and maternity programs. She wanted to explain to the Committee that there is actually a lot of common ground regarding midwives and other medical professionals. Illinois may seem over regulated, but she finds herself in a world that cares about Medicaid and urban health, and that if the State took advantage of the great structures that are available in Illinois and Chicago it would provide very positive results. In fact, the Birth Center has been called, by a Boston University doctorate student, a “positive deviant.” When talking about the future of health care, she suggested that the Committee should look at the people doing things that seem impossible, but they can work it out. She believes that a structure like the Birth Center, does not have to be on the receiving or reactive end but can actually be on the proactive end. She believed that the reason it has not happened for CPMs is that they have been marginalized for so long that they do not know the players and the inside game. So, to even build those relationships they are marginalized. In her case, it was not hard to find collaborative care because people know her, and she is in the system. When a person is in the system, they make bridges for more in the system. Her first plea was that part of the problem is that CPMs are not regulated or licensed. There are always going to be renegade midwives, and her observations have shown her that over time, renegade midwives disappear because the average consumer does not want to use someone who is not licensed. When a group does not have critical mass, they have a problem



and when a group does not have a license, they cannot take advantage of available education. Even though she is a CPM, she cannot be a primary midwife, but that is fine with her because she gets to participate in Morbidity and Mortality Reviews, Grand Rounds and all the regulatory learning processes and that is what she wants. If you just license midwives and did not consider a system of collaboration, the State would be like Indiana with 50 home births. Also, because approximately 50% of the people who give birth are on Medicaid, it shows that CPMs have not championed that across the nation. Even in states like Florida with 35 birth centers, they do not have relationships with Federal Qualified Health Centers (“FQHCs”). They did not set themselves up that way. Where FQHCs are structured with CPMs, it takes care of collaboration, malpractice, the community base. Also, there are 500 FQHCs across the nation. She explained that she was not saying this is the only way to structure health care, but the point is there is other ways to look at the problems. She also noted there are a large number of CPMs in Chicago. She admitted that she is not an expert regarding rural births, but if you look in an urban setting, you will see high rates of women on Medicaid. In her Birth Center, they have women from 42 different neighborhoods in Chicago and 54 municipalities, which tells you a lot of people want out-of-hospital births. They drive from all over to come to the birth center. What she likes about the Birth Center’s structure is that they transport into themselves when problems arise. That is very much how all the systems work. There are problems when you are spreading yourself thin, but if you have these collaborations all around these problems do not arise. She said that she knows Dr. Wolfe from a time when they assisted home births and hospital births, and they had a collaborative model and if one has a collaborative model they will risk better and have better outcomes. There are many women who do not even have a birth with the birth center but end up using their hospitals team so that they share information a lot faster. She said that what she is saying is first license CPMs, because the biggest obstacle is you do not have licensure. If you do not have licensure then you do not have education and processes. What failing to provide for licensure does is honor the renegade midwife, because the renegade midwife never wants to be regulated, and they do not care and the more that midwives are legal the more they want to do crazy things at home births. That is just the nature of the beast and not the nature of people who want to be licensed. If they do not know the players, then they will not know how to ask for help, which hurts patient safety. She thought that there are a lot of jobs that nursing takes now that quite frankly a CPMs would be better qualified. With things like the Mayor’s desire to start postpartum home visit and will be hiring a lot of brand-new nursing graduates for those positions. She asked whether it would be lovely if CPMs or community doulas could move up to a CPM role to make these visits. That is part of the structure. They are looking at home births and embedding into those systems a better way of practicing. It is a win-win. She said that CPMs offer a nice way of looking at normal physiological birth. She did not think anyone should choose a home birth and lose the resources that we actually desperately need. Regarding medication, she said that there is a scope of practice that would need to be written and there are standing orders than could exists if considering education levels, risks,

and so forth. If you consider a patient that has diabetes you would likely need a CNM. However, if you look at a scope of service within a normal home birth, for hemorrhage, you better do the three lines of medicines in the order it is supposed to be that is not very different from the National Resuscitation Program (“NRP”), which is standard. She noted that the Birth Center, is regulated by the state, as a national birth center, as a FQHC, the joint commission and that is a lot of people coming in to make sure that the birth center is properly doing its job. Something that CPMs need to give up is that they need some regulation and she thought that the good CPMs would welcome the regulation. However, when people are marginalized, and she sees this all across the world, they are afraid to pass over that bridge. She explained that barriers have to be broken down and the first step would be the licensure of CPMs with the MECA accreditation with the scope of practice. At the Birth Center, they do not have CNMs knocking on their doors to work there and it is because hospitals can be more accommodating with their schedules and the CNMs like it that way. CNMs can even get their doctorate, but she said that some of those getting in the school for doctorates are entering the school with zero births. These CNMs are looking at birth very academically. Whereas some CPMs will graduate with over 100 births under their belt. She then discussed an analogy involving a friend who was the Chief of a Fire Department. She explained that he told her that the Department started hiring applicants with bachelor’s and master’s degrees, and they understood the science of fire, but at the end of the day the Fire Department needed people who were willing to run into the fire. Physicians keep thinking the answer is CNMs and the truth is there is a limited amount of people willing to go to work in the needy communities, or in an out-of-hospital setting. She said that we need to build that desire within the people who are from those poor communities and are willing to run into the fire and help the mothers and babies in those communities. It is not a glamorous job, because they have to go into the community in the middle of the night and assist in the births. While some CNMs are willing to do more, many of them are not willing to make these kinds of sacrifices. Again, this all starts with the licensure of CPMs. She believes that everyone would agree that midwives want education, and collaboration. She noted that in the past there has been a polarization of position but also thinks that everyone is now all at the same table. There may be a plan that people can agree with, but we should go look at the structures that Illinois has and can work toward those in everyone’s favor. She said let’s care about the urban Medicaid woman who wants to stay in her community. Let’s actually develop more midwives of color, which is something that both CNMs and CPMs have failed to accomplish. That is because a number of them have been outside the system for so long they do not care about Medicaid, and it is not on their priority list. She said that she has been in community health and a CPM in a State that does not recognize her licensure, which is alright if it means that she is moving forward. However, she wants to develop more women like her, who are licensed and legal, and use existing structures to provide more services to the women of Illinois.

- **Ms. Wickersham:** Asked if, in summary, Ms. Sommers is saying that licensing is the beginning step, and that CPMs could help people with home births, but also can become part of the FQHC systems where they

may not be the primary midwife but take care of women on Medicaid who are high-risk births and are birthing with a team of CNMs and doctors. As part of this team, CPMs can assist high-risk mothers, by providing nutritional counseling, home visits or similar things.

- **Ms. Sommers:** Responded “absolutely.” She has worked in three community health centers who have all hired CPMs. Continued that the Committee should look at the structures that are already collaborative, community base and already existing. She suggested that this is a good starting place but again they cannot do anything until there is licensure. She explained that she happens to have a Licensed Practical Nurse license on the side which is why she can work at the birth center, but that is not why she can practice midwifery. She said that these alternatives have not been examined because most CPMs work outside of the system, so they cannot imagine the system. Also, the system knows so few of the CPMs, so others cannot imagine what a CPM can bring to the table. She stated that a CPM can bring a lot to the table.
- **Ms. Valrie-Logan:** Noted that she loved the part about needing people who were willing to run into the fire, because that is what she was attempting to articulate. She stated that people cannot imagine themselves going in the direction of a CPM, because there is no licensure. There is no reason to study and work hard if there is no licensure.
- **Ms. Sommers:** Responded that even with the popularity of home birth, CNMs are not interested in providing that service to people in the poorer communities. She explained that due to that, the reliance on CNMs cannot be the answer to provide safety for home births.
- **Dr. Wolfe:** Noted that Ms. Sommers’ discussion about collaboration rings true, and that Ms. Sommers and her both remember days when there was not always that collaboration. Stated that it was a time when patients were arriving at the hospital and the physicians knew what was happening with the patients. Asked if Ms. Sommers could speak about how well it worked when the hospital had collaboration with home birth providers.
- **Ms. Sommers:** Responded that what was so lovely is that we had CNMs were backing physicians at Mercy Hospital. The patients received their care at the clinic, no different from someone having a hospital birth. Also, the protocols were the same for the clinic as was at the hospital. She said that the physicians had final say on who the midwives could accept or not but that was how it should have been if they were on the receiving end if an event occurred. Then, if a patient chose a home birth, she would go to the midwives. The team was a CNM with a CPM, which was very common for community health. While CNMs who served in private hospitals did not care about Medicaid patients, CNMs who served in community health centers do care about women on Medicaid. That was the model of care. If the midwives saw someone deviating from the normal birth process, then the patient would be taken to the hospital and the hospital would already know them and have their medical records and right away the CNM was collaborating with the obstetrician/gynecologist on call. It did not get any better than that. Nobody felt dumped on or did not know what was arriving. While the transfer birth can be tough, but if you can trust your colleagues to follow a protocol then it is easier. Also, she noted that if someone did not follow a protocol then the committee

