



A Report on Expanding and Strengthening Community Birth Options in Illinois

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Executive Summary

This report underscores the necessity of establishing a more robust and sustainable community birth infrastructure in Illinois. Data was obtained from written surveys, individual interviews, and focus groups provided by community midwives, doulas, physicians, healthcare leaders, and birth center staff. The recommendations aim to foster a coordinated effort among community birth practitioners, midwives, policymakers, funding entities, healthcare leaders, and community partners to enhance and expand access to community birth services. The report's findings and recommendations are grouped in five categories, with the Recommendations summarized below.

Category 1: Expand the Availability, Accessibility, and Equity of Community Birth Setting Options

Recommendations:

1. A minimum of four additional birth centers should be opened in Illinois, with a planning process developed to recommend a more targeted number and locations of birth centers needed throughout the state.
2. Widely embed Certified Nurse Midwives (CNMs) in all birthing hospital maternity teams.
3. Adequately reimburse and staff all safety-net birthing hospitals.

Category 2: Establish Equitable Medicaid & Private Insurance Reimbursement Rates to Insure Financial Sustainability of Community Birth Settings

Recommendations:

1. Set the Medicaid professional reimbursement fees for CNMs and CPMs providing home and birth center care to reflect the same work performed by hospital-based providers.
2. For birth center reimbursement, Medicaid and commercial insurers should include a facility fee for the services provided to the newborn baby.
3. To support midwives providing birthing services in the home, establish a reimbursement rate that provides compensation for all the supplies, materials, and other infrastructure that they bring into the home (similar to an “all-inclusive” home birth fee in four other states - NY, NM , VT, NH).
4. For home births, ensure that Medicaid covers all required diagnostic testing.
5. To remove the financial disincentive for safety-driven transfers to a hospital, . adequately compensate CNMs and CPMs for labor management provided in the home and at a birth center (prior to a needed transfer to hospital-based care).
6. Provide Medicaid and commercial insurance reimbursement for birth assistant services provided in the home.
7. To reduce the administrative burden on small homebirth practices and birth centers, simplify the Medicaid enrollment process to avoid multiple Managed Care organization negotiations.
8. A billing support infrastructure should be established to streamline the third party billing process.
9. To reduce cost inefficiencies in obtaining emergency equipment, pharmacy items, PPE, etc., extend the supply & equipment purchasing cooperatives available to homebirth CPMs.

Category 3: Build a Funded Workforce Training & Preceptorship Pipeline for CNMs & CPMs

Recommendations:

1. Create Medicaid-funded midwifery student stipends and preceptor reimbursement for midwives providing care in the home, birth centers, and in the hospital.
2. Provide funding for formal structured preceptor training, mentorship and resources for CNMs and CPMs.
3. Invest in community birth workforce diversity by providing early education and exposure opportunities, scholarships, stipends, and training opportunities.

4. Expand the OB/GYN workforce by incentivizing clinicians to train and serve in rural and medically underserved areas.

Category 4: Improve Continuity of Care, System Integration, and Effective Transfers of Care through Collaborative Relationships with Hospitals & Diagnostic Services

Recommendations:

1. Develop and implement statewide standardized transfer protocols for all hospitals to receive home and birth center patient transfers.
2. Expect all hospitals within the Perinatal Hospital system to accept transfers from birth centers and home birth midwives.
3. Improve hospitals' communication of clinical updates to home birth midwives who have transferred their patients for a higher level of care.
4. Encourage hospitals to designate a liaison for home birth and birth center midwives and the sharing of medical records
5. Encourage transfer agreements to include annual stimulations.
6. Expect home birth midwives to have referral agreements with hospital systems & diagnostic imaging centers.

Category 5: Safeguard Midwife Safety & Emotional Sustainability

Recommendations:

1. Support a team-based approach for solo on-call home birth midwives, and encourage networking and mutual support among all home birth providers.
2. Expand access to mental health and peer support services for solo community midwives.
3. Ensure adequate staffing workload and compensation for community midwives.

Purpose of Report

This report aims to help strengthen and expand access to community birth services in Illinois (including care provided at both freestanding birth centers and at home) by:

- Analyzing the current landscape
- Identifying the challenges and barriers that hinder progress
- Making recommendations that support meaningful policy and programmatic changes

It draws on numerous data sources, including a literature review, online surveys, community birth worker focus groups, and in-depth interviews with midwives, physicians, and healthcare leaders. By incorporating the perspectives of those most affected and those with the ability to influence the

landscape, this report reveals disparities among different communities within Illinois and recommends several strategies to address these issues.

The target audience for this report includes: midwives, community birth workers, and physicians seeking safe and sustainable ways to provide care to their clients; hospitals seeking to expand birthing options and collaborations with birth centers and home birth providers; policymakers interested in recommendations to improve maternal health equity; funders aiming to align their resources with community-led solutions, and other grassroots and community partners dedicated to expanding equitable, culturally relevant birthing options.

By combining research, practice-based insights, and community perspectives, this report lays the groundwork for developing policies, strategic planning, and making investments that address systemic gaps and support the sustainability of midwifery and community birth infrastructure across the state. Ultimately, the findings and recommendations aim to guide collective efforts to reduce maternal health disparities and ensure that every birthing person in Illinois has access to safe, trusted, and culturally appropriate community-based care.

Background for Report

Illinois stands at a critical juncture. There is a continuum of location options for giving birth and receiving maternity services in Illinois: a) at home; b) at a birth center; or c) at a level I, II, or III perinatal center. Expanding access to home births and birth centers offers a validated and equity-centered approach to transforming the state's maternal healthcare infrastructure, reducing disparities, and ensuring that every individual giving birth—regardless of race, income, or geographic location—receives safe, dependable, and culturally sensitive care of their choice.

Community-based midwifery care, provided both at home and in a birth center, has long served as culturally sensitive, trusted, and evidence-based models of care that provide safe and satisfying experiences for birthing people.

The intent of this report is not to promote one part of the birth setting continuum over another, but to focus on the challenges and opportunities reported by professionals providing care at birth centers and at home. See Appendix A for comments about the community birth setting model of care.

As is documented in the literature review, midwifery-led care has been consistently shown to improve maternal and neonatal outcomes, enhance patient autonomy, and reduce unnecessary interventions, particularly among low-risk pregnancies. Despite this, the growth of community birth options in Illinois has been severely constrained by numerous barriers, disproportionately impacting communities where hospitals have closed.

Expanding community birth infrastructure in Illinois is an urgent priority due to the increasing reduction of access to Maternity Care [See Appendix B – Reduced Access to Maternity Care].

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Doing so requires a comprehensive understanding of existing disparities across urban and rural areas, identifying access barriers within the health system, and strategically using evidence supporting midwifery-led models of care. Strengthening midwifery and community birth pathways is both an equity-driven and cost-effective solution to the state’s maternal health crisis. It can restore local access to care, increase workforce diversity, and ensure that every birthing person—regardless of race, income, or geography—has the opportunity to give birth safely in the setting of their choice.

Methods

1. National & International Literature Review of Birth Center Best Practices

See *APPENDIX C: Free-Standing Birth Center Models: A Comprehensive US & International Review*

2. Field Work

To enhance understanding of the current community birthing environment in Illinois, a team of two Certified Nurse Midwives (CNMs) and a Master of Public Health (MPH) student conducted a landscape analysis of community birth practices in Illinois. Data was collected over three months, from April 2025 to July 2025.

- a. A one-page flyer inviting community birth workers and administrative personnel to participate in an on-line survey, individual interviews, focus groups, or any combination thereof, according to their preferences.
- b. A total of thirty (30) community birth workers and stakeholders were subsequently invited to participate in the project through either an individual interview or a focus group with other key stakeholders and community birth workers.
- c. In a 90-minute virtual focus group that was recorded with their consent participants answered a series of questions in the following focus areas: i) stability; ii) reimbursement; iii) collaboration; iv) access to care; v) operational model; vi) liability; and, vii) demographics. [See *Appendix D - Survey Instrument Practice Questions for Home Births & Birth Center Births*]
- d. The interviewees who agreed to a recorded interview were recorded using the Zoom recording feature. The recordings were transcribed and summarized with transcription software.
- e. Three midwives responded to the written survey, all currently providing care through their individual solo homebirth practices in Illinois. Two of the three are Certified Nurse Midwives, and one did not specify their credentials.

