Anna Wrigley Miller, Office of Planning and Budget

Good morning. We will have a rotation of representatives on the council today due to the different bills. For our first bill, four-seventeen (417), we have Chairman Bill Hitchens on the phone. For the next two bills, we will have representative Alan Powell. For our fourth bill, seven-seventeen (717), we will be having Chairman Sharon Cooper coming in for that. To start with, a notice for all of the speakers, please talk into your mics because we are recording this for minutes. If you talk off to the side, it is hard for us to understand and track what you have said.

To recap what happened at our long meeting last week, we had a long discussion with BioPTO, Les [Schneider], and his team culminated in a few recommendations that I am going to go over later when we discuss the report. Then we had our first introduction to structural engineers for House Bill five-sixteen (516), and they are back today to answer any more questions. We have also gotten some estimates from the Secretary of State on what the cost will be for that. We then heard from the veterinarian on Senate Bill seventy-five (75) regarding the addition of a veterinary technician to their board and implementation of a professional health program for impaired veterinarians. They are also back to answer anymore questions.

Meeting minutes were sent out Friday to everyone and have since been posted online. So, to start with, I am looking for a motion to approve minutes

Jonna West motioned for approval of the minutes, and Gabriel Sterling seconded

Alright, all in favor say, “aye.”

On the motion to approve the minutes, eight (8) votes for aye were cast, zero (0) nays, and one (1) absence (Chairman Chuck Hufstetler)

Okay, moving on. We will start with talking about the final vote on the report for House Bill four-seventeen (417). Councilmembers, I sent this report out to you last Friday, and for everybody’s benefit, I am going to walk through what the findings and the recommendation were that we came up with for this bill. Basically, we ended the meeting last week voting on how we should move forward. I’d like to start with reading what the finds were that we came up with. Councilmembers, this is on page nine (9) of the report for House Bill seven-seventeen (717), it’s in your first pocket.

The first finding is that there are recognizable cases were an uninformed public doing business with unregistered companies providing removal and disposal of regulated biomedical waste services experienced emotional and financial harm, for example, mistreatment of bodies, not properly cleaning the site, overcharging for services, and theft of personal property. These instances all resulted with criminal charges being brought against the offender. A registry would provide Georgians a vetted list of companies from which to choose.

The second finding is there is a specific need for specialized training to remove and dispose of regulated bio-medical waste from a trauma scene. Practitioners must follow Federal regulations and Georgia EPD guidelines. Additionally, there are many organizations who provide certifications in bio-medical waste cleanup. However, the bill as currently drafted does not require that potential registrants provide proof of any certifications, nor provide proof of holding EPD generation and transportation permits.

Finally, the last finding is the cost for the GBI to host the registration process would be much higher than the fees collected from registrants. The cost estimate in state funds for the GBI to host a registration processes is much greater than the funds that would be coming in from registrations. The cost analysis also does not take into consideration any marketing to promote the new registrant list or the potential cost of following up on complaints.

So, our recommendation is due to the findings listed above, the Council recommends that HB 417 does not pass as currently written. The Council suggests that an agency other than the Georgia Bureau of Investigation be selected to host the registry. Additionally, the Council recommends that additional registration requirements be added. The first being that the registrant should hold a valid EPD generation and transportation permits or sign an affidavit saying that they contract with someone who does hold valid EDP permits. The second being that the registrant should provide the current certifications that they hold.

If there are any comments from the council on this. No? Okay, do I have a motion?

Brent Vendola motioned to pass the final draft; Kelly Dudley seconded.

Okay, all in favor of the motion say, "Aye."

On the motion to approve the Final Report on House Bill Four-Seventeen (417), eight (8) votes for aye were cast in favor of the recommendation (including Chairman Bill Hitchens via conference call), zero (0) nays, and one (1) absence (Chairman Chuck Hufstetler)

Now, we will have the final report emailed out and posted on our website as soon as possible. We are now going to move on to structural engineers. So, Ashley [Jenkins] et al. would like to come up. Remember to state your name when you first speak because we had a hard time matching names to voices in the last minutes.