	<p>would find out. This way there was no one not knowing what was occurring, and there were discussions how the process could be improved. She also said that the quality control was always raised. She believed that has made her a better midwife because of the access to the information and from the feedback she received. In addition, she stated that even the dynamics that they have had from this hearing was helpful because people were sharing ideas. She said that you want collaborative care.</p> <ul style="list-style-type: none"> <li>• <b>Senator Martinez:</b> Thanked Ms. Sommers for speaking to the committee.</li> </ul> <p><b>B. <u>Discussions and Decisions Regarding Topics for Recommendations Which Will be Contained in the Committee’s Report</u></b></p> <ul style="list-style-type: none"> <li>• <b>Senator Martinez:</b> Begins to discuss the topics for recommendations that will be included in the Home Birth Maternity Care Crisis Study Committee Report. The committee was provided with a list of fifteen prompts to vote on.</li> </ul> <p><b>1. <u>Topic for Report No. 1</u></b></p> <ul style="list-style-type: none"> <li>• The Committee considered the first topic for a recommendation, which asked whether the Committee Members agreed or disagreed with the following statement:</li> </ul> <p style="padding-left: 40px;">The available evidence shows that from the year 2007 to 2017, while the number of all Illinois births has decreased substantially, the number of home births has remained between about 700 to 900 per year, and that expectant mothers in Illinois continue to have planned births in their homes.</p> <ul style="list-style-type: none"> <li>• The Committee Members were asked to agree with the above statement, to disagree with the above statement or abstain from voting regarding this statement. As there was no discussion regarding this issue, the matter was called to a vote.</li> <li>• <b>Committee votes:</b> Eleven Committee Members agreed with the statement (Senator Martinez, Senator Anderson, Mr. Tryon, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Dr. Wolfe, and Ms. Vickery); no one disagreed with the statement; two Committee Members abstained from voting (Ms. Harris and Mr. Wiggins), and two Committee Members were absent (Representative Moeller and Dr. Carlson).</li> </ul> <p><b>2. <u>Topic for Report No. 2</u></b></p> <ul style="list-style-type: none"> <li>• The Committee considered the second topic for a recommendation, which asked whether the Committee Members agreed or disagreed with the following statement:</li> </ul> <p style="padding-left: 40px;">Based on the testimony provided, the Home Birth Maternity Care Crisis Committee concludes that about 50% of planned home births take place with an unlicensed Certified Professional Midwife or other unlicensed individuals which threatens the health, safety and welfare of both the expectant mothers and babies.</p>	<p>Statement Adopted by Committee</p>
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	<ul style="list-style-type: none"> <li>• The Committee Members were asked to agree with the above statement, to disagree with the above statement or abstain from voting regarding this statement. As there was no discussion regarding this issue, the matter was called to a vote.</li> <li>• <b>Committee votes:</b> Eleven Committee Members agreed with the statement (Senator Martinez, Senator Anderson, Mr. Tryon, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Dr. Wolfe, and Ms. Vickery); no one disagreed with the statement; two Committee Members abstained from voting (Ms. Harris and Mr. Wiggins); and two Committee Members were absent (Representative Moeller and Dr. Carlson).</li> </ul> <p><b>3. <u>Topic for Report No. 3</u></b></p> <ul style="list-style-type: none"> <li>• The Committee considered the third topic for a recommendation, which concerned the available solutions to increase the safety of home births.</li> <li>• <b>Ms. Valrie-Logan:</b> Raised a question about the wording of the second option which stated that the best way to increase safety of home births was to only enact legislation designed to provide incentives for CNMs to assist in home births.</li> <li>• Mr. Tryon left the meeting.</li> <li>• <b>Ms. Lowrance:</b> Stated that in the last few months the law has changed for CNMs, in that they are now allowed to have full practice authority. She believes that this will permit more CNMs to be participate in home births in Illinois. However, she would not like to see anything connected with CNMs in the recommendations, because she does not believe that this was the reason that the Committee was formed. She views the purpose of the Committee to consider issues related to a bill about licensing CPMs and not involve CNMs who have licensure.</li> <li>• <b>Senator Martinez:</b> Agreed with Ms. Lowrance’s statement.</li> <li>• <b>Ms. Sawicki:</b> Stated if the Committee was to consider provisions in a piece of legislation, it could create licensure for CPMs and also to amend the statutes related to CNMs.</li> <li>• <b>Senator Martinez:</b> Responded that she believes that they are looking to enact a law that would just license CPMs and not amend the laws regarding CNMs.</li> <li>• <b>Ms. Wickersham:</b> Noted that the selections involve the best solutions to increase safety of home births, whether it be by licensing CPMs, helping CNMs to assist in home births or to do both options.</li> <li>• <b>Dr. Wolfe:</b> Added that the Committee should look for solutions to increase the safety of home births. One could be to license CPMs, and another could be to encourage CNMs to assist in home births. She explained that to her the issue was safety of home births, and not who is regulated and who was not regulated.</li> <li>• <b>Mr. Schultz:</b> Suggested dropping the “only” in the second option to avoid the inconsistencies regarding the third option.</li> <li>• The Committee agreed to that change.</li> <li>• <b>Dr. Quinlan:</b> Asked whether the incentives noted in the second option would be financially, or other types of incentives.</li> </ul>	<p>Statement Adopted by Committee</p>
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	<ul style="list-style-type: none"> <li>• <b>Mr. Schultz:</b> Responded that it could be financial, additional education options or other incentives that the Committee determines would assist in the safety of home births.</li> <li>• <b>Dr. Wolfe:</b> Added that the physicians are provided financial incentives if they are willing to practice in southern Illinois, and this could be something similar.</li> <li>• <b>Ms. Vickery:</b> Explained that she would not select option B because there was no testimony from CNMs regarding what incentives they thought would be appropriate to increase the safety of home births. She has no objection to providing incentives to increase CNMs participation in home births but could not vote provide incentives without any testimony regarding that issue.</li> <li>• <b>Ms. Belcore:</b> Added that the Committee cannot create requirements for the education of CNMs without knowing whether such programs would interfere with existing educational programs.</li> <li>• <b>Ms. Lowrance:</b> Stated that she is opposed to including provisions regarding CNMs. She represents ISAPN and CNMs are already covered under separate licensure and separate requirements. Incentives for CNMs to participate in home births involve separate issues that can be tackled at a separate time. The Committee needs to focus on CPM licensure.</li> <li>• As there was no further discussion regarding this issue, the matter was called to a vote. The Committee Members were requested to indicate their preference for the best solutions to increase the safety of home births among the following alternatives: <ul style="list-style-type: none"> <li>(1) The best way to increase the safety for women who choose to deliver their babies in their homes is to license and regulate CPMs, with certain requirements for such licensing.</li> <li>(2) The best way to increase the safety for women who choose to deliver their babies in their homes, is to enact legislation designed to provide incentives for Certified Nurse Midwives (“CNMs”) to assist home births in Illinois, both down-state and in the Chicago area.</li> <li>(3) I believe that both A and B are the best way to increase the safety for women who choose to deliver their babies in their homes.</li> <li>(4) I abstain from voting for these alternative statements.</li> </ul> </li> <li>• <b>Committee votes:</b> Seven Committee Members agreed with Statement (1) (Senator Martinez, Senator Anderson, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, and Ms. Vickery); no one agreed with Statement (2); two Committee Members agreed with Statement (3) (Dr. Quinlan and Dr. Wolfe), three Committee Members agreed with Statement (4) (Ms. Harris, Ms. Sawicki, and Mr. Wiggins), and three Committee Members were absent (Representative Moeller, Mr. Tryon<sup>1</sup> and Dr. Carlson).</li> </ul> <p><b>4. <u>Topic for Report No. 4</u></b></p>	<p>Majority Agreed with Statement (1)</p>
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<sup>1</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement 3.