Findings & Recommendations

Category 1: Expand the Availability, Accessibility, and Equity of Community Birth Setting Options

Findings

The State of Illinois faces significant and enduring challenges in attaining maternal health equity, characterized by profound racial and geographic disparities in services availability and accessibility that continue to influence birth outcomes.

- Communities of color—especially Black, Indigenous, and Latinx birthing populations—suffer from disproportionately elevated rates of maternal morbidity and mortality in comparison to their white counterparts.^{1,2}
- According to the 2024 Maternal Health Desert report by the March of Dimes, 43.1% of Illinois counties (35) are designated as maternity care deserts, indicating the absence of a hospital or birth center providing obstetric services and the lack of obstetric providers. This situation results in limited access to essential obstetric care for many families. The deficiency in infrastructure compels rural families to undertake long journeys to access care, thereby elevating the risk of adverse maternal and infant health outcomes.
- Over the past decade, more than twelve hospitals and obstetric units have closed in both urban and rural areas throughout Illinois^{3,4} requiring families residing in these areas to frequently travel over 30 miles to obtain prenatal or intrapartum care, experience delays in emergency response, and lack continuity of care from culturally responsive providers aware of their lived experiences.³ [See Addendum B for additional details]

Feedback: One home birth midwife explained that she “drives more than an hour just to get to the client’s home, because there simply are no providers closer,” while another described that many families “don’t have reliable transportation, so if we don’t go to them, they simply won’t get care.”

In counties with few or no community-based birth options, families have a painful choice between traveling long distances or being funneled into hospital settings that do not reflect their cultural or personal needs.

The interviews confirmed that access to community birth settings throughout Illinois is largely determined by race, income, and ZIP code — not by family choice or clinical need.

Feedback: As one midwife noted, “Access shouldn’t depend on your bank account or where you live. Midwifery care saves lives — but only if people can reach us.”

As of January, 2026, there are six birth centers currently operating in Illinois:

- One owned by a Federally Qualified Health Center (The Birth Center at PCC South, Berwyn, opened in 2014);

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- One owned by a hospital (Northpointe Birth Center, Roscoe, opened in 2024); and
- Four privately owned (The Birth Center of Bloomington-Normal, Bloomington, opened in 2016; Birth Center of Chicago, Chicago, opened in 2021, Burr Ridge Birth Center, Burr Ridge, opened in 2021, and Quincy Medical Group Birth Center, Quincy, opened 2025).
- A seventh birth center is expected to open in 2026: a non-profit on Chicago's south side (Chicago South Side Birth Center).

All the birth centers have faced challenges relating to staffing, Medicaid and commercial reimbursement, meeting IDPH requirements, and establishing on-going relationships with birthing hospitals.

Recommendations

1. A minimum of four additional birth centers should be opened in Illinois, with a planning process developed to recommend a more targeted number and locations of birth centers needed throughout the state.
 - As part of the IDPH's development in 2026 of its Maternal Health "Plan of Strategic Plans", it should include charging the Illinois Health Services & Review Board, in conjunction with the Illinois Department of Public Health and other maternal health stakeholders (e.g., IHA, HMPRG's Birth Center Task Force, IPQC, IRHA, IPHCA, UISPH) with the responsibility for initiating a planning process to recommend the number and location of additional birth centers needed in Illinois. This would include determining whether it is appropriate to count a birth center bed as equivalent to an inpatient obstetrical bed in a hospital.
 - One planning proposal is to ensure there is a minimum of one birth center serving every one of the current 40 obstetrical planning areas in Illinois (they are grouped into 6 planning regions). With the likelihood of 7 birth centers operating by the end of 2026, that would mean an additional 33 birth centers are needed. In rural areas, this projection might be reduced by the 30 minute transfer travel time restriction to a back-up referral birthing hospital.
 - Another possible indicator of maternity care need is the 2024 March of Dimes report noting that 35 Illinois counties are maternity deserts (lacking a birthing hospital or birth center).
 - Still another planning approach is to insure that, at a minimum, all 10 of the Illinois Regional Perinatal Networks have at least one birth center. As of 12/26, 4 additional birth centers are needed for the Networks that do not have one.
 - There are currently four ownership model types of birth centers in Illinois (private commercial, private non-profit, Federally Qualified Health Center, hospital). Based on research regarding the success of international models, establishing a public-sector operated birth center should be considered by city or county health departments.

2. Widely embed Certified Nurse Midwives (CNMs) in all birthing hospital maternity teams to increase access to midwifery-led care and improve the hand-off of transfers from birth centers.
3. Adequately reimburse and staff all safety-net birthing hospitals to ensure access to necessary inpatient maternity services.

Category 2: Establish Equitable Medicaid & Private Insurance Reimbursement Rates to Insure Financial Sustainability of Community Birth Settings

Findings

- Home birth and birth center care are frequently perceived as more affordable alternatives to hospital-based maternity care. Participants stressed that community birth care could reduce hospital admissions and interventions, while achieving equal or better outcomes for low-risk pregnancies.
- Certain reimbursement failures impact both birth centers and home birth midwives, mainly when transfers occur. There is a perverse incentive where midwives risk losing their entire birth fee when they prioritize safety.

Feedback: “If a home or birth center labor requires hospital transfer, “that birth is going to finish in a hospital setting. So that hospital is going to bill for the birth... and we don’t get to bill for that time,” even though homebirth midwives provided all early labor management and made the appropriate transfer decision. “You don’t want the thought that if I transfer this person, I’m not even going to get the birth fee... but actually, that’s the way it is.”

- Addressing these reimbursement failures is essential to advancing cost-effective birth center and home birth care as a statewide solution, to improve equity, to expand provider workforce capacity, and to reduce spending tied to preventable hospital interventions.

Home Birth Specific Findings

- The low reimbursement rates for home birth practices do not cover all administrative, licensing, and clinical compliance obligations. This includes essential medical supplies, charting systems, emergency equipment, and liability protections that support safe birth.

Feedback: “Midwife reimbursement has to pay for our assistants... our supplies... our licensing fees, certification fees... continuing education fees, all from one blanket amount.”

- There is a need for Medicaid and commercial payers to establish an “all-inclusive” community birth fee (comparable to a facility fee), recognizing that home birth midwives must transport equipment, supplies, and clinical infrastructure directly to birthing families.

Feedback: “There needs to be a consideration for a community birth fee. If you’re bringing the environment to them... there are some expenses that come with that.”

- Without coverage for labor support, equipment, and travel, midwives are effectively prevented from sustainably serving Medicaid-insured communities or families who lack financial reserves.

Feedback: “It shouldn’t only be wealthy families who get the kind of care that leads to better outcomes.”

Feedback: “We want to serve Black and Brown families — we are here because those moms deserve options, yet without reimbursement, midwives must restrict their caseload to people who can pay out-of-pocket — the opposite of an equity-driven system.”

Feedback: “We should be compensated appropriately for our labor — the system saves money because of us, but we can’t afford to serve the families who need us most.”

- The insurance contracting processes are administratively burdensome. Feedback: “Home birth midwives must attempt to negotiate contracts with each individual MCO despite lacking a business infrastructure that is too cumbersome for a small independent practice to manage.”

Recommendations

1. Set the Medicaid professional reimbursement fees for CNMs and CPMs providing home and birth center care to reflect the same work performed by hospital-based providers.
2. For birth center reimbursement, Medicaid and commercial insurers should include a facility fee for the services provided to the newborn baby.
3. To support midwives providing birthing services in the home, establish a reimbursement rate that provides compensation for all the supplies, materials, and other infrastructure that they bring into the home (similar to an “all-inclusive” home birth fee in four other states - NY, NM, VT, NH).
4. For home births, ensure that Medicaid covers all required diagnostic testing.
5. To remove the financial disincentive for safety-driven transfers to a hospital, adequately compensate CNMs and CPMs for labor management provided in the home and at a birth center (prior to a needed transfer to hospital-based care).
6. Provide Medicaid and commercial insurance reimbursement for birth assistant services provided in the home.