To begin, are there any opening questions from the committee now that you have been able to digest this material? No?

Gabriel Sterling, Office of the Secretary of State

Is there a list that exists of what types of structures are under the designated type? Like stadiums, etc.

Michael "Sully" Sullivan, ACEC Georgia

PELS Board rule 180-2-.04-(3)(b)(2). Michael Sullivan with the American Council of Engineering Companies of Georgia. The transportation language is Georgia grown, if I can use that language without being sued by the agriculture department. That was generated by the Georgia Department of Transportation as we said in our last meeting. They worked very closely with us and are in support of the legislation. The other definition is really for the most part a national definition that was worked out and used in most states that delineate structural engineers with very few tweaks.

Gabriel Sterling, Office of the Secretary of State

Thank you.

Michael "Sully" Sullivan, ACEC Georgia

The thing about gravity and physics is that it really is the same in every state.

Gabriel Sterling, Office of the Secretary of State

Except California.

Anna Wrigley Miller, Office of Planning and Budget

I wanted to take a minute to point out that we had a few questions last week about the difference between our OPB state-by-state comparison and what they had shared on licensing. If you look in your packet there is an updated OPB state-by-state comparison for House Bill five-sixteen (516). So, to briefly explain what the differences are for that, our report only included states that specifically regulate the practice or the specific title of structural engineering. Ten (10) were listed in the original report, but we have added Alaska because they had just added the recognition for structural engineering in March to their Administration Code. So, that was why we had missed that. In the new report, there were eleven (11) states that allow professional engineers to practice a specific discipline and then allow for that specific discipline to be added to their seal. Your survey also mentions Connecticut and Kentucky, but OPB could not find anything that was specifically codified or in the rules. It may be the way it is practiced, but not in the codes. That explains the differences for a clarification point since there was a question.

Michael "Sully" Sullivan, ACEC Georgia

Of course, and there are different flavors as with anything at the state level. Some states have a registry list, some states allow you to use the S.E. designation but do not restrict practice, and some states do a full practice restriction where you not only create the designation but also restrict the design of designated structures to those folks that have the designation. So, the total number of states that have all the flavors is twenty-four (24).

Anna Wrigley Miller, Office of Planning and Budget

Okay, great. Gabe, do you want to talk about professional licensing boards cost wise for this?

Gabriel Sterling, Office of the Secretary of State

The initial estimates from this involve doing the back end, which would be the technology portion of this. With our vendor, we are looking at twenty-five thousand ($25,000), or so, as it always seems to be on these items. With the small number of certificates we are talking about, including the affidavits with the grandfathered in engineers, we are estimating maybe ten percent (10%) of an F.T.E. (full-time employee). We would spitball around four thousand ($4,000). We are really looking at less than thirty thousand ($30,000) for all of this, and most of that is one-time fees.

Anna Wrigley Miller, Office of Planning and Budget

Great.

Michael “Sully” Sullivan, ACEC Georgia

And we are willing to do a bake sale.

Anna Wrigley Miller, Office of Planning and Budget

Okay, any other questions from people on this? No? Okay, is there anyone here from the PELS Board?

Darien Sykes, Professional Engineers and Land Surveyors Board

I am. Darien Sykes.

Anna Wrigley Miller, Office of Planning and Budget

Is there anything else you would like to add to this?

Darien Sykes, Professional Engineers and Land Surveyors Board

No.

Anna Wrigley Miller, Office of Planning and Budget

Okay. Councilmembers, you’ll see the draft I sent out yesterday in your packet. There are draft findings that do not have a recommendation yet. What I would like to do today is read through these findings, and then I would like to have a motion about where we should go with the recommendation. You’ll see I did not put page numbers on this draft, so apologies. We are above where it says, “intentionally left blank.”