	<ul style="list-style-type: none"> <li>• The Committee considered the fourth topic for a recommendation, which asked whether the Committee Members agreed with certain statements about licensing.</li> <li>• As there was no discussion regarding this issue, the Committee Members were asked to show their preference from the following statements: <ul style="list-style-type: none"> <li>(1) CPMs should be licensed and regulated in Illinois, as long as there are certain requirements placed on their licensure, such as necessary education, testing, and continuing education, an established permissible scope of practice, and other regulations.</li> <li>(2) CPMs should not be licensed in Illinois, even with requirements placed on their licensure.</li> <li>(3) I abstain from voting regarding this issue.</li> </ul> </li> <li>• <b>Committee votes:</b> Ten Committee Members agreed with the Statement (1) (Senator Martinez, Senator Anderson, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Dr. Wolfe, and Ms. Vickery); no one agreed with Statement (2); two Committee Members agreed with Statement (3) (Ms. Harris and Mr. Wiggins); and three were absent (Representative Moeller, Mr. Tryon<sup>2</sup> and Dr. Carlson).</li> </ul> <p><b>5. <u>Topic for Report No. 5</u></b></p> <ul style="list-style-type: none"> <li>• The Committee next considered issues related to the licensure of CPMs and specifically the education requirements for licensure.</li> <li>• <b>Ms. Valrie-Logan:</b> Questioned the wording of third option regarding whether it could require education through either a MEAC approved school or the portfolio evaluation process (“PEP”) process with the Midwifery Bridge Certification (“MBC”).</li> <li>• <b>Ms. Wickersham:</b> Explained that the third option was the PEP plus the MBC, while the second option would permit an education by the PEP without the MBC requirement.</li> <li>• As there was no further discussion, the Committee Members were asked to show if they agreed with one of the following statements regarding educational requirement issues, <ul style="list-style-type: none"> <li>(1) CPMs can be licensed in Illinois only if they receive didactic formal education in Illinois or another state at a school which has been accredited by the Midwifery Education and Accreditation Council (“MEAC”).</li> <li>(2) CPMs can be licensed in Illinois if they receive didactic formal education in Illinois or another state at a school which has been accredited by MEAC, or if they obtain certification through an education pathway which was not accredited by MEAC, without having to obtain the Midwifery Bridge Certificate.</li> <li>(3) CPMs can be licensed in Illinois only if they receive didactic formal education in Illinois or another state at a school which has been accredited by MEAC, or if they obtain certification</li> </ul> </li> </ul>	<p>Majority Agreed with Statement (1)</p>
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<sup>2</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement 1.

	<p>through an education pathway which was not accredited by MEAC and have separately obtained the Midwifery Bridge Certificate.</p> <p>(4) CPMs should not be licensed in Illinois.</p> <p>(5) I abstain from voting regarding this issue.</p> <ul style="list-style-type: none"> <li>• <b>Committee votes:</b> Two Committee Members agreed with Statement (1) (Ms. Lowrance and Dr. Wolfe); no one agreed with Statement (2); eight agreed with the Statement (3) (Senator Martinez, Senator Anderson, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Sawicki, Dr. Quinlan, and Ms. Vickery); no one agreed with Statement (4); two Committee Members agreed with Statement (5) (Ms. Harris and Mr. Wiggins), and three Committee Members were absent (Representative Moeller, Mr. Tryon<sup>3</sup> and Dr. Carlson).</li> </ul> <p><b>6. <u>Topic for Report No. 6</u></b></p> <ul style="list-style-type: none"> <li>• The Committee then considered the continuing education (“CE”) requirements for CPMs if they become licensed.</li> <li>• <b>Ms. Belcore:</b> Mentioned that as part of CPMs certification process, every three years CPMs must complete 32 hours of approved and accredited CE for recertification, as required by NARM. As a CE requirement is already in place, this would require unnecessary duplication of efforts in managing these requirements, rather than just requiring CPMs to submit their new certifications. Believed that an additional requirement would create more work on CPMs to manage their CE requirements for the State, and for NARM.</li> <li>• <b>Ms. Valrie-Logan:</b> Stated that she is required to do similar things to recertify as CNMs with the American Midwifery Certification Board (“AMCB”) and Illinois.</li> <li>• <b>Ms. Lowrance:</b> Agreed that as a CNM, she can use the same CE units which she obtains for her CNM recertification for the CE requirements for licensure with Illinois. However, their cycles are different with the AMCB, versus their cycles with licensure.</li> <li>• <b>Ms. Valrie-Logan:</b> Confirmed that for CNMs the same continuing education units can be used for both recertification and licensure. Asked whether the same would be true for CPMs.</li> <li>• <b>Ms. Belcore:</b> Stated that the national certifying board is already managing the CE hours, and that it would be a duplicate process if the State made that an additional responsibility when it is already built into the program for CPMs.</li> <li>• <b>Ms. Sawicki:</b> Stated that she did not believe the CE requirement, listed in first option, is duplicative of the CPM certification requirements. She also does not see it as requiring the Department to reassess the CE that is required for CPM recertification. It is consistent with the CPMs giving their certification to the Department as proof of certification, to satisfy the CPMs’ compliance with the licensure process. She suggested that it strikes a balance between not wanting to impose additional responsibilities on CPMs to provide information to the Department with</li> </ul>	<p>Majority Agreed with Statement (3)</p>
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<sup>3</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement 2.



	<p>someone who reads the legislation has some comfort or security that there are CE requirements built into the legislation.</p> <ul style="list-style-type: none"> <li>• <b>Mr. Wiggins:</b> Stated that there are some CE requirements which are mandated by State law that may not be covered by the certification requirements to continue to be a CPM. For example, sexual harassment training is mandated for every profession, but may not be included in the certification requirements for CPMs. So, while the certification CE are fungible to apply for the CE requirements for the Department, the State may have additional CE requirements, which are required to be completed.</li> <li>• <b>Ms. Belcore:</b> Stated that she just wanted to make sure that CPMs are not required to take 30 hours of CE on top of the 32 hours that CPMs are currently required to complete to become recertified.</li> <li>• <b>Dr. Wolfe:</b> Explained that this requirement is no different from the requirements that physicians and other professionals have regarding their CE requirements.</li> <li>• <b>Ms. Vickery:</b> Stated that the wording of the recommendation is not clear because it does not say that CPMs have to document all 30 hours of the CE. It would be written into proposed legislation how the CEs are documented.</li> <li>• <b>Ms. Harris:</b> Explained that it is important to remember that the Committee is not deciding on language which will be in proposed legislation, but only general topics from which language would be contained in some sort of proposed legislation at a later date. Can explain in the Report that it is the same kind of CE hours, and hours in addition to the requirements of the hours needed for certification, except for State mandates, such as sexual harassment.</li> <li>• As there was no further discussion, the Committee Members were asked to show if they agreed with one of the following statements regarding continuing educational requirement issues: <ul style="list-style-type: none"> <li>(1) CPMs can be licensed in Illinois only if they are required to receive at least 20 hours of continuing education if there is a 2-year license renewal cycle, or at least 30 hours of continuing education if there is a 3-year license renewal cycle.</li> <li>(2) CPMs can be licensed in Illinois without a requirement that they receive any continuing education.</li> <li>(3) CPMs should not be licensed in Illinois.</li> <li>(4) I abstain from voting regarding this issue.</li> </ul> </li> <li>• <b>Committee votes:</b> Ten Committee Members agreed with the Statement (1) (Senator Martinez, Senator Anderson, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Dr. Wolfe, and Ms. Vickery); no one agreed with Statement (2); no one agreed with Statement (3); two Committee Members agreed with Statement (4) (Ms. Harris and Mr. Wiggins); and three Committee Members were absent (Representative Moeller, Mr. Tryon<sup>4</sup> and Dr. Carlson).</li> </ul>	<p>Majority Agreed with Statement (1)</p>
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<sup>4</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement 1.

**7. Topic for Report No. 7**

- The Committee then considered any requirements regarding the integration of home births assisted by CPMs into the health care system.
- The topics for discussion included the following alternatives:

(1) CPMs should be permitted to be licensed in Illinois, and for every birth that they assist, they should prepare a plan for emergencies during the birth, which must include: the planned location for delivery; a designation of a hospital or hospitals where the client can receive emergency care; the name, address and telephone number of a collaborating physician and any other designated practitioner; a signed release of the mother's medical records; and a requirement that the mother's medical records are filed with the designated hospital or hospitals.