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7. To reduce the administrative burden on small homebirth practices and birth centers, simplify the Medicaid enrollment process to avoid multiple Managed Care organization negotiations.
8. A billing support infrastructure should be established to streamline the third party billing process.
9. To reduce cost inefficiencies in obtaining emergency equipment, pharmacy items, PPE, etc., extend the supply & equipment purchasing cooperatives available to homebirth CPMs.

Category 3: Build a Funded Workforce Training & Preceptorship Pipeline for CNMs & CPMs

Findings

- Illinois lacks sustainable infrastructure to support the next generation of midwives, critically threatening workforce growth and equitable access to community birth.
- CPM licensure is new in Illinois, and there are currently has less than five licensed CPMs of color in Illinois.
- There's a large need in terms of infrastructure for students and preceptors, especially for students of color.

Feedback: “There is not much formal training... in stewarding the next generation, and no structured preceptor training system like those seen internationally.”

- In home birth settings, the reimbursement model cannot support student compensation, although students often function as birth assistants.

Feedback: “My students are more than students — they are my assistants, yet there is no stipend left over from current Medicaid or sliding-scale fees to pay them for their labor.”

- There are financial barriers to entering the profession for aspiring midwives who lack economic privilege; they cannot afford training without scholarships, childcare funding, gas support, or stipends for “basic living necessities”.
- There is no funded preceptor pipeline and culturally representative educators in Illinois.
- Illinois cannot diversify the perinatal workforce or expand access to birth centers if midwives themselves cannot afford to stay in practice, attract new graduates, or scale care into maternity care deserts.

Feedback: “the state has communities crying out for better outcomes, and midwives are ready to answer — but the system has to let us do the work.”

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- The financial and emotional strain discourages new midwives from entering the profession; this then pushes existing providers to reduce caseloads or leave practice entirely.

Recommendations

1. Create Medicaid-funded midwifery student stipends and preceptor reimbursement for midwives providing care in the home, birth centers, and in the hospital.
2. Provide funding for formal structured preceptor training, mentorship and resources for CNMs and CPMs.
3. Invest in community birth workforce diversity by providing early education and exposure opportunities, scholarships, stipends, and training opportunities.
4. Expand the OB/GYN workforce by incentivizing clinicians to train and serve in rural and medically underserved areas.
 - Increase funds for the Illinois National Health Service Corps State Loan Repayment Program to provide financial incentives encouraging maternity providers to serve in federally designated health professional shortage area
 - Expand the eligibility of providers in the State Loan Repayment Program to include licensed certified professional midwives.

Category 4: Improve Continuity of Care, System Integration, and Effective Transfers of Care through Collaborative Relationships with Hospitals & Diagnostic Services

Findings

- Some hospitals refuse to recognize community midwives as legitimate members of the care team; this not only fractures communication but also creates preventable safety risks and reinforces inequities for families already marginalized by the healthcare system. This lack of respect and coordination disrupts continuity, causes families distress during a vulnerable moment, communicates a harmful message that community midwives are not legitimate clinicians, and perpetuates bias against those who seek birth outside the hospital.
- Hospitals' hesitancy toward forming transfer agreements is often shaped by past negative transfer experiences — including limited communication, lack of follow-up data, and the absence of accountability systems to evaluate outcomes. Effective communication feedback loops and oversight are needed for receiving hospital clinicians to build trust in community birth safety practices.
- Frequent exclusion occurs from care conversations after a client is transferred to a hospital, even when the transfer was initiated for appropriate clinical reasons.

Feedback: A midwife shared that when she called ahead to notify the hospital and provide clinical context, “they were fine with that... but they had no interest in collaborating with me. They did not want to talk to me. They did not report back to me. Hospital staff told her that if she wanted updates she can talk to the client, rather than being treated as a member of the care team.”

- While some hospital-based teams are receptive and respectful, responses are inconsistent across different regions, staffing, and the individual biases of receiving clinicians.

Feedback: “A midwife practicing regularly in Milwaukee explained that in areas where Certified Professional Midwives (CPMs) have been legal for a longer period and birth centers are well-established, collaborative agreements foster mutual respect and effective team communication during transfers.”

- Home birth midwives often lack knowledge of which hospital staff will attend to their clients and whether they will exhibit hostility toward a home birth. This underscores the concern that bias may hinder care and dignity during the transfer process. This unpredictability imposes an emotional burden on midwives and results in trauma and confusion for families, especially those already vulnerable to discrimination within health care environments.
- While Illinois requires birth centers to establish formal transfer relationships with their birthing hospital, this advantage does not extend to homebirth midwives, who often “may have no relationship established with that particular hospital” when a transfer becomes necessary.

Feedback: Home birth midwives described transfer processes as “inconsistent across the board.”

- Access to safe home births depends on collaborative systems, because community midwives cannot ensure optimal outcomes if hospitals are unwilling to partner with them.

Feedback: From a home birth midwife, “we all want the same thing — a healthy parent and a healthy baby” — but that goal can only be achieved when the system honors midwives’ expertise, respects client choice, and establishes transfer pathways built on trust rather than hierarchy or stigma.

- For home births, a lack of integrated care pathways forces clients and midwives to navigate fragmented systems on their own, often without cooperation from hospital clinicians. Accessing routine maternal care services such as ultrasounds are difficult; clients must often seek care through independent imaging centers when hospitals will only provide scans if the pregnant person is already an established patient with their obstetric group.

Feedback: “Most people... are going to an independent ultrasound clinic, and even when hospital-based imaging occurs, they had to be an established patient of that OB to receive that service.”

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- This fragmented approach means home birth midwives are responsible for coordinating multiple external referrals, labs, and diagnostic scans without reimbursement or shared records — this ultimately limit the seamless, continuous care that their models are designed to provide.
- This disconnect particularly harms Medicaid beneficiaries, who may lack transportation, time off work, or the financial flexibility to navigate multiple care settings to complete basic prenatal care.

Recommendations

1. Develop and implement statewide standardized transfer protocols for all hospitals to receive home and birth center patient transfers.
2. Expect all hospitals within the Perinatal Hospital system to accept transfers from birth centers and home birth midwives.
3. Improve hospitals' communication of clinical updates to home birth midwives who have transferred their patients for a higher level of care.
4. Encourage hospitals to designate a liaison for home birth and birth center midwives and the sharing of medical records
5. Encourage transfer agreements to include annual stimulations or practice drills to ensure rapid transfer and reduce risks associated with time-sensitive obstetric emergencies. This will improve the timeliness of care, accuracy of clinical decision-making, and patient safety.
6. Expect home birth midwives to have referral agreements with hospital systems & diagnostic imaging centers.

Category 5: Safeguard Midwife Safety & Emotional Sustainability

Findings

- The current midwifery workforce operates under extremely high emotional demands without the structural support found in hospital systems.

Feedback: “Because clients need intensive relationship-based care, the work is so emotional and pregnant people are emotional... they need so much, and we want to give that — that’s why we do this work.”

- The emotional workload is amplified by home birth midwives having limited peer support, despite the work being overwhelming when practiced in isolation. Solo home birth midwives carry a 24/7 on-call burden, attend long labors, and must also handle charting, billing, and travel personally. This relentless demand leads to cumulative burnout,

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particularly when complex clinical decision-making is coupled with administrative responsibilities. Without systemic relief and equitable pay, emotional exhaustion poses a significant risk to workforce retention.

- Home birth midwifery remains financially and emotionally unsustainable without adequate reimbursement for all their significant labor and added expenses...this ultimately limits access for Medicaid-eligible families.

Feedback: “We don’t get paid time off... no insurance... no 401K... We have to absorb those costs personally, despite performing the same work as providers earning ten times as much... in a hospital setting.”