Our findings are that it is recognized that the practice of structural engineering requires special skills due to the types of structures they work with. This bill allows for structural engineers to be recognized for the specialized level of education they have obtained and allow them to be competitive with similarly educated and licensed individuals from out-of-state. This separate structural engineering delineation of professional engineers will also protect Georgians from professional engineers working on designated structures without proper education.

We also find that the Georgia Board of Professional Engineers and Land Surveyors (PELS) took all steps allowed to them to designate structural engineering as a separate license delineation. The board cannot create a new designation through rulemaking, only statutory change could create the structural engineer designation.

Gabriel Sterling, Office of the Secretary of State

It seems that we should essentially pass this as structured currently, nothing seems to need to be changed or has been brought up to make me think that.

Anna Wrigley Miller, Office of Planning and Budget

Okay, can I get a second to that?

Jessica Simmons, Department of Revenue

Second.

Anna Wrigley Miller, Office of Planning and Budget

All in favor say, "Aye."

On the motion to approve the draft report language, seven (7) votes for aye were cast in favor of approving the findings, zero (0) nays, and two (2) absence (Chairman Alan Powell and Chairman Chuck Hufstetler)

Alright. At our next meeting, we will vote on a finalized report on this. Thank you for coming.

Can the veterinarians come up, please? For this report, I do have page numbers on them, so go to page nine (9). You guys will also find a letter from the State Board written by Dr. Malphus in support of this. Any questions for the Veterinarians now that we have had time to digest what this bill entails? No? Okay, as with the last bill, I am going to read through the draft findings that we came up with and then take motions for recommendations. The profession of veterinary technicians requires specialized skill and training. The State Board of Veterinary Medicine has been licensing veterinary technicians for many years. The Council finds that it is appropriate that they have representation on the board. Because the practice of veterinary medicine takes specialized skill, the implementation of a professional health program gives those skilled professionals the ability to receive the help they need without the cost burden being on the state. Does anybody have anything they believe we should add to the recommendation? Anything you feel I have left out?

Gabriel Sterling, Office of the Secretary of State

Since I missed the discussion last time, I apologize, but is this that they may or that they shall have a veterinary technician on the board?

Anna Wrigley Miller, Office of Planning and Budget

I believe it is shall. Anything else? Any motions?

Kelly Dudley, State Accounting Office

I'll motion the recommendation as is.

Jessica Simmons, Department of Revenue

I second.

Anna Wrigley Miller, Office of Planning and Budget

Alright, all in favor say, "Aye."

On the motion to approve the draft report language, seven (7) votes for aye were cast in favor of the recommendation, zero (0) nays, and two (2) absence (Chairman Alan Powell and Chairman Chuck Hufstetler)

Alright, thank you guys for coming. Our next meeting on the thirtieth (30th), where we will vote on the final report.

Katie Roberts, Fiveash-Stanley, Inc.

Thank you. If you need anything from us in the meantime, let us know.

Anna Wrigley Miller, Office of Planning and Budget

Okay, now that we have the main business out of the way…

For everyone else in the room, we are going to move on to House Bill seven-seventeen (717). To start with, the Office of Planning and Budget has put together an overview of the bill and a state-by-state comparison. For the councilmembers, the binder with the peach cover was provided by the applicant group, and the applicant group survey is in the front of the folder. It makes references to material in the binder. The flash drive we provided has the survey, resources, support letters, and extra material provided by applicant group in digital format. We did not want to kill trees printing four hundred (400) support letters. After we go through OPB's presentation, we are going to have a presentation by Paige White. Cassie [Scoggins], will you kick us off please?