(2) CPMs should be permitted to be licensed in Illinois, and for every birth that they assist, they should prepare a plan for emergencies during the birth, which must include: the planned location for delivery; a designation of a hospital or hospitals where the client can receive emergency care; and a signed release of the mother's medical records.

(3) CPMs should be permitted to be licensed in Illinois and need not prepare a plan for emergencies during the birth.

(4) CPMs should not be licensed in Illinois.

(5) I abstain from voting regarding this issue.

- **Ms. Vickery:** Explained that she requested the inclusion of Statement (2), which she believed was in between the requirements of Statements (1) and (3). She explained that Statement (2) eliminates the requirement of written collaboration agreement and a requirement to file the mother's medical records that are contained in Statement (1). She explained that the reason that she eliminated that requirement to submit medical records is because some consumers have privacy concerns regarding the records that are given to someone who does not have a doctor-patient relationship.
- **Ms. Harris:** Requested a clarification, because the patient would be turning the medical records over to a hospital because the patient is being transported to the hospital.
- **Ms. Belcore:** Stated that the Statement (1) states that they medical records would be turned over to the hospital regardless of transport.
- **Ms. Vickery:** Explained that Statement (1) required that the records be provided prior to going into labor and have them on file even if the patient would not have to be transported to the closest hospital, or more than one hospital, if a number of hospitals are close.
- **Dr. Quinlan:** Stated that it would be a precaution to file medical records in case the patient has to be transported to the ER, the physicians have some of the backstory about the patient. Also, the records would be treated in a confidential manner just like any other medical record.
- **Ms. Harris:** Added that the Health Insurance Portability and Accountability Act ("HIPAA") requires that the information in the records cannot be disclosed. While she understood that some people may be

sensitive to some loss of privacy, the reality is that the records are being disclosed to a covered entity under HIPAA and cannot by law redisclose the information in the documents. She noted that it may be more of education of the patient that the records are required to be held in confidence by the hospital and cannot be distributed or used in any manner, except if the person comes in for an emergency.

- **Ms. Belcore:** Noted that Statement (2) does include the signed release of the mother's medical records, just not the filing the prefilling of the mothers' medical records with the hospital. Also, the records may be sent to a hospital which is not the hospital where the patient is eventually transported, because the hospital is too busy or not the closest location.
- **Ms. Harris:** Suggested that if one considers the safety perspective, simply showing up at an ER and handing someone the medical records at the door in the middle of an emergence, does not afford the doctors much time to review the documents.
- **Dr. Wolfe:** Stated that people are assuming that in the middle of an emergency someone is grabbing records, but nobody is grabbing records at that time.
- **Ms. Belcore:** Added that if licensure existed, the midwife could give a report while the patient is being transported to the ER.
- **Dr. Wolfe:** Explained that a verbal report is not the same as receiving the records.
- **Ms. Lowrance:** Believed that there is a statement in the Hospital Licensing Act that providers have to submit prenatal records at thirty-six weeks to the delivering facility. She understood the hesitancy of submitting the records ahead of time, but she had found in her practice that it was helpful. The exception was that she has had a couple of hospitals that over-reacted to those records and then went to maternal-fetal medicine ("MFM") specialists in her region and tried to figure how to squelch her activity.
- **Ms. Vickery:** Explained that was exactly the consumers concerns.
- **Dr. Quinlan:** Stated that her concern is for patient safety. If those records are received and someone who reviews them and is convinced that delivery should not occur at home, then it would be safer for the patient.
- **Ms. Belcore:** Explained that her experience has been that even in those situations where a doctor or a midwife in a practice who has never met this patient before is not going to be well-versed on the what they were walking into when seeing the patient. There is still a need to take some time to read the records and gain an understanding of the condition of the patient. She explained that the records could be maintained electronically and sent as the patient is being transferred to the hospital, so it is prepared for the patient who will be arriving. Noted that there are still people who just show up at the hospital with no records for a variety of reasons.
- **Dr. Wolfe:** Explained that if the records are sent to one hospital then the hospital who received the records could easily transfer the records to another hospital. Ask if everyone has an EMR for their patients.
- **Ms. Wickersham:** Responded that most midwives have an EMR, and reports can be sent in to the hospital by facsimile.
- **Dr. Wolfe:** Believed that everyone was saying that patients who come into the hospital who may not have any records, need records. Explained

that it is so much better for the doctor to have those records, even for just two minutes before the arrival of the patient. In emergencies and working with patients who come in to the ER in the heat of the matter you are not grapping records or thinking about sending records, you are trying to get the patient and assist the patient. She does not see anything wrong with the hospital getting the records early. She does not have a problem with the receipt of the records early.

- **Ms. Valrie-Logan:** Added a caveat, that when they have a patient who needs to be transported from the birth center to a hospital, they still have to take the records with them. She explained that what they see at that moment has nothing to do with what happened during the first trimester. Also, it is still the same practice, same hospital the doctors are being handed the records for both emergent and nonemergent births. That is the system at her hospital. Also, that is the same practice the same system for people who go to the hospital.
- **Ms. Wickersham:** Stated that was under an agreement between the hospital and the birth center. She also added that she previously worked at a birth center at a westside hospital and as a CPM she has been on three transports. The way that CPMs set up their practice, they are not at a home birth alone. There is an assistant midwife, and often two assistants. Someone is thinking about and actually grabs the records. She wants the receiving hospital to have those records for the patient's safety. The records can be sent through the EMR or sent by facsimile, so someone can read them during the transport to the ER. She also worked in a birth center where they receive patients from CNMs or unlicensed midwives and she knows that it is not a perfect situation when the transport arrives. It is nicer to have the records, but perhaps the Committee could acknowledge that some birth families will never agree to the transfer of records. However, this is not a reason to block progress on this issue. The Committee could add a mandate that the CPM must explain to the patients, possibly by using a pamphlet, that there are distinct possibly life-saving advantages to registering ahead of time and giving permission to deposit your health records with the hospital ahead of time, perhaps at 36 weeks. That would acknowledge the families who would never agree to the transfer of records, but it would inform them that they are taking a risk by not agreeing to the transfer.
- **Dr. Wolfe:** Stated that the topic does not state that the CPM would not assist them if the patient does not agree to the transfer of health records.
- **Ms. Wickersham:** Responded that the topic does state that the emergency plan is a requirement.
- **Dr. Wolfe:** Stated that it is a requirement that patients get HIV testing, but they can decline, so this requirement can be similar.
- **Ms. Sawicki:** Raised a procedural question in that there seems like there are two subtopics upon which there may be dispute. The first is the preexistence of a collaboration agreement and the second being the issue of the medical records. She wonders whether it makes sense to be discussing those together because she expects that there may be people who have different perspective on the collaboration agreements than they do on the medical records issue. She just wanted to flag that issue.

- **Ms. Valrie-Logan:** Asked if the matters raised in the topics would be requirements for the CPMs or if there would be some flexibility in these matters.
- **Mr. Schultz:** Explained that the topics for report were designed to determine the Committee's positions on various issues involving the licensure of midwives, and the best way to implement licensure. It would be left to the Committee to decide whether on certain issues there should be restrictive requirements on CPMs, or if CPMs would provide information to the families so that they can make an informed decision regarding the various requirements. The topics were designed to provide a range of requirements, so that the Committee could determine which requirement would be the most effective.
- **Mr. Wiggins:** Asked whether the Committee had any other suggestions for requirements that are not listed on the list. He also suggested that a new possibility could be added to the list and considered by the Committee with the others.
- **Ms. Sawicki:** Suggested that if someone believes that there should be a collaborating physician, but not a requirement that the medical records be sent to a hospital. That could be a possibility requirement regarding collaboration, which is not reflected on the list of possibilities.
- **Senator Martinez:** Stated that there was a lot of discussion regarding this topic and suggested that the topic be placed on hold and the Committee should move on to other topics. She is trying to cover as many topics as possible for the report, but she realized that more work needs to be done on these issues.
- The Committee decided it would be best to place this topic on hold for further discussions, if possible and moved on to the next topic without taking a vote on the possibilities presented for these issues.