- Maintaining needed staffing levels at birth centers has been affected by both the availability of midwives and the ability to provide competitive salaries, benefits, and call coverage. This has led to the temporary suspension of birth center services.

Recommendations

1. Support a team-based approach for solo on-call home birth midwives, and encourage networking and mutual support among all home birth providers.
2. Expand access to mental health and peer support services for solo community midwives.
3. Ensure adequate staffing workload and compensation for community midwives.

APPENDIX A: Reduced Access to Maternity Care in Illinois

Between 2016 and 2022, Illinois experienced the closure of 29 hospitals or obstetric units statewide—a 22 percent reduction in birthing capacity.⁵ These service losses result in:

- Longer travel times;
- Higher risks of emergency out-of-hospital unplanned deliveries;
- Delays in reaching more intensive levels of care;
- A higher likelihood of delayed prenatal and postpartum care;
- Emergency transport complications;
- Less continuity with trusted local providers; and,
- Reduce options for low-intervention, community-centered births.

These are gaps that community birth models can help mitigate in underserved regions.^{5,6}

- In southern Illinois, birthing options have become increasingly constrained due to the withdrawal of obstetric services and the closure of maternal health clinics, compounding longstanding rural health access challenges. Thirteen southern counties currently lack a maternal healthcare provider (a “maternity desert”), necessitating families to travel considerable distances not only for childbirth but also for prenatal appointments.⁷ SIH Memorial Hospital in Carbondale and SSM Health Good Samaritan Hospital in Mt. Vernon,

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are the only two facilities in the entire 18-county area with a delivery unit, compelling many families to cross state borders to deliver their infants.⁷ In 2022, over 82% of births in southern Illinois were financed through Medicaid; however, a limited number of maternity providers accept Medicaid for delivery services.⁷

- In early 2025, Heartland Women’s Healthcare announced it would discontinue labor and delivery privileges at SIH Memorial Hospital of Carbondale, forcing many families to reorganize their birth plans on short notice.⁸ Although the hospital’s birthing center remains open under new staffing arrangements, the change has reduced continuity of care and heightened uncertainty for patients.⁹
- Local families have reported traveling more than 45 minutes to alternative hospitals in Mt. Vernon—an especially difficult burden in regions with limited public transportation and under-resourced infrastructure.¹⁰
- In central Illinois, access to local birthing options has declined significantly, particularly in more rural counties. For example, in November 2022, Lincoln Memorial Hospital in Logan County announced it would close its three maternity suites and discontinue all labor and delivery services by the end of that year, leaving expectant patients to travel to Springfield or other distant hospitals.⁶ Within a month of the closure, one birthing person gave birth along Interstate 55 near Elkhart while en route to care—a tragic signal of the risks created by disappearing obstetric capacity.⁶
 - The closure of Lincoln Memorial is part of a broader trend across central Illinois: counties such as Woodford, Piatt, DeWitt, and Iroquois are now classified as maternity care deserts, having lost local obstetric services and requiring residents to drive 30 minutes or more for delivery care.^{5,6}
 - The erosion of birthing infrastructure has gone beyond the Lincoln Memorial’s closure to include more hospitals that have reduced or eliminated obstetric services. In 2022 in Livingston County, OSF HealthCare moved its labor and delivery patients from OSF St. James in Pontiac to its larger Bloomington facility, citing low birth volume and financial unsustainability.⁶ Before the move, St. James averaged just 10 to 15 deliveries per month—levels too low to keep on-site obstetric staff available 24/7.⁶ The consolidation caused many residents in nearby rural counties to lose access to the nearest birthing hospital, forcing them to travel 40 minutes or more for routine deliveries or in cases of intrapartum complications.⁶
- In Cook County and the city of Chicago, reductions in obstetric and midwifery access have disproportionately impacted communities of color, especially on the city’s South Side and in underinvested neighborhoods. Between 2016 and 2022, 13 of Illinois’s 29 obstetric hospital closures occurred in the greater metro Chicago area, and 4 of those were located in Cook County.⁵ Many of these closures were concentrated in Chicago’s southern half, a region with a large Black population, leaving only three of the city’s remaining 16 birthing hospitals in the South Side.⁵ Moreover, the recent closure in August, 2025 of Louis A. Weiss

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Memorial Hospital in Chicago eliminated its inpatient services and emergency department, removing one more critical facility that served diverse, vulnerable communities.¹¹ These losses have intensified travel burdens, delayed emergency obstetric care, and deepened disparities in maternal health access in Cook County.

- In the northern Chicago region and adjacent suburban areas, the persistent reduction of birthing and delivery services jeopardizes local access for numerous families.
 - Vista Hospital in Waukegan, located in Lake County, has announced its intention to cease its maternity and obstetrics/gynecology services starting October 28, 2025.¹² Ascension Alexian Brothers Medical Center in Elk Grove Village plans to dissolve its 28-bed inpatient obstetrics unit and transfer delivery services to Ascension Saint Alexius in Hoffman Estates.¹³
 - West Suburban Medical Center in Oak Park abruptly withdrew its delivery privileges for midwives and family medicine practitioners, citing concerns related to liability and insurance, which effectively eliminates a significant alternative for comprehensive birth care in the western suburbs.¹⁴

APPENDIX B: Free-Standing Birth Center Models: A Comprehensive US & International Literature Review

ABSTRACT

The authors analyzed peer-reviewed articles and grey literature from the US and internationally published between 2018 and 2024 to identify key factors contributing to the establishment, operations, and sustainability of non-hospital community birth settings (free-standing birth centers, midwifery-led practices, and home births). The major findings from this literature review included the following:

Major Barriers:

1. Lack of supportive state regulations, including restrictive scope-of-practice laws, burdensome licensure requirements, and inconsistent recognitions;
2. Inadequate commercial insurance and Medicaid reimbursement rates, along with billing challenges;
3. Failure to coordinate care through collaborative and transfer agreements with hospitals and their staff; and,
4. Insufficient investment in the training and supply of midwifery providers.

Major Supporting Factors:

1. Collaborations and partnerships with hospitals and maternity care providers;
2. Having an adequate supply of certified nurse midwives, certified professional midwives, and traditional midwives;

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3. Government policies, funding, and reimbursement that support community births;
4. The availability of additional private and public sector financial resources; and,
5. Strong FSBC leadership and management that both guide collaboration within the practice and identify appropriate stakeholders and partners.

BACKGROUND

Systemic racism, poor outcomes, and inequitable access to appropriate care continue to drive the worsening maternity care crisis in the United States, as hospital labor & delivery units and safety-net hospitals close in some of the most vulnerable communities. This has led to a notable rise in interest in community birth – freestanding birth centers (FSBC) and home births.¹⁵

Studies consistently show that for comparable low-risk pregnancies, midwife-led birth centers have outcomes equal to or better than those in hospital settings; this includes lower cesarean section rates, episiotomies, epidural anesthesia use, labor inductions, and neonatal outcomes, such as fewer low birth weight babies, higher Apgar scores and rates of exclusive breastfeeding.¹⁶ In addition, childbirth costs are 21% lower.

Individuals seeking the midwifery model of care often prefer community birth settings, which are primarily led by midwives.¹⁶ Additionally, these studies emphasize that better integration of community midwives into the health care system could help achieve similar positive outcomes elsewhere in the United States.¹⁷

Despite evidence-based research showing that community birthing options lead to positive outcomes, communities still lack access to these choices. FSBCs, along with home birth practices, face significant barriers affecting their sustainability, especially among rural and black, indigenous, and people of color (BIPOC) populations.

Overall, the literature shows that the use and sustainability of FSBCs and home births to provide alternatives to hospital births in the United States depends on four interconnected areas:

- adequate reimbursement and payment systems;
- public policy reform;
- workforce expansion; and,
- collaborative provider relationships leading to system integration.

METHODOLOGY

A comprehensive review of the literature was conducted to identify barriers and key factors that promote sustainable community birth practices, using both U.S. and international sources. Peer-reviewed articles and grey literature published between 2018 and 2024 were collected through databases such as PubMed, Google Scholar, and ScienceDirect.