Cassie Scoggins, Governor's Office of Planning and Budget

Good morning. House Bill seven-seventeen (717) would create the advisory board for licensed midwives, and then require midwives to be licensed under this board. The board would have six (6) members appointed by the governor. The makeup of this board can be found in the bill summary, as well as the bill. Eligibility for licensure through this board, you have to be eighteen (18) years of age, you have to be certified by the North American Registry of Midwives (NARM), and have completed an educational program or pathway accredited by the Midwifery Education Accreditation Council (MEAC) or possess a midwifery bridge certificate from the North American Registry of Midwives or have maintained a license in another state that does not require such education or pathway. Licensees are required to display licenses in an appropriate and public manner. The board does have the authority to revoke, suspend, or deny a license for obtaining a license by fraud, the conviction of a midwife for a felony, neglecting a patient's welfare, and there are some other problematic circumstances that are listed in the bill summary and the bill as well. Midwives are required to provide disclosers to clients which should include his or her name, address, telephone number, license number, educational information, training experience, fees and billing methods, whether or not the midwife possesses liability insurance, and any other information deemed necessary by the board. Midwives should acquire signed consent or refusals from their clients and maintain them for six (6) years. The bill and bill summary list all the duties of a midwife and the things that they are not supposed to do, which are a lot to go through. A midwife is not to practice if he or she is impaired, due to any physical or mental illness or under the influence of alcohol or drugs. A midwife may also discontinue services as long as the client has reasonable access to other professional care, but also be sure to note that the practice of midwifery does not constitute the practice of medicine. The last part of the bill requires that insurance policies or organizations, including Medicaid, they cannot deny coverage or reimbursement for midwifery services if they already reimburse or cover maternity services. That is all on that.

OPB staff did put together a state-by-state review of how midwifery is regulated in other states. Currently, there are thirty-three (33) states that have chosen to regulate the practice of midwifery. Those are all found in the state-by-state review that is in the right pocket of your folder. Those states are Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming. The first thing we looked at was the educational requirements for the profession, and overall, they kind of have the same educational requirements that are required by House Bill seven-seventeen (717). They require midwives to be credentialed by NARM and also have completed a pathway that is accredited by MEAC, or it has to be approved by the Department of Education. If you look in the state-by-state review, you can see the states that have those same educational requirements. We also broke it down by the type of regulation. Currently, twenty-seven (27) of the thirty-three (33) states require a full licensure of the practice, Alabama, Alaska, Arizona, Arkansas, California, Delaware, Florida, Hawaii, Idaho, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Jersey, New York, Oregon, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming. There are three (3) states that currently have only a certification process, those are Indiana, New Hampshire, and Tennessee. The two (2) states with the least regulatory oversight, where they only have a registry of the midwives listed on the regulatory body's website, are Colorado and New Mexico. I also looked into their requirements for insurance policies and organizations, and currently., Alaska, Alabama, New Jersey, New Mexico, New York, Rhode Island, and Vermont specifically codify requirements for insurance. Alabama actually states in their code that insurance policies and organizations are not required to cover or reimburse midwifery services, but for the other states, I listed if the insurance coverage covers maternity services and also required to cover midwifery services as well. I also added a section on data collection. This isn't really something required by House Bill seven-seventeen (717), but it is something that other states are currently doing, so I thought it would be important to mention. Basically, a lot of states' boards or regulatory bodies require midwives to submit reports on clients and the outcomes of the pregnancies to the board. The board then provides all of that data to their department of public health, or similar, so that they can issue annual reports on midwifery services and the impact on the state. The states that do this are found on the last page of the state-by-state review. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Thank you, Cassie. Representative Mathiak, would you like to speak to the bill before we get started with this?

Representative Karen Mathiak, House of Representatives 73rd

Thank you. I would like to hold off until after their presentation. There were three things I heard from her that I would like to visit with the board.