**8. Topic for Report No. 8**

- The Committee next considered issues related to professional liability insurance requirements for CPMs.
- **Dr. Quinlan:** Reminded that Committee that at the last meeting Ms. Erin O'Brian confirmed that physicians did not have any legal requirement to maintain liability insurance.
- **Ms. Lowrance:** Mentioned that advanced practice nurses and CNMs were also not required to maintain professional liability insurance.
- As there was no further discussion, the Committee Members were asked to show if they agreed with one of the following statements regarding the professional liability insurance issue:

- (1) CPMs can be licensed in Illinois only if they obtain professional liability insurance of some amount, the minimum being \$200,000 for each incident and \$600,000 annual aggregate amount.
- (2) CPMs can be licensed in Illinois without a requirement that they obtain professional liability insurance placed in the Act licensing them, but disclosure of insurance status will be mandatory.

	<p>(3) CPMs can be licensed in Illinois without a requirement that they obtain professional liability insurance and disclosure of insurance status will not be required.</p> <p>(4) CPMs should not be licensed in Illinois.</p> <p>(5) I abstain from voting regarding this issue.</p> <ul style="list-style-type: none"> <li>• <b>Committee votes:</b> No Committee Members agreed with Statement (1); ten Committee Members agreed with the Statement (2) (Senator Martinez, Senator Anderson, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Dr. Wolfe, and Ms. Vickery); no Committee Members agreed with Statement (3); no Committee Members agreed with Statement (4); one Committee Member agreed with Statement (5) (Mr. Wiggins), and four Committee Members were absent (Representative Moeller, Mr. Tryon<sup>5</sup> and Dr. Carlson).</li> </ul> <p><b>9. <u>Topic for Report No. 9</u></b></p> <ul style="list-style-type: none"> <li>• The Committee next considered issues related to vicarious liability issues concerning the CPMs, doctors and hospitals.</li> <li>• Regarding vicarious liability issues, the Committee considered the following options, which were read by Senator Martinez: <ul style="list-style-type: none"> <li>(1) CPMs can be licensed in Illinois only if the law licensing CPMs states that no health care practitioner (“HCP”) shall be liable in any civil action seeking recovery of damages for an injury caused solely by an act or omission of a CPM, even if the HCP has consulted with or accepted a referral from the CPM.</li> <li>(2) CPMs can be licensed in Illinois only if the law licensing CPMs states that, in the absence of a formal contract of employment or agency, independently licensed CPMs are not agents, ostensible agents or employees of a health care practitioner who is consulted with or who accepts a referral from the CPM based solely on the consultation or referral.</li> <li>(3) CPMs can be licensed in Illinois only if the law licensing CPMs states that health care practitioners or systems that employ CPMs or have CPMs acting as an agent of the provider or system are not exempted from vicarious liability. However, absent express contractual agreement between the parties, independently licensed CPMs are not agents, ostensible agents or employees of a health care provider, even a provider who is consulted with or who accepts a referral from the CPM based solely on the consultation or referral.</li> <li>(4) CPMs can be licensed in Illinois without language in the bill that limits the liability of other HCPs.</li> <li>(5) CPMs should not be licensed in Illinois.</li> <li>(6) I abstain from voting regarding this issue.</li> </ul> </li> <li>• <b>Mr. Schultz:</b> Explained that Statement (1) limits the liability of physicians, nurses and hospitals in any civil action based on a CPMs</li> </ul>	Majority Agreed with Statement (2)
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<sup>5</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement 2.

actions or the CPMs failure to take appropriate action even if the other parties had consulted with the CPMs or accepted a referral from the CPM.

- **Ms. Wickersham:** Explained that the Statement (2) was suggested by Ms. Fisch during her presentation. Ms. Fisch's option was designed to recognize the Illinois Trial Lawyer's Association's ("TLA's") position but alleviate that by adding an extra clause, explaining that CPMs are not agents so there is no liability so that would give the doctors less concern about the licensure for CPMs. Regarding Statement (3), Ms. Fisch suggested that option to make it clear that while doctors and hospitals are not exemption from vicarious liability, CPMs, without a contractual agreement, are not liable as an agent of the doctors and hospitals. This option states that if doctors or hospitals hire a CPM they have some liability. But if they do not hire a CPM, then they are not agents and even if they consult with or accept a referral, she is not an agent and there is no liability. It combines what the TLA was seeking with the language that ACOG preferred.
- **Ms. Sawicki:** As a clarification, she noted that the last part of Statement (3) is the same as Statement (2). They both stated that if you do not have an employment agreement the doctors and hospitals are not going to be responsible for the actions of the CPM. The first sentence of Statement (3) does not state that a hospital or doctor will necessarily be liable, it just says that they are not going to be exempt from liability.
- Senator Anderson left the meeting.
- **Ms. Sawicki:** She continued that there is a potential for doctors or hospitals who works with a CPM beyond a referral, there is the possibility that they may be liable but does not impose liability. She also pointed out regarding Statement (1) that it does not contain language related to agency or vicarious liability, but in substance what Statement (1) means is if the only one who did something wrong is the CPM, then the doctor or hospital is not going to be liable for that. So, in some respects, Statements (1) and (2) are substantively more or less equivalents. She explained that Statement (1) is a simplified version of saying what Statement (2) says, and what the second sentence of Statement (3) says.
- **Mr. Wiggins:** Stated that to be clear, the report will not use this kind of legalese, but address the substantive sense of apportionment of liability. Also, he cautioned the Committee not to vote on every comma or work, but the sense of apportionment of potential liability.
- **Ms. Sawicki:** Pointed out that Statements (1) and (2) in a sense, say the same thing.
- **Ms. Wickersham:** Asked Ms. Sawicki why the TLA rejected the language in Statement (1).
- **Ms. Sawicki:** Responded that her understanding was the first sentence is Statement (3) is the part that was preferable to the TLA, because it assured that patients have some possible recovery against hospitals that employ a CPM. To the extent that Statement (1) and (2) just cover when hospitals and other health care providers are not going to be liable. Statement (3) discusses that and here are the circumstances where they might face liability.

	<ul style="list-style-type: none"> <li>• <b>Senator Martinez:</b> Requested the thoughts of a representative of TLA concerning this issue, because it was so contentious the last time that a bill licensing CPMs was considered.</li> <li>• <b>Tim Mclean, Representative of TLA:</b> Stated that based on a brief review of the language, Statements (1), (2) and (3) seem to be limited to employment positions for CPMs. However, there are all types of situations where agency relationships are created, and those relationship establish liability for additional parties. To the extent that someone is an agent, whether or not there is an employment agreement, the person overseeing that agent could potentially be liable for the injury as well.</li> <li>• <b>Dr. Quinlan:</b> Stated that this is the sticking point between the parties.</li> <li>• <b>Ms. Wickersham:</b> Asked if language is included in the statute that they are not agent, will that not prevent potential liability.</li> <li>• <b>Mr. McLean:</b> Responded that it depends on what their actions were related to the injury, and whether there was any direction or communication. If a doctor is advising on how to proceed with the medical protocol, then there is some potential liability for the doctors or hospitals.</li> <li>• <b>Dr. Quinlan:</b> Stated that this goes back to collaboration, which has been a topic of discussion for years. She stated that insurers would not let the doctors or hospitals collaborate with CPMs in that setting. However, removing the collaboration requirement and creating categories of mothers who would not be permitted to for home births or “risking out,” was the alternative then. She acknowledged that the liability issue is very complex.</li> <li>• <b>Ms. Wickersham:</b> Asked if there could be no clause related to liability at all in the statute.</li> <li>• <b>Ms. Harris:</b> Responded “no,” in that hospitals would not accept a bill without language about liability.</li> <li>• <b>Senator Martinez:</b> Asked if there was any language which would be acceptable to the TLA.</li> <li>• <b>Mr. McLean:</b> Responded that as a practical matter to protect mothers and babies, would require sufficient education, and collaboration. Their concern on the tail end is when mistakes are made by a midwife, a hospital doctor, staff or a combination of them, the statute would not erode the rights of someone because they choose to use a midwife, rather than conventional health care. So, a mother and baby should have the same rights whether the mother chooses to use a midwife or a hospital. That is their position on the issue.</li> <li>• <b>Ms. Harris:</b> Explained the hospital’s position is that the hospital should not be responsible unless they do something wrong after a transfer. So, anything that happens prior to transfer, the hospital needs not to be part of the litigation. They need very clear language in a bill that says that the hospital is not responsible. She could accept if the hospital employed the CPM, which is a different story, because the CPM is an employee and the hospital is responsible for the actions of its employees. Aside from that, anything that happens before hitting the ER door, is not the hospital’s liability.</li> <li>• <b>Ms. Sawicki:</b> Asked if Statement (1) is a compromise in that it specifies that the injury is cause solely by the act or omission by the CPMs,</li> </ul>	
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someone else is not going to be liable. That still leaves open the possibility of liability if other actions are taken by a separate health care practitioner who caused the injury. It does not use the language of vicarious liability. It gets the point across that if the only one who did something wrong is the CPM, the CPM is the only one who will be responsible.