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Key search terms included: alternative birth settings, sustainability, birth centers, free-standing birth centers, sustaining midwifery-led practice, and home birth.

Report Inclusion Criteria:

- Studies conducted between 2018 and the time of the database search in November 2024
- Studies that align with the primary objectives of the literature review
- Peer-reviewed articles, government or policy reports, organizational white papers, and systematic reviews.

The review covered literature from Canada, Sweden, New Zealand, the United States, Australia, and England because of the well-established community birth models and the availability of relevant research, despite differences in how systems are integrated and sustainable. The researchers examined the findings to identify patterns, challenges, and best practices that could guide the sustainable development and expansion of FSBCs.

RESULTS

The studies reviewed showed significant variation in study design and sampling methods. Many factors influence and challenge the sustainability of community birth practices as described below.

Accessibility and Equity

Geographic, racial, and socioeconomic disparities continue to limit access to community-based birthing options. Marginalized populations—including Black, Indigenous, and rural communities—face compounded barriers such as provider shortages, insufficient insurance coverage, and long travel distances to care facilities. These obstacles are worsened by systemic issues like low reimbursement rates, restrictive scope-of-practice regulations, and the ongoing marginalization of community midwifery models.¹⁸

According to the 2024 March of Dimes report card, many communities across the U.S. still face maternal care deserts, with limited or no access to community-based birth options.¹⁹ Although research shows that rural populations benefit from high-quality outcomes at freestanding birth centers, these facilities are disproportionately concentrated in urban or high-density areas. The lack of supportive state policies and ongoing reimbursement challenges have significantly impeded the expansion of birth centers in rural communities.²⁰

Rural families, especially agricultural workers and those with limited disposable income, often prioritize healthcare less due to cost issues. Counties without local midwifery care are more likely to be classified as “noncore” (outside metropolitan or micropolitan areas). These counties also tend to have higher proportions of Medicaid-funded births and are mostly BIPOC.^{19,21} In communities with hospital-based midwifery services, patients still report traveling more than 30

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miles for childbirth care. Additionally, only 27% of rural hospitals that currently offer childbirth services also provide midwifery care on-site, and just 18% have midwives available within the wider community.¹⁹

Black communities and other underserved populations face ongoing structural barriers to accessing healthcare—particularly reproductive and sexual health services—due to the combined effects of systemic racism, income disparities, and a lack of culturally responsive care.²¹ These systemic inequities pose sustainability challenges for community birthing providers in these areas, as they often find it difficult to balance their expenses with limited reimbursement, especially when coverage for newborn care is inadequate. Consequently, birth center options are less likely to be established or sustained in underserved communities.^{22–24}

Cost-Effectiveness

States with well-established and regulated birth center models report measurable economic benefits across their healthcare systems. For example, under the Strong Start for Mothers and Newborns initiative, Medicaid beneficiaries who received care from midwives in freestanding birth centers experienced better health outcomes and fewer complications compared to a risk-matched group receiving birth services in a hospital. Importantly, these outcomes were achieved at a significantly lower overall cost.²⁵ These savings mainly come from lower medical intervention rates, including fewer cesarean sections, labor inductions, and epidurals.

Evidence from comparative analyses indicates that birth center births save, on average, \$2,000 per delivery for individuals with similar risk profiles within the same geographic region.²⁶ These findings emphasize the cost-effectiveness of midwifery-led care in birth center settings and highlight its potential to decrease public spending without sacrificing quality of care.

Regulatory Requirements

Restrictive state regulations and licensure requirements significantly impede the growth and sustainability of freestanding birth centers and hinder midwives' ability to practice fully.

In Tennessee, midwives face restrictive scope-of-practice laws that require collaboration with physicians, which limits their ability to provide independent care. Memphis, in particular, is experiencing a shortage of reproductive healthcare providers and regulatory restrictions that worsen this access issue.²¹

Other states impose additional restrictions. Some require a physician to be physically present during births in freestanding birth centers, while others impose burdensome licensure fees that can prevent birth centers from qualifying for Medicaid reimbursement.²⁵ Although home birth is legal in every state, the legality of midwife-attended home births varies. For example, in Nebraska, statutory restrictions effectively make it illegal for CNMs to attend home births.²⁷

Furthermore, many states do not have licensing frameworks for Certified Professional Midwives (CPMs) and Certified Midwives (CMs), which prevent them from practicing legally. As of 2023, CPMs are legally recognized in only 37 states and Washington, DC, while CMs are recognized in only nine states and Washington, DC.²⁸ Other obstacles, such as the lack of national standards for

designing childbirth facilities, also cause inconsistencies in care settings. While states may choose to follow the Facility Guidelines Institute (FGI) standards, they are not required to do so, and many end up using outdated versions. As of the most recent review, only 36 states had adopted any edition of the FGI guidelines—ranging from the 1992 to the 2018 editions—while 14 states had not adopted any. This absence of uniform facility regulations results in variability in care quality and can undermine public trust in childbirth facilities.²⁹

Regulatory frameworks also affect midwifery pay and workload. One national study found that midwives practicing in birth centers earn less than those in hospitals or outpatient clinics and consistently report longer on-call hours. Additionally, midwives working exclusively in home birth and birth centers report longer on-call hours than those who split their time between birth centers and hospitals.³⁰

Medicaid Reimbursement

An in-depth 50-state analysis of midwifery policies conducted by the National Academy for State Health Policy (2023) found that each state uses different Medicaid payment and care models for CNMs and other midwives in their delivery systems.²⁸ Furthermore, reimbursement is structured based on national midwifery certification policies. Although Medicaid service delivery systems differ in operation and coverage of midwifery services, those integrating midwives into primary and behavioral health care are a key strategy in many states' efforts to improve maternal health outcomes.

The analysis identified 36 states that allow CNMs to be reimbursed for services like care coordination, substance use disorder (SUD) screening, behavioral health screening, well-woman exams, and smoking cessation. In Michigan, licensed CNMs are eligible for reimbursement for providing medication-assisted treatment (MAT), SUD screening and treatment, and other vital behavioral health services. Additionally, in Missouri, care for newborns up to two years old is covered when provided by CNM providers. In Mississippi, Medicaid also covers home visiting services offered by CNMs.

The analysis also revealed that Medicaid reimbursement rates differ by state. CNMs are reimbursed at 100% of physicians' rates in some states. However, in twenty states, CNMs receive between 75% and 98% of the physician reimbursement rate. In states with a Medicaid managed care model, like Tennessee, CNM reimbursement rates vary depending on the specific Medicaid Managed Care Organization (MCO).

Additionally, the analysis highlights differences in practice environments for CNMs and CPMs regarding reimbursement. While 18 states and Washington, DC, allow midwives without a nursing degree to become Medicaid providers, they are often required to care for patients at home or in a free-standing birth center. CPMs in Delaware can only practice in outpatient settings. Conversely, CNMs are permitted to work in hospitals and outpatient clinics. The Medicaid program in Washington state covers behavioral health screenings and services like care coordination as part of its overall obstetric payment or standard maternity care. Virginia limits reimbursement for midwives without a nursing degree to its fee-for-service model because Medicaid managed care

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organizations (MCOs) do not contract with these providers. Maryland policy makes CNMs eligible providers for value-based payment metrics related to timely prenatal and postpartum care, and MCOs that perform well on these metrics may receive incentive payments. In Idaho, CNMs supporting hospital births are included in statewide and primary care value-based care initiatives. Similarly, CNMs in Connecticut are part of obstetric pay-for-performance programs and are expected to be included in an upcoming maternity care bundle.