Anna Wrigley Miller, Office of Planning and Budget

Okay. Ms. White? Again, before you begin talking please state your names and speak clearly into the microphone.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Thank you for your time and thank you to all the families that came today. I think you did a great job doing an overview of the bill. This is a graph that shows you what you guys have in your binders and have a digital copy of also. The thirty-three (33) states that are licensing, and then you can see all of the states surrounding Georgia. We decided for our bill to use the CPM training. It is an easier process for the state with continuity between states and less confusion for the consumers. We are Certified Professional Midwives, and I know that is a type of midwifery that no one has heard of for the most part unless you are having babies. In the state, we have about thirty (30) certified professional midwives. We have more people that would like to be. We are primary providers of maternity care. We are the only nationally credentialed care providers specifically trained in out-of-hospital birth. NARM, which you will see a lot of information in your packets about, has been credentialled since nineteen-ninety-four (1994), and we use the same accreditation that a lot of healthcare providers use. We are trained to promote health and promoting preventative care for low-risk women. So, we are not taking on high-risk women. This document is also in your binder and on the flash drive where you can see the difference between a certified professional midwife (CPM) and then the certified nurse midwife (CNM). Not many states license a family-practice physician to deliver babies, but there are some states that do, so we compared that training also.

So, what do CPMs do? We monitor the physical, psychological, and social well-being of the mother throughout the childbearing cycle. We provide the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support. We minimize technology interventions and identify and refer women who require obstetrical attention. Most, we have one-hour prenatals [sic]. Some of us do in-home care and some of us have offices where we do prenatal care, then we do the birth and postpartum care in home, and that is how it is on the national level. We have excellent outcomes. The report talked about some of the states that have midwives report their birth outcomes. Georgia has taken advantage of MANA stats, and there is some information on that in your binder too, where we have voluntarily turned in information on births.

Anna Wrigley Miller, Office of Planning and Budget

Could you explain what MANA is?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Midwives of North American [sic]

[For public clarity, MANA stands for Midwives Alliance of North America]

And they are one of the national organizations. I talk about them in the top of the application and link to them and tell what they're about. They have started across the country collecting statistics for quite a while, and that is how we are showing outcomes of births that are happening at home. Our hospitals transfer you can see over here. Also, home birth costs about one-third (1/3) the price of a hospital birth. Then we touched on our delivery verses cesarean rates, which of course we would be transferring to the hospital for. Georgia's overall caesarean rate with hospital birth is about 34.2%, and for a planned community birth for the same time period was 3.20% with the Georgia CPMs.

Gabriel Sterling, Office of the Secretary of State

Is that in part because you don't take on high-risk pregnancies?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Correct, yes. Then we are also not doing a lot of the interventions to kind of encourage labor along in the same timeframe.

We offer postpartum care. This is another area were CPM care really stands out. Not only are we spending an hour with each mom prenatally throughout her pregnancy, we are also staying with them about three (3) to four (4) hours after the baby is born monitoring everybody, helping establish breastfeeding. We are also coming back a couple times within the first three (3) weeks, and then also seeing people at six (6) weeks. Another benefit is that our clients have access to us twenty-four/seven (24/7) via phone and text. That is really beneficial for moms getting help that they may not have reached out to a call center, or something like that, for. We also screen for postpartum depression which has helped reduce the rate of postpartum depression.

Why we need licensure for the Certified Professional Midwife (CPM):

We want better outcomes for Georgia moms and babies and access to labs and emergency medications. On a national level, we are trained to be able to read labs and administer emergency medication in the instance of say, a postpartum hemorrhage, or something like that. We would like access to do so. The ability to bill insurance, Medicaid coverage being sought at a federal level, there're two bills right now in Washington [D.C.]. Also, a recourse for families to file complaints. Right now, we are self-governing where we have, it'll be in there, but the Georgia Midwifery Association has some bylaws and scope of practice that the CPMs that are a part of that group have agreed to practice by. While we try to self-govern and help each other meet at standards of care, there is no official recourse that parents could have if they had a complaint. Of course, board oversight if a midwife practicing outside of scope, there would be ways that we could take action to fix that.