- **Ms. Valrie-Logan:** Asked about who is liable regarding consultation, if a physician is asked a question by a CPM and provides information. She asked whether it is still only the CPM who would be liable, or whether a consulting physician or others who would be held liable. She explained that these questions are not answered by the Statements.
- **Ms. Harris:** Stated that the practical realities of the situation are, based on statements from the physicians, they are not able to freely provide collaboration because of insurance because if something goes wrong their insurance is not going to cover them for collaborating with the CPM and providing that advice. The Committee just voted that they are not going to require that the CPMs acquire professional liability insurance, so they have to figure out who is liable for mistakes. She does not have the answer because she does not represent physicians but represents hospitals.
- **Ms. Belcore:** Stated that we can tie that into the previous discussion regarding the issue if a CPM is required to submit the mother's health records to a hospital during prenatal care and asked whether that created liability for the hospital.
- **Ms. Harris:** Responded that it did not create liability because the hospital is not responsible for the care of that patient until the patient walks into the hospital's door. The fact that they have the patient's medical records does not mean that they are liable for anything that has happened previously to that patient.
- **Ms. Vickery:** Noted that a midwife can consult with a doctor and receive direction, which is similar to a doctor consulting with another doctor, the CPM can decide to take that advice or not. Asked how would the consultation create liability for the doctor, because there would be no liability for the consultation between doctors.
- **Ms. Harris:** Responded that if two doctors confer, they are both covered by the hospital's medical insurance and their own medical insurance. If the bad outcome is caused by the doctor receiving the advice not taking that advice, then the hospital's or the receiving doctor's insurers will pay for the injury. When dealing with people in separate systems, the doctors are still likely both covered by their insurance. If CPMs do not want to be covered by insurance, then the people who have the insurance will be sued. That is the way that the American litigation works. The party who has the deep pockets will be sued. Unless the physicians can be assured that they will not be sued for the collaborating with midwives they will not collaborate because they fear that they will be sued.
- **Ms. Vickery:** Noted that part of the concern with vicarious liability is a transferred patient walking into the ER. Asked whether currently physicians are concerned because they could be held liable for actions taken by the midwife before the patient arrived at the hospital.
- **Ms. Harris:** Responded "yes," in that if a person walks into an ER, the ER has to care for you regardless of how they ended up there. But if a

person currently just shows up in the ER in distress and without a midwife, the hospital does not have medical records or know what previously occurred, but they just try to save the situation. If the doctor and hospital cannot save the situation, they are going to be sued. She noted that at the first meeting she was asked whether that was the current situation for hospitals, so why are they requesting the provision in a bill regarding liability. She explained that if she knew who the midwives were, they would be currently suing the midwives for payments. She also could not stress enough the amount of money involved in these lawsuits for catastrophic injuries, because these families need to take care of these babies. The TLA would state that someone has to step up to pay for the care caused by the injuries to the babies. The question is who is the party who is responsible. She does not believe that it is the hospital until it has hands-on care and has done something wrong. Physicians do not want responsible unless they are collaborating, and midwives do not want to carry insurance because of the costs which would make licensure unattainable. This is the dilemma.

- **Ms. Vickery:** Stated that she thinks that the party which caused the injury should be responsible, but the difficulty is developing the words which would describe this responsibility.
- **Mr. Wiggins:** Suggested that that is not a solvable problem by the Committee at this moment. Rather than taking a vote regarding language because there will not be a consensus on the issue. Mr. Schultz will attempt to reflect the view points of the various stakeholders for the draft report. The report will not be perfect, but it is meant to provide the sense of the Committee's positions. They can make sure that their stakeholders' positions are reflected in the document because they will be presented with the draft. Also, it appears that the Committee will not reach a consensus on this issue, but their viewpoints will be represented in the report.
- **Senator Martinez:** Agreed that it does not appear that the Committee will reach an agreement on the issue with the time available.
- **Ms. Wickersham.** Mentioned that there were no TLA members on the Committee, so it is difficult to have input from all stakeholders regarding a proposed bill. Asked whether the Committee could receive a clear understanding of the language that the TLA would find acceptable.
- **Mr. Mclean:** Stated that the TLA could provide guidelines regarding their position. but without having a proposed bill with language they could not take a position regarding the language. They could not provide language but could provide guidance regarding their positions. Also noted that liability has to be proven in court, and it rests in control. From their standpoint, hospitals accept injured parties in all situation, and are in a certain condition. The hospital notes that condition and what happens going forward is the hospital's liability responsibility that TLA's members would have to prove. What happened before the patient walks into the hospital is not their responsibility, because they have no control over the patient at that time. So, the notion that there needs to be a statement that certain parties are not responsible is contrary to common law standard and exists nowhere else in Illinois law.

- **Ms. Harris:** Stated that they would disagree with that and the reality of the situation is that the midwives do not want to have any insurance, or the levels of insurance that they would have are not going to reach the amounts necessary to meet the damages that are being assessed. So, hospitals will get sued and even though the attorneys would have to prove that the hospital's negligent, they would have to defend that suit, which costs a lot of money which can be used to improve other patient care. They include the women who are coming to the hospital for deliveries by improving the experience for those women.
- **Ms. Wickersham:** Stated that the TLA is stating that the language is unacceptable, and the hospitals are saying they need it in anyway. Asked whether the hospitals would need that language in a bill if it required that CPMs are required to maintain professional liability insurance with certain amounts of coverage.
- **Ms. Harris:** Stated that the insurance cost would not be feasible for the midwives to purchase. She suggested that the report state that there was no consensus of the Committee and describe the viewpoints that were expressed by the various Members.
- **Senator Martinez:** Stated that want to see some sort of guidance from the TLA to see if any consensus can be reached or not.
- **Mr. Wiggins:** Reminded the Committee that the report is due on January 1, 2020, so that the matter was very time sensitive.
- There was general discussion about adding another meeting, but it was concluded that it was not possible to add another meeting date.
- **Mr. Dixon:** Explained that a draft report will be circulated to the Committee prior to the next meeting, which will provide an opportunity for the Committee Members to make comments, corrections or concerns to the report before it is adopted by the full Committee. These can also be fleshed out during the December meeting.
- **Ms. Quinlan:** Asked Mr. McLean whether Statement (1) would be acceptable for the TLA.
- **Mr. Mclean:** Responded that if something is placed in the statute which would limit liability, the TLA will object to that provision, and objects to the inclusion of Statement (1) in proposed legislation.
- **Mr. Schultz:** Explained that the TLA's position is that people should not be limited from bring litigation to investigate if the various parties were negligent, and the hospitals do not want to be included in such a suit because of the expense which they would incur even if they know and can prove that they provided appropriate care and were not at fault for any injuries.
- **Ms. Harris:** Concurred and stated that hospitals are being brought in to law suits because they are the only party that has deep pockets to provide for the injured parties.
- **Senator Martinez:** Asked what CPMs that live in other states that require insurance do to acquire insurance.
- **Ms. Wickersham:** Responded that most states only require that CPMs provide notice to patients whether they have insurance. Then questioned, given how difficult licensure is, how litigious the State is, and how catastrophic injuries occur, even if midwives obtain liability insurance

would it be enough for the hospitals and physicians to cease their demand for language regarding vicarious liability.

- **Ms. Belcore:** Expressed concern regarding the precedent that it would set to require that CPMs purchase liability insurance when no other professions require the purchase of such insurance.
- **Ms. Harris:** Responded to the question about what other states are doing, by stating that most states are not requiring that CPMs purchase liability insurance, instead they are requiring that CPMs disclose whether they are carrying the insurance. Her reviewed of the laws in other states showed that out of the 35 states that license CPMs, 21 have provisions that limit liability for hospitals and doctors like Statement (1). She explained that trial lawyers in those states did not object to the language.
- **Ms. Sawicki:** Pointed out that the Committee was attempting to determine the liability risk, they should consider the liability risk now when home births go wrong and arrive at hospitals without documentation. She explained that in passing legislation licensing CPMs, they do not want to make liability issues worse for anyone. From her perspective, it is important to look at all of the options in terms of how they will change the liability landscape compared to what it is now, as opposed to what is the ideal situation for liability.
- **Senator Martinez:** Noted that the liability issue has been the most contentious part of the last three years. It has been the sticking point for them not being able to move forward on legislation. She believes that everyone has to do a better job of coming together and finding a solution. Whether it is following what other states are doing for CPMs or never reach an agreement on the issue.
- The Committee decided that the perspectives can all be expressed in the draft Report and determined to move on to consider other topics for the report.