Collaborative Practice Models

Collaboration is essential for the success and sustainability of free-standing birth centers and home birth practices. Interprofessional collaborative care promotes positive patient outcomes and is also associated with increased access, lower costs, and long-term sustainable practices.^{21,31,32}

Danhausen et al. (2022) describe the collaborative model between the Vanderbilt Birth Center (VBC) and Vanderbilt University Medical Center (VUMC) as an innovative approach that combines the expertise of a tertiary care hospital with the specialized care provided at FSBCs. Midwives, obstetricians, and nurses work together across both settings to provide seamless care. Although VBC is owned by VUMC after being acquired from a previous owner, it remains a free-standing facility.³²

The availability of the birth center allows approximately 500 low-risk women annually who seek low-intervention births to achieve their goals while still having access to the specialized services of a tertiary care medical center.³³ The collaboration with VUMC plays a vital role in ensuring smooth transfers for VBC patients who develop complications or need obstetric care from specialists. Staff at both facilities use a shared electronic health record system, which has enhanced communication, efficiency, and patient care, ultimately reducing operational barriers.

To ensure continuity of care, reduce confusion, and create a more sustainable approach to patient management across both settings, they adopt a "move the midwife, not the patient" approach, where hospital midwives provide prenatal care at the birth center. This method ensures continuity of care even when patients need to transfer to the hospital, fostering a sustainable provider-patient relationship and maintaining quality care despite location changes.

Community partnerships are essential to the collaborative care model and crucial for the sustainability of FSBCs and home birth practices. In 2022, Welch et al. shared in their research on Birth Detroit, a Black-led birth center, how they use collaboration to provide culturally competent care that empowers families and addresses racial disparities in birth experiences.³⁴ Birth Detroit partnered with Brilliant Detroit, a nonprofit dedicated to supporting families, children, and neighborhoods. This partnership helped establish Birth Detroit Care, a midwifery Easy Access Clinic that offers vital prenatal and postnatal care within the community. The Michigan Health Endowment Fund, a foundation focused on improving the health of Michigan residents, also provided important financial support to launch Birth Detroit Care. Their involvement was key in making community-based, midwifery-led care accessible to Detroit families. Birth Detroit adopted a community organizing approach, actively involving community members as leaders of their own

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care. Volunteers play a crucial role in the program's development, participating in workgroups focused on midwifery, advocacy, communication, and resource development.

Grayson et al. (2022) highlight that collaboration between midwives within FSBCs and physician colleagues is crucial, especially for patients requiring care beyond the midwifery scope. They also emphasize that the CHOICES midwifery model offers collaborative management with an obstetrician or a maternal-fetal medicine (MFM) physician for patients needing joint management of medical issues and those with complex pregnancies. As a vital part of the Memphis community, CHOICES midwifery fosters a collaborative environment that promotes learning through various initiatives, including opportunities for students, resident training, and educational experiences for family medicine, pediatric, and OB-GYN residents, all modeled by CHOICES midwives.²¹

Smith and Corbett (2021) demonstrate a hybrid midwifery care model that employs a multidisciplinary collaborative approach to support a midwifery practice dedicated to serving underserved rural areas in New York State. Recognizing the need to reduce transportation barriers, the midwives travel up to 7 hours to meet patients at their homes. Through collaboration with healthcare providers, including hospitals, public health departments, and alternative medicine practitioners, a CNM and her team (including experienced assistants, three midwives-in-training, and two doulas) can sustain their practice, enhance the midwifery workforce in New York, and address barriers such as long distances, travel times, financial difficulties, and regulatory restrictions that limit the availability of Certified Professional Midwives (CPMs).²⁴

This collaborative care model, where births occur at home or at a birth center, expands patient coverage and improves access to resources while exposing various healthcare providers supporting the patients to different perspectives on care. Nurses from the Public Health Department in nearby counties assist in securing medications and supplies for traditional birth attendants to support this hybrid midwifery care model and its patient population. Additionally, the WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) nurses help provide resources for low-income clients, especially regarding infant nutrition. Planned Parenthood is another vital partner that offers family planning services to clients who might otherwise lack access. These collaborations enhance healthcare access and resources for the practice's clients.

Integrating FSBCs with a federally qualified health center (FQHC) is another strategy used to address birth centers' financial challenges, leverage resources from an existing healthcare system, increase accessibility for rural and BIPOC populations, and promote financial sustainability. Aligning with FQHCs allows FSBCs to share fixed costs). With 1,400 FQHCs in the U.S. serving underserved areas and populations, merging FSBCs with an existing location offers an opportunity to reduce some startup costs for birth center operations while providing alternative birth options for many pregnant individuals. The infrastructure available through an FQHC, such as physical space, fixed utilities, malpractice insurance, system coordination, and community trust, provides FSBCs with essential support to maintain operational costs.³⁵ Additionally, since many FQHCs are situated in BIPOC and rural communities, partnering with FQHCs helps expand birthing options to these populations.

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Birth Centers operated under the auspices of an FQHC have a unique opportunity to be reimbursed at a higher rate for their outpatient visits compared to FSBCs that operate as independent practices. Becoming part of an FQHC enables the birth center to be eligible for increased prenatal and post-partum visit reimbursement rates through the Medicaid Prospective Payment System.³⁵ Additionally, with the persistent challenges in the midwifery workforce, this collaborative model presents an opportunity for clinician recruitment through the National Health Service Corps program. By being employed at a FQHC, nurse midwives are eligible for school-related loan repayment programs.³⁵

A case study and peer-reviewed research study identified the Community of Hope, an FQHC in Washington D.C., partnered with an FSBC, as an example of this model. As of 2022, the Community of Hope is one of five FSBCs within FQHCs across the United States.^{35,36} The birth center offers group care classes during pregnancy and the early postpartum period, monthly prenatal check-ups, and the option of volunteer, no-cost doulas for labor support.³⁵ Although most clients receiving prenatal care at the Community of Hope deliver at hospitals with their midwives, many continue to seek care at the birth center after delivery. The frequent changes in coverage by Medicaid Managed Care Organizations (MMCOs) are a challenge that the Community of Hope highlights. Staying updated on covered services is essential to providing clients with necessary information about their payment options under their insurance.³⁵

In Illinois, the state's first Freestanding Birth Center opened in 2014 within an FQHC. The PCC South Birth Center relied on the services and support of the Parent-Child Center (PCC) FQHC, which also managed several outpatient clinics in nearby areas. Located in a predominantly Hispanic community, this Birth Center has a unique and extensive partnership with various health care providers—CNMs, CPMs, Family Physicians, Obstetricians, and Maternal-Fetal Medicine specialists—as well as social services, nutritionists, childbirth educators, and doulas. For patients needing transfer to a hospital, they were attended by hospital-based PCC CNMs if risk screening permitted (such as transfer for labor augmentation or pain management). Despite its success, the birth center faced staffing challenges and changes in the ownership of the collaborating hospital.³⁷

Business Models

While the range of FSBC ownership can include hospitals and the public-sector, almost all generally operate either as for-profit or nonprofit organizations.³⁸ Jolles' article highlights that multiple studies have shown that for-profit health systems tend to encourage overuse and provide lower quality care, while not-for-profit health systems usually perform better. To our knowledge, researchers have not yet examined the connections between legal entity status, birth center staffing, and clinical outcomes. Of the 83 birth centers in this sample reporting legal entity type, a mix of for-profit and nonprofit models was observed, with 54.2% of births occurring in for-profit centers and 45.8% in nonprofit centers. Nonprofit birth centers served populations with higher social and medical risks, were more likely to have hospital privileges (56.0% vs. 21.1%), were more likely to be accredited by the Commission for Accreditation of Birth Centers (CABC; 66.7% vs. 50.5%), attended over 200 births annually (45.2% vs. 18.3%), employed staff midwives expected to take less than 25 hours of call per week (45.5% vs. 17.9%), and relied on a higher proportion of full-

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time midwifery staff (67.8% vs. 57.7%). Nonprofit birth centers were also more likely to serve Black (9.5% vs. 8.2%) and Hispanic (10.5% vs. 7.9%) populations compared to for-profit centers. When controlling for sociodemographic risk factors, differences in birth center outcomes were not linked to the legal entity status of the birth center.