Barriers for Entry into the Certified Professional Midwife (CPM):

The landscape of CPM education and training is changing. Our unregulated status currently prevents more CPMs from training in our state. Current ICM standards include formal education and MEAC accreditation schools. You guys will have a lot of information in your binder on that too, and it talks about how ICM, the World Health Organization (WHO), and ACOG have all worked together to come to a ground which comes through the MEAC accreditation where they all support the Certified Professional Midwife. Funding is a challenge, but scholarships in Title IV fund it. The national organization, NACPM, has two federal bills requesting federal funding for midwifery education that would help the certified professional midwife afford education. On a local level, the Georgia Midwifery Association and the Georgia chapter of NACPM currently support a lending library for students, as well as a mentorship program specifically for students who face socio and economic barriers. We have had organizations that have offered scholarship money to cover testing and things like that.

Gabriel Sterling, Office of the Secretary of State

How many are currently in the mentorship program?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We have three (3) people right now in the mentorship program. It's just started up in the last little bit, but we also have had quite the graduation rate in the last two (2) years of certified professional midwives that have graduated from mentorship.

Anna Wrigley Miller, Office of Planning and Budget

In Georgia?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

In Georgia, yes. In your binders, it states the number three thousand six hundred (3,600) CPMs nationwide.

Georgia Needs Licensure for CPMs:

Thank you. I am assuming you guys have questions for us. I brought two of my colleagues that are helping with the legislation.

Anna Wrigley Miller, Office of Planning and Budget

I guess the biggest question I have is can you please explain the difference in education requirements you need to be a CPM verses a certified nurse-midwife (CNM). I did a little googling, and there are nurse-midwives that do practice outside of hospital and in-home that I found that could come to my house and deliver my baby tomorrow.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

I think there's about three (3) or four (4). You think five?

Tracey Cuneo, Certified Professional Midwife (CPM)

Five in the entire state. They are pretty much located to [sic] the urban Atlanta area.

Anna Wrigley Miller, Office of Planning and Budget

And please state your name.

Tracey Cuneo, Certified Professional Midwife (CPM)

I'm sorry. My name is Tracy Cuneo, and I am a certified professional midwife.

Anna Wrigley Miller, Office of Planning and Budget

Okay. To recap, please explain what the education process is to become a CPM. Do you have to have a college degree? Do you have to have a GED or equivalent? And what specific trainings you go through?

Tracey Cuneo, Certified Professional Midwife (CPM)

There are two different pathways to become a certified professional midwife. There is an accredited route, going through a MEAC accredited school, the Midwifery Education Accreditation Council. I went to a school, and at that school you can receive an associate, actually they've done away with that and now it is a Bachelor of Science in midwifery. So, it is a four-year (4-year) degree. Along with the didactic education in the accredited route, there is also the clinical requirements that are required. So, I had about two (2) years of supervised clinical practice with certified nurse-midwives, actually, supervising my practice. For women who go through the MEAC route, they are going to have a didactic education and then they are going to have the requirements she put up there with the numbers of births. They are going to have the prenatal exams under supervision, the initial exams, the continuity of care, all of those requirements. Then at the very end of all of that, they are going to take a seven (7) hour exam that is a national exam that all certified professional midwives take for accreditation. The other route is a pep route…

Anna Wrigley Miller, Office of Planning and Budget

And you're calling the first route MEAC?

Tracey Cuneo, Certified Professional Midwife (CPM)

Yes, the first route is an accredited route, and it is with a MEAC school. M-E-A-C. Midwifery Education Accreditation Council. So, it is a national certification for schools. We don't have a MEAC school in Georgia. I had to go to Utah to go to school.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Schools are interested in coming if we got licensure.

Tracey Cuneo, Certified Professional Midwife (CPM)

Yeah, they won't be here because we don't have licensure. They want to be here. The school that I went to actually had Title IV funding, so I was able to tap into that to pay for my education.

Anna Wrigley Miller, Office of Planning and Budget

Okay, you said it was equivalent to a bachelor's degree?

Tracey Cuneo, Certified Professional Midwife (CPM)

Oh, it is a bachelor's degree. It is a Bachelor of Science in Midwifery. Yes.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

The other one is called a portfolio entry, excuse me, portfolio evaluation, and that is what I did. It was an intense, about four-years (4-years), clinical time with two (2) local certified professional midwives that have become preceptors with the NARM organization. With them, I did all of the prenatal care, all the births, all the postpartum care, along with the independent book study. I used a non-accredited online program that did all of the didactic work, and things like that, and after I met all the

requirements that NARM had us do, I was eligible to sit for the same national accredited exam that the MEAC pathway does.