**10. Topic for Report No. 10**

- The Committee next considered issues related to limitations on CPMs assisting with high-risk births. The Committee Members considered the following Statements:

(1) CPMs can be licensed in Illinois only if the law licensing CPMs states that CPMs are prevented from planning to attend and assist out of hospital births with patients who would be considered “high-risk,” which would be contained on a separate list in the statute or rules.

(2) CPMs can be licensed in Illinois only if the law licensing CPMs states that CPMs are prevented from caring for patients as a primary midwife if a patient is not considered “low-risk,” as defined on a separate list in the statute or rules.

(3) CPMs can be licensed in Illinois without any limitation on CPMs assisting in births if the mother or baby are considered “high-risk.”

(4) CPMs should not be licensed in Illinois.

(5) I abstain from voting on this issue.

	<ul style="list-style-type: none"> <li>• <b>Ms. Lowrance:</b> Asked for clarification about the wording of the Statements. She had a question about differentiating between the Statements because Statement (1) states that involves a list of patients who are high-risk and CPMs are not allowed to care for them. However, she is confused about Statement (2) which involves a list that categorizes low-risk patients.</li> <li>• <b>Ms. Wickersham:</b> Explained that Ms. Sommers had testified that if CPMs were licensed that they could assist high-risk expectant mothers who are too high-risk to have home births, but they are going to give birth at a FQHC, and with a maternal-fetus specialist and an obstetrician. However, the mother could benefit from a supervised CPM, who could assist by giving nutrition counseling or provide other assistance. Statement (1) prevents the participation with a high-risk mother. Statement (2) says that CPMs can only be a primary midwife for “low-risk” mothers. It opens the door to the FQHC work for CPMs.</li> <li>• <b>Ms. Belcore:</b> Noted that Statement (1) states that CPMs cannot attend or assist patients who would be considered “high-risk.” That would exclude CPMs from assisting doctors and other CNMs from participating in that care. It would exclude them from that practice.</li> <li>• As there was no further discussion, the Committee Members were asked to show if they agreed with one of the following statements regarding the issues related to CPMs caring for “high-risk” patients.</li> <li>• <b>Committee votes:</b> No Committee Members agreed with Statement (1); eight Committee Members agreed with the Statement (2) (Senator Martinez, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Dr. Wolfe, and Ms. Vickery); no Committee Member agreed with Statement (3); no Committee Members agreed with Statement (4); two Committee Members agreed with Statement (5) (Mr. Wiggins and Ms. Harris); and four Committee Members were absent (Representative Moeller, Senator Anderson, Mr. Tryon<sup>6</sup> and Dr. Carlson).</li> </ul> <p><b>11. <u>Topic for Report No. 11</u></b></p> <ul style="list-style-type: none"> <li>• The Committee next considered issues related to CPMs authorization to obtain and use prescription drugs. The Committee Members considered the following Statements: <ul style="list-style-type: none"> <li>(1) CPMs can be licensed in Illinois and can carry and administer: postpartum antihemorrhagic drugs, which will be listed in rules, for use in emergency situations: oxygen; local anesthetics, only for postpartum repair of lacerations, tears and episiotomy; Rhogam; IV fluids; Sterile H2O papules; sutures; vitamin K injections; erythromycin ointment; ibuprofen; and prophylactic antibiotics for Group B Strep (also known as Beta Strep).</li> <li>(2) CPMs can be licensed in Illinois but cannot carry and administer any drugs needing a prescription.</li> <li>(3) CPMs should not be licensed in Illinois.</li> </ul> </li> </ul>	<p>Majority Agreed with Statement (2)</p>
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<sup>6</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement (1), with the statement “Collaborative relationship for high-risk pregnancy.”

	<p>(4) I abstain from voting regarding this issue.</p> <ul style="list-style-type: none"> <li>• <b>Ms. Belcore:</b> Requested that the it be noted that the list of drugs in Statement (1) be in the rules rather than the statute, because the types of drugs that CPMs would need changes from time to time, to it would be easier to change a rule than the statute.</li> <li>• As there was no further discussion, the Committee Members were asked to show which of the above Statements regarding the issues related to CPMs authorization to carry and administer various drugs with which they agreed.</li> <li>• <b>Committee votes:</b> Nine Committee Members agreed with Statement (1) as amended (Senator Martinez, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Dr. Wolfe, and Ms. Vickery); no Committee Members agreed with Statement (2); no Committee Member agreed with Statement (3); two Committee Members agreed with Statement (4) (Mr. Wiggins and Ms. Harris); and four Committee Members were absent (Representative Moeller, Senator Anderson, Mr. Tryon<sup>7</sup> and Dr. Carlson).</li> </ul> <p><b>12. <u>Topic for Report No. 12</u></b></p> <ul style="list-style-type: none"> <li>• The Committee next considered issues related to CPMs reporting any injury or mortality events. The Committee Members considered the following Statements: <ul style="list-style-type: none"> <li>(1) CPMs can be licensed in Illinois but are required to report any injury or mortality events in connection with the births on an annual basis.</li> <li>(2) CPMs can be licensed in Illinois but are not required to report injury or mortality events in connection with the births.</li> <li>(3) CPMs should not be licensed in Illinois.</li> <li>(4) I abstain from voting regarding this issue.</li> </ul> </li> <li>• As there was no discussion regarding this issue, the Committee Members were asked to show which of the above Statements regarding the issues related to CPMs reporting any injury or mortality events with which they agreed.</li> <li>• <b>Committee votes:</b> Ten Committee Members agreed with Statement (1) (Senator Martinez, Ms. Belcore, Ms. Wickersham, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, Dr. Quinlan, Ms. Harris, Dr. Wolfe, and Ms. Vickery); no committee Members agreed with Statement (2); no Committee Member agreed with Statement (3); one Committee Member agreed with Statement (4) (Mr. Wiggins); and four Committee Members were absent (Representative Moeller, Senator Anderson, Mr. Tryon<sup>8</sup> and Dr. Carlson).</li> </ul> <p><b>13. <u>Topic for Report No. 13</u></b></p>	<p>Majority Agreed with Statement (1)</p> <p>Majority Agreed with Statement (1)</p>
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<sup>7</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement (1).

<sup>8</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement (1).