CHOICES Midwifery Services in Memphis was added to their service offerings at their independent nonprofit clinic, which focuses on reproductive and sexual health. In 2017, CHOICES expanded its approach to improve access for Black and Brown, uninsured or underinsured, sexual minority, and low-income individuals by adopting a new reproductive justice and Black feminist, midwifery-led model for comprehensive reproductive and sexual health care.²¹ Services at CHOICES include perinatal care and community birth, abortion procedures, testing and treatment for STIs, and ongoing reproductive and sexual health education.²¹ Note that despite challenges from insurance companies and regulatory barriers due to state policies, operating as a nonprofit allows CHOICES to provide care without profit concerns. As a nonprofit, CHOICES can apply for grants and seek charitable donations from individuals and foundations. The ownership of the CHOICES building has been vital to its success because it eliminates the financial burden of rent and facility fees and reduces the risk of losing the facility due to anti-abortion protests.

Workforce, Education, and Training at FSBCs

The expansion of the midwifery workforce is essential for sustaining FSBCs. The Black midwifery fellowship program offered by CHOICES provides one solution to the shortage of maternity and reproductive health service providers.²¹ The training offered through the fellowship aims to prepare recent Black nurse-midwife graduates with the knowledge and skills necessary to support CHOICES' model of care and reproductive justice.

The partnership between Vanderbilt Birth Center (VBC) and Vanderbilt University Medical Center (VUMC) offers unique educational opportunities for student midwives and health care providers. Students rotate through both the birth center and hospital, gaining experience in midwifery care at various risk levels, physiologic birth, and transfer protocols. Providing educational events and rotations for midwifery students helps ensure a consistent supply of trained professionals familiar with both birth center and hospital care models, supporting long-term workforce development.³²

In New York state, to address the workforce shortage the hybrid midwifery care model trains community health interns from local universities by giving them hands-on experience in midwifery care through ride-alongs during home and office visits. Nursing students and new nurses help with births and gain exposure to low-risk, out-of-hospital deliveries.²⁴

Additional efforts to grow the midwifery workforce include increasing the number of birth centers nationwide. These centers, led by midwives, expand access to maternity care in underserved areas and provide employment and training opportunities for midwives, thereby strengthening the workforce pipeline.³⁹ Expanding birth centers into these underserved areas and maternity care deserts would improve equitable access for birthing people and help distribute the midwifery workforce more evenly across regions.⁴⁰

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At the state level, policy reforms have played a key role in supporting the growth of birth centers to strengthen the midwifery workforce. In Vermont, Senate Bill 18 (2025) established licensure pathways for freestanding birth centers, mandated Medicaid and commercial insurer coverage, and removed Certificate-of-Need barriers—primarily to expand midwifery practice options and increase the workforce.⁴¹

Similarly, evidence from the federal Strong Start for Mothers and Newborns initiative shows that birth-center care reduces adverse outcomes such as preterm birth and low birthweight while lowering Medicaid costs—helping to grow the workforce through this model.^{15,42} Moreover, the COVID-19 pandemic demonstrated how freestanding birth centers can manage low-risk births and ease hospital capacity, highlighting their importance in strengthening workforce resilience and system adaptability⁴³

New Mexico has been a national leader by integrating community midwives, including Certified Professional Midwives (CPMs), into its Medicaid program. This proactive policy has significantly boosted midwifery use and has been recognized as a strategy to diversify the workforce and improve midwife availability in rural and underserved areas.²⁸ In Washington State, reforms under Apple Health have ensured Medicaid reimbursement for planned births at freestanding birth centers and at home, helping to sustain the financial viability of midwife-led practices and expanding locations where midwives can work safely and independently.⁴⁴

In Illinois, a series of recent laws have explicitly linked the expansion of birth centers to the growth of the midwifery workforce. In 2021, the Birth Center Licensing Act, PA 102-518, removed the cap on the number and location of licensed freestanding birth centers and established a clear licensing process; this increased the number of practice sites available for Certified Nurse-Midwives (CNMs) and other midwives.⁴⁵ In 2025, PA104-244 expanded CNM practice authority in birth centers and home births by removing restrictive physician collaboration requirements in underserved areas, specifically to improve access to care and grow the midwifery workforce^{46,47} Importantly, Illinois also passed legislation in 2021 authorizing the licensure of Certified Professional Midwives (CPMs) under the Licensed Certified Professional Midwife Practice Act, creating a new legal pathway for out-of-hospital community midwives to practice in birth centers and attend home births in the state.⁴⁵ By officially recognizing CPMs, Illinois not only increased birthing options but also expanded its midwifery workforce by legalizing and regulating a group of providers previously unable to practice in licensed settings.

Overall, these findings indicate that increasing and expanding birth centers across the United States is a promising, evidence-based strategy to address the midwifery workforce shortage.

Leadership and Management

Research published about countries like Australia and England argues that strong leadership is a necessary component to promote staff retention, midwife satisfaction, and the sustainability of a midwifery group practice or FSBC.^{48,49} Strong leadership enables clear communication and intentional decision-making that foster workplace culture, professional autonomy, and identity, which contribute to job satisfaction and the sustainability of midwives' practice.

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An Australian study found that managers promote sustainability by managing budgets, developing succession plans, promoting the service, engaging stakeholders, and ensuring midwife satisfaction.⁴⁸ The intentional decisions made by leadership at CHOICES to “advance health equity and midwifery and work to reclaim Black midwifery in the South” are reflected in the diverse representation in their workforce, as well as decisions that led to the development of a comprehensive reproductive and sexual health care model that includes home births and birth centers as part of their practice.²¹ Leadership and management of FSBCs play a pivotal role in guiding collaboration within the practice and identifying appropriate stakeholders and partners.

International Models

Canada

Canada provides maternity care through several publicly funded health systems. Midwifery care specifically is publicly funded by individual provinces or territories. Canadian Registered Midwives are mandated to offer a choice of birthplace—home, birth center, or hospital—to stay consistent with the Canadian midwifery model of care and the principle of informed choice.

The government of Ontario, Canada, opened its first standalone midwifery-led birth centers in Ottawa and Toronto in 2014, with a strategy to shift health services from hospitals to non-profit community clinics to improve quality of care and reduce costs. Findings from the first year reported that care guidelines were followed, and morbidity, mortality, and intervention rates were low.⁵⁰

Rural maternity care in Canada faces the same challenges seen worldwide, including provider shortages, inadequate reimbursement, difficulties in forming collaborative relationships, hospital closures, and poor system support.⁵¹

A 2020 report by the Sustainable Midwifery Practice Taskforce evaluating occupational stress and burnout among Canadian midwives recommended advocating for birth centers and increasing home births as a way to support midwives' well-being, since the majority of midwives prefer out-of-hospital settings. There is significant variation between provinces in the rates of home births and birth center births, and birth centers are not available in all provinces.⁵²

Sweden

In Sweden, the hospital delivery system remains the main model for maternity care, with government resources primarily allocated to hospital-based childbirth services. Alternative birth settings have been tested, such as Södra BB and BB Sophia in Stockholm and the ABC Clinic in Gothenburg, which operated as midwife-led units offering home-like environments outside traditional hospital maternity wards. These birth centers were popular among parents looking for less medicalized birth options. However, all three facilities have since closed due to policy and funding priorities that favor hospital-based care. The closure of these centers underscores limited government support for maintaining alternative midwifery care models, which has slowed the growth of midwife-led birth centers in Sweden.⁵³

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New Zealand

New Zealand provides one of the most comprehensive models of midwifery-led maternity care worldwide. Its maternity system is built around the Lead Maternity Carer (LMC) model, where midwives attend about four out of five births. Most pregnant women select a community-based midwife as their LMC, although LMCs can also be family doctors or, rarely, obstetricians. LMCs are responsible for coordinating care throughout pregnancy, labor, and the postpartum period—up to 4–6 weeks after birth—including at least five home visits. While most LMCs are self-employed and work in small group practices, core midwives employed by District Health Boards (DHBs) provide 24/7 care in maternity facilities and collaborate with LMCs through Maternity Facility Access Agreements. Although the New Zealand government fully covers maternity services, sustainability challenges have emerged due to underpayment, heavy workloads, and inequitable reimbursement structures. Reports indicate that midwives often work 17–26% more hours than a standard full-time employee, with inadequate pay for travel, after-hours care, and higher-acuity patients^{54–56}. Despite these issues, New Zealand remains a global leader in a midwifery-led model that offers home births, birth centers, and hospital-based options under a single, publicly funded system.