Missi Burgess, Certified Professional Midwife (CPM)

I would like to also speak to your question. My name is Missi Burgess, I am a certified professional midwife. I went to the same school that Tracy [Cuneo] did, and to become a nurse-midwife, you have to do all of the nursing school prerequisites. Then, you would get your bachelor's in the science of nursing. Then, you would go on to get your master's in midwifery. So, you would spend a limited portion of your time as devoted to the study of midwifery. The greatest number of births that they are required to attend clinically would be forty (40), often it is around twenty (20). When I was considering which route I wanted to take, because I was originally at Georgia State University with a full scholarship for a nursing degree. I walked away from that and became a certified professional midwife because I wanted the four (4) years of study specifically for midwifery. I think that is the thing that gets overlooked a lot.

Anna Wrigley Miller, Office of Planning and Budget

And you did not finish the degree?

Missi Burgess, Certified Professional Midwife (CPM)

Right, yeah. It is not that one is better than the other, they're two different routes of study and two different outcomes. Most nurse-midwives are not interested in practicing out of hospital. They want to work in a group practice, they want to have on-call hours, they want to have a room they can sleep in. Their clients also are more comfortable with giving birth in a hospital environment, so that is what their training is for. Some of them do have a portion of training, if they seek it, for out-of-hospital birth, but they are trained to practice in the hospital. And we do work together.

Anna Wrigley Miller, Office of Planning and Budget

Just as a clarification, there are two (2) pathways, the bachelor's degree and the self-study? Is that kind of what it is?

Missi Burgess, Certified Professional Midwife (CPM)

And the self-study also has a bridge.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Oh, yes, I am sorry. I also have to get the bridge certificate, which is MEAC approved, and it is what the World Health Organization, the ICM, and ACOG worked on so that people that did my pathway would meet the national requirements moving forward in states that are licensed.

Anna Wrigley Miller, Office of Planning and Budget

Okay, so basically there is a bachelor's degree and a self-study with a bridge certificate, and you both have to take the same exam to get the certification?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Yes, we like to say apprenticeship, like doing clinical hours instead of self-study.

Gabriel Sterling, Office of the Secretary of State

Help us with some of the acronyms. What is ACOG?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

American College of Obstetricians and Gynecologists, and all of that is also in there [binder] when it talks about different groups. I tried to spell it out, but I know it is hard.

Missi Burgess, Certified Professional Midwife (CPM)

And ICM is International Confederation of Midwives. It is hard to keep straight.

Anna Wrigley Miller, Office of Planning and Budget

Okay, I have another question. Currently, there are thirty (30) Certified Professional Midwives in the state, right?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Yes, thirty (30) that have registered with NARM that allow their information to be used.

Anna Wrigley Miller, Office of Planning and Budget

Do you think that there are some that choose not to?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Yes.

Anna Wrigley Miller, Office of Planning and Budget

Why would they do that?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Because they would like to practice to national standards in a licensed state, and until they are, they don’t want to report.

Anna Wrigley Miller, Office of Planning and Budget

So, they are practicing in the state currently?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

They may be CPMs, but they are not practicing. They don’t want to practice until they have licensure.

Anna Wrigley Miller, Office of Planning and Budget

Okay. Do you know how many certified nurse-midwives there are? Are there any certified nurse-midwives here? We've got one.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We have a little over four hundred (400) letters [of support] and about ten (10) nurse-midwife and other professionals.

Kay Johnson, Certified Nurse-Midwife (CPM) and Applicant Group

There are probably about three hundred (300) in the state. Is it?... Over five hundred (500).

Anna Wrigley Miller, Office of Planning and Budget

Okay. In twenty-fifteen (2015), the Department of Public Health made a rule change that resulted in only midwives that are currently legally allowed to practice in the state of Georgia are nurse-midwives that are currently licensed by the state board of nursing. So, does that mean that you guys have not been able to deliver any babies in the state since twenty-fifteen (2015)?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

That is what the law states. Correct.

Anna Wrigley Miller, Office of Planning and Budget

To your point earlier, you said that, by licensing, it would allow recourse for people who were treated by somebody who was unlicensed. To play devil's advocate here, technically you are not allowed to practice at all, so isn't that currently a recourse? The state has said the only midwives that are allowed to practice are nurse-midwives.

Missi Burgess, Certified Professional Midwife (CPM)

No, the question right now is if someone is treated, maybe there's a case of negligence or something like that, it is very difficult for them to have recourse. If everyone is unlicensed, first of all, there is no standard being set for it, for midwives that are doing out-of-hospital delivery. Those five (5) nurse-midwives cannot possibly do… it says up there how many births it was.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Eight-hundred and seventy-three (873).

Missi Burgess, Certified Professional Midwife (CPM)

They can't possibly do that. Currently, if someone suffers neglect, or something like that, by an unlicensed midwife who is possibly nationally credentialed, there is no recourse for them. There is nowhere for them to go. They can try a criminal lawsuit, they can try a civil lawsuit, but often, that doesn't go anywhere. Because we are self-regulated, that means that likely a midwife who is practicing

that way is not part of our group and there is nothing we can do about it either other than asking her to stop.

Tracey Cuneo, Certified Professional Midwife (CPM)

And I would say licensing would offer the general consumer some type of ability to see who is following state standards and guidelines, who is following state protocols, because right now, to the general consumer, it is confusing who is a nurse-midwife, who is a certified professional midwife. We have another group of midwives that are direct-entry midwives that may have other types of training, but they don't have a CPM credential. So, we have that group too. It is very confusing to the general public who has credentials, who is following practice guidelines that are safe, that are evidence based. We want certification, we want licensure so that we can show to the public which midwives are following evidence-based protocols

Anna Wrigley Miller, Office of Planning and Budget

I only have a few more questions, and then I will let you guys ask questions. Where do your statistics come from? In your applicant survey, I wrote down page nine (9). Where did the statistics come from?

Tracey Cuneo, Certified Professional Midwife (CPM)

These specific statistics for the Georgia midwives?

Anna Wrigley Miller, Office of Planning and Budget

Yes.

Tracey Cuneo, Certified Professional Midwife (CPM)

That is from the MANA stats collection. So, MANA stats is the Midwives Alliance of North America. [sic] They have been…They are like on their third (3rd) or fourth (4th) data set now. It's voluntary to participate in it. So, this is not a snapshot of every single Georgia midwife. Just the ones that participate in them. What we do is we log a client into the database prior to delivery at the onset of care once they give us permission to do that, and then we report everything to them, the outcome, where does the baby sleep after it's born. It's very specific. So, that is where we got those numbers from.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

There also are some state numbers that are pulled, and you're getting the official name, Debbie? Okay, so some of it came from the CDC and birth certificate data.

Anna Wrigley Miller, Office of Planning and Budget

So, it is a reasonable argument to say that there's more than this, and I obviously applaud you guys for saying that you've had no field or maternal deaths in that five-year (5-year) sample.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And some people ask about how those stats work, and you have to register before the baby is born, before the mom gives birth, so you cannot just pick and choose which ones you want to report. You've already submitted it before.

Anna Wrigley Miller, Office of Planning and Budget

Okay, that was going to be my question, do you choose to just report the ones that are successful?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

No, you can't. You have to choose, and then you have to follow up.

Missi Burgess, Certified Professional Midwife (CPM)

And it is only one percent (1%) of the population that is choosing out-of-hospital birth, so there's really not that many more.

Anna Wrigley Miller, Office of Planning and Budget

Sorry, I have a data question. Would this include certified nurse-midwife births too, or is it just CPMs