	<ul style="list-style-type: none"> <li>• The Committee next considered issues related to the makeup of a board to recommend disciplinary actions and other matters regarding midwives.</li> <li>• <b>Ms. Wickersham:</b> Noted that Statement (1) contained on the list of options sent to the Committee included a reference to the proposed board being made up of three to five members and asked that the reference be eliminated. She explained that she was requesting that the majority of the board be CPMs.</li> <li>• The Committee agreed to change Statement (1) by eliminating the reference to “three to five members.”</li> <li>• <b>Ms. Sawicki:</b> Asked that the Committee Members keep in mind while they are considering the composition of the board, that the more that the composition of the board deviates from other existing boards, the more it will cost for the Department, and likewise the licensing fees will be higher. For example, if a whole board is required, that will involve additional licensing costs for CPMs.</li> <li>• <b>Ms. Wickersham:</b> Noted that Statement (1) is the only option which complies with International Confederation of Midwives (“ICM”) standards, which are the same standards that ACOG has agreed to for education of midwives. ICM states that midwives should be self-governed. The idea of a board of midwifery composed of a majority of non-midwives is not in compliance with these standards.</li> <li>• <b>Dr. Quinlan:</b> Noted that this board serves a different purpose and there needs to be other complementary health care professionals as part of this board.</li> <li>• <b>Ms. Wickersham:</b> Responded that she would welcome one doctor or CNM, but the majority of the board should be CPMs. If the majority are not CPMs then that does not allow the CPMs to self-govern, and they are not in compliance with ICM.</li> <li>• <b>Mr. Wiggins:</b> Noted that he did not know how self-governing is defined but professional boards are advisory. They do not govern but make recommendations that are adopted or rejected by the Director of the Department.</li> <li>• <b>Ms. Valrie-Logan:</b> Requested a clarification, because Statement (1) could be the same as Statement (2) depending on the individuals who are on the board listed in Statement (1).</li> <li>• <b>Mr. Wiggins:</b> Asked if they want Statement (2) to include a reference that the board may not contain a majority of CPMs.</li> <li>• The Committee agreed to change Statement (2) by added the phrase “the majority of which are not CPMs and eliminating the numbers of contained in the example.</li> </ul> <p style="margin-left: 40px;">(1) CPMs should be licensed in Illinois and the Board that recommends disciplinary action and other matters regarding CPMs should contain a majority of CPMs.</p> <p style="margin-left: 40px;">(2) CPMs should be licensed in Illinois and the Board that recommends disciplinary action and other matters regarding CPMs should be made up of a combination of physicians, CNM and CPMs the majority of which are not CPMs</p> <p style="margin-left: 40px;">(3) CPMs should be licensed in Illinois and recommendations regarding disciplinary actions regarding CPMs and other matters</p>	
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	<p>regarding CPMs should come from the existing Board of Nursing, with a CPM being appointed to either sit as a member of the Board or to provide expertise to the Board regarding disciplinary and other actions.</p> <p>(4) CPMs should not be licensed in Illinois.</p> <p>(5) I abstain from voting regarding this issue.</p> <ul style="list-style-type: none"> <li>As there was no discussion regarding this issue, the Committee Members were asked to show which of the above Statements regarding the issues related to a CPM board with which they agreed.</li> <li><b>Committee votes:</b> Three Committee Members agreed with the revised Statement (1) (Ms. Belcore, Ms. Wickersham, and Ms. Vickery); three Committee Members agreed with Statement (2) (Senator Martinez, Dr. Quinlan, and Dr. Wolfe); no Committee Members agreed with Statement (3); no Committee Members agreed with Statement (4); five Committee Members agreed with Statement (5) (Mr. Wiggins, Ms. Valrie-Logan, Ms. Lowrance, Ms. Sawicki, and Ms. Harris), and four Committee Members were absent (Representative Moeller, Senator Anderson, Mr. Tryon<sup>9</sup> and Dr. Carlson).</li> </ul> <p><b>C. Issues Related to the Licensure of CNMs</b></p> <ul style="list-style-type: none"> <li><b>Ms. Lowrance:</b> Stated that the Committee earlier decided that it would not consider issues related to CNMs and home births, so she suggested that the Committee not consider the last two topics related to CNMs.</li> <li><b>Senator Martinez:</b> Stated that when the Committee previously considered the CNMs that they decided to keep the issues exclusively to CPMs and not CNMs.</li> <li><b>Ms. Harris:</b> Noted that the proposed topics would add standards for CNMs, not CPMs.</li> <li><b>Mr. Schultz:</b> Explained that the topics were included based on comments from Representative Moeller, and that the Committee is entitled the Home Birth Maternity Care Crisis Study Committee. The topics were based on testimony from Dr. Pont.</li> <li><b>Ms. Lowrance:</b> Stated that the topic related to the education requirements of CNMs, includes a requirement that CNMs attend a home birth, is simply not feasible. She added that most institutions require excessive liability and Illinois cannot find anyone who will provide insurance for her to have a student assist her in her home birth practice as an observer. So that requirement cannot be implemented in Illinois. Regarding scholarships for CNMs in Illinois, she stated that she would love to have more scholarships, but CNMs are already required by law to have that collaborative agreement for two years and then once they obtain full practice authority CNMs would be able to practice outside of that agreement. So as an Advance Practice Nurse and CNM, these suggestions are not feasible. She also emphasized that the bill is about CPM licensure, not CNMs.</li> <li><b>Senator Martinez:</b> Stated that if the Committee agrees, number 14 and 15 of the Topics for the Report will be eliminated.</li> </ul>	<p>Equal number of Committee Members Agreed with Statements (1) and (2)</p>
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<sup>9</sup> Mr. Tryon left a packet indicating that if he had stayed he would have selected Statement (2).



	<ul style="list-style-type: none"> <li>• <b>Dr. Wolfe:</b> Stated that while she has no objection to eliminating number 14 and 15 of the Topics for the Report, the Committee was about home births, not about CPMs. She believed that the Committee should ensure that it is focusing on home births, regardless who assists the home births.</li> <li>• <b>Ms. Harris:</b> Suggested that Mr. Schultz include in the report a statement to note that this study is about home births and include a paragraph in the report that states that the Committee wants to provide for more opportunities for home births. For example, by providing for scholarships for providers, including CPMs, CNMs and others, who would be willing to deliver babies at the mothers' homes.</li> <li>• <b>Senator Martinez:</b> Agreed that the Committee should keep the matter open to other ideas and to provide more encouragement to health care professionals to what to assist in home birth deliveries.</li> <li>• <b>Ms. Wickersham:</b> Stated that she had discussion about these proposals and concluded that the State could provide scholarships for health care providers with a requirement that the individuals would have to work for five years providing home births. However, these individuals would have to set up their own entrepreneurial home birth practice and the odds of that succeeding for a brand-new graduate are very low. She added that the suggested topics are not realistic because observing one birth will not prepare someone to deliver home births, and a whole semester class will require some much time that it will prevent a person from taking other classes. She also questioned what would happen if the graduate's practice fails. Asked whether the person have to return the scholarship money. She just believes that neither of the Topics is realistic. She added that of course she would like CNMs to succeed, if they want to assist in home births and have found the means to establish a home birth business. She supports scholarships and other ways to encourage CNMs to participate in home births, but the options before this Committee are not realistic.</li> <li>• <b>Senator Martinez:</b> Agreed that there is enough involving CPMs to include in the Report.</li> <li>• The Committee agreed to eliminate number 14 and 15 of the Topics for Report and include a statement in the Report that other options be explored to increase the number of health care providers who are willing to assist in home deliveries.</li> <li>• <b>Ms. Wickersham:</b> Confirmed that Illinois does not provide funds to the Department to establish any boards, and board have to be self-funded by the professions that they regulate. She also noted that the licensure fees for CPMs were estimated to be over \$3,000 a year based on certain assumptions. Asked whether that was based on language in the statute or is it just custom that the Department does not accept money from the State.</li> <li>• <b>Mr. Schultz:</b> Responded that the Department is self-funded pursuant to language in the statute.</li> <li>• <b>Senator Martinez:</b> Added that she was the Chairperson of the Committee that oversees the Department for many years and the funding for the Department comes from license fees, fines which are collected and administrative charges.</li> <li>• <b>Ms. Wickersham:</b> Asked whether an exception to this statute could be made due the extraordinary circumstance facing CPMs and the lives that may be saved involving home births.</li> </ul>	<p>Majority Agreed to Eliminate Numbers 14 and 15 of Topics for Report and include statement in Report</p>
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	<ul style="list-style-type: none"> <li>• <b>Ms. Harris:</b> Responded that she could write anything she wanted, but getting it passed through the legislature is another story.</li> <li>• <b>Mr. Wiggins:</b> Responded that such a bill would be the first of 76 other bills asking for exceptions for the fees charged for other professions.</li> <li>• <b>Senator Martinez:</b> Confirmed that the next meeting would be December 19, 2019 and thanked everyone for participating in the long meeting that was required to review the many topics for the report. She believed that there were some important issues that the Committee was able to agree upon, and a few that the Committee could not reach an agreement. She asked that everyone review the draft report which is circulated over the next few weeks regarding everything that they have discussed. She stated that if there is anything that needs to be changed, to feel free to forward those comments to Mr. Schultz. The Committee is made up of the experts on the issues and their input is very important. She explained that the intention is that when the Committee meets on December 19, 2019, the Committee will review the report and ensure that it reflects the recommendations of the Committee. She asked the Committee Members to ensure that they do not provide edits on the day of the meeting because the Committee will not be able to consider all of those changes on that day but provide any changes to Mr. Schultz prior to the meeting. She stated that they have come a long way from three years ago and that there are good things that could result from the Committee's work. Therefore, it is important that they provide input regarding the report and that it be provided to Mr. Schultz prior to the next meeting date. It is also important that the report provided to the General Assembly is very clear and concise as possible, while covering what the Committee considered and where the Committee is headed.</li> <li>• The Meeting was adjourned by unanimous consent.</li> </ul>	
<b>Adjournment</b>	<ul style="list-style-type: none"> <li>• Adjourned 4:41 p.m.</li> </ul>	