Australia

Australia's maternity care system includes various models such as public hospital care, shared care, midwifery group practice (MGP), and private obstetric or midwifery care. Most births (97%) occur in hospitals, with only 1.8% in birth centers and 0.3% at home. Despite the dominance of hospitals, midwives provide the majority of maternity care, while physicians assist with high-risk pregnancies. Currently, there are 18 publicly funded homebirth programs, but strict eligibility criteria and limited geographic reach restrict broader access. MGP models represent Australia's most comprehensive continuity-of-care programs, where women receive care from a primary midwife or small team throughout pregnancy, labor, and postpartum. These models are mainly based within the public hospital system. Although MGPs improve outcomes and satisfaction, long-term sustainability faces challenges due to midwives' workload, insufficient pay for on-call duties, and workplace culture. Many midwives report exhaustion, stress, and concerns that pay does not adequately reflect the demands of caseload care, adding to workforce strain.⁴⁸

England

In England, maternity care is publicly funded through the National Health Service (NHS), which provides women with options for different birth settings: home birth, free-standing midwifery units (FMUs), alongside midwifery units (AMUs), or obstetric units (OUs). AMUs are midwife-led units located within obstetric units, offering women with uncomplicated pregnancies a home-like environment while ensuring quick access to medical care if needed. FMUs operate independently from hospitals, offering fully midwife-led care. Research emphasizes the importance of relational care in these settings:⁵⁷ found that trust and strong midwife–service user relationships within FMUs foster autonomy, well-being, and professional satisfaction. These models support midwives' professional identity and help prevent burnout, but their sustainability faces challenges due to low utilization rates in some areas and perceptions of higher costs. Consequently, FMUs remain at risk of closure in some NHS Trusts, despite evidence that they provide safe, relationship-centered, and

cost-effective care for low-risk women.⁵⁷ Studies from England show that regulatory structures and institutional priorities can act as barriers to accessing midwife-led units, despite their proven safety and cost-effectiveness.⁵⁸

Discussion

Inadequate or absent reimbursement by Medicaid and private insurers remain among the most persistent barriers to the sustainability of both freestanding birth centers (FSBCs) and home birth practices in the US. Current payment structures do not fully capture the patient-centered, holistic services embedded in the midwifery model of care.

The evaluation of the Strong Start for Mothers and Newborns program highlighted that FSBCs caring for Medicaid beneficiaries often struggle to cover baseline costs due to low reimbursement and exclusion from value-based care models. Similar concerns apply to home birth practices, where midwives are frequently excluded from Medicaid managed care networks, face delays in payment, or are denied coverage altogether, forcing many to limit or stop serving publicly insured clients.

Beyond reimbursement, federal, state, and institutional regulatory barriers further hinder the sustainability of community-based models. FSBCs and home birth midwives must navigate restrictive scope-of-practice laws, burdensome licensure requirements, and inconsistent recognition across states.

Some states require physician supervision or presence in birth centers, which effectively undermines midwifery autonomy and limits access to community birth options. In Illinois, CNMs without Full Practice Authority need physician collaboration agreements, and barriers still exist around hospital collaboration and emergency transfer protocols. Similarly in Nebraska, statutory restrictions largely prevent CNMs from attending home births, and in states without CPM recognition, midwives still cannot practice legally despite community demand. These policies create geographic inequities, leaving rural and BIPOC populations with limited or no access to midwifery-led community birth services.

Workforce challenges contribute to these systemic barriers. Both FSBCs and home birth practices depend on a strong, diverse midwifery workforce. However, one report observed that midwife shortages and a lack of racial diversity hinder the growth of community birth models in an equitable way. This is particularly concerning in rural areas and communities of color, where workforce shortages overlap with structural racism and economic disparities, resulting in reduced access to safe, culturally sensitive care. Therefore, expanding training opportunities, supporting BIPOC midwifery pipelines, and ensuring fair pay are essential strategies for maintaining both FSBCs and home birth practices.

Collaboration and integration within the larger health system are crucial for sustainability. Effective transfer systems between FSBCs, home birth providers, and hospitals are vital for ensuring patient safety and increasing provider confidence. Studies indicate that collaborative models—such as the Vanderbilt Birth Center’s partnership with Vanderbilt University Medical Center—enhance continuity of care and sustainability through shared protocols and electronic health records. Home

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birth practices also gain from collaborative agreements with hospitals, public health agencies, and community organizations, as demonstrated by hybrid models in rural New York State, where midwives partnered with local health departments and Planned Parenthood to broaden access. However, in many states, hospital staff often lack experience with community midwifery practices, and liability concerns foster distrust, further impeding collaboration.

Innovative organizational and business models can help address these challenges. Nonprofit FSBCs and home birth practices are often better positioned to seek grants, philanthropic funding, and community partnerships compared to commercial for-profit models. For instance, Birth Detroit, a Black-led midwifery practice, used partnerships with local nonprofits and foundations to establish sustainable access to culturally centered community birth. Similarly, integrating FSBCs within Federally Qualified Health Centers (FQHCs) offers opportunities to share infrastructure, increase Medicaid reimbursement rates, and create training opportunities for midwives while expanding access to underserved populations. These models demonstrate that when financial and institutional support align, community birth options can succeed despite broader systemic challenges.

Finally, international models offer valuable lessons for both FSBCs and home birth practices here in the United States. Canadian midwives are required to provide choices among different birth setting options. Canada's publicly funded birth centers have been well-received and successful, and home birth rates are higher than in other countries. Rural Canadian maternity services face the same challenges of provider shortages, reimbursement issues, and access as other nations, and efforts to address these problems are underway. Sweden's experience highlights the vulnerability of midwife-led units when government funding is directed only toward hospital systems. New Zealand's Lead Maternity Carer model demonstrates how midwives can coordinate care across home, birth center, and hospital settings within a publicly funded system, though sustainability is challenged by low pay and heavy workloads. Australia's publicly funded homebirth programs and midwifery group practices emphasize the benefits of continuity of care but also reveal the risk of workforce burnout when caseloads become too high. In England, NHS-supported midwifery units and home birth options show the importance of relationship-based care, even though free-standing midwifery units (FMUs) are threatened by closures when underused or considered too costly. Collectively, these models demonstrate that financial support, regulatory backing, and workforce investment are essential for maintaining FSBCs and home birth practices on a large scale.

LIMITATIONS

There is a clear gap in the literature examining the infrastructure and operational models of freestanding birth centers (FSBCs) and home birth practices. While many studies offer valuable evidence on clinical outcomes, patient experiences, and satisfaction within midwifery-led care, fewer publications explicitly analyze the organizational, financial, and policy frameworks that support or threaten sustainability. Most of the available evidence relies on inferential analysis,

critical interpretation, or extrapolation from outcomes-based research rather than direct investigation of sustainability as a distinct concept.

Furthermore, although barriers to FSBC viability—such as reimbursement challenges, licensure restrictions, and regulatory hurdles—are often mentioned, there is limited research that systematically evaluates the structural or business models that could ensure long-term sustainability. The literature on home birth infrastructure is even more limited. While several studies look at outcomes and safety, few address the operational realities, regulatory inconsistencies, or systemic barriers that home birth midwives face in maintaining financially viable and integrated practices. Additionally, much of the existing scholarship is scattered across state-specific contexts or focuses mainly on Medicaid reimbursement, leaving gaps in understanding the broader landscape of private insurance, liability frameworks, and interprofessional collaboration. Overall, these limitations highlight the need for future research that explicitly examines the infrastructure, sustainability strategies, and systemic integration of both FSBCs and home birth models, with special attention to equity, workforce development, and community-level impacts.

APPENDIX C: Survey Instrument Practice Questions for Home Births & Birth Center Births

See separate attachment.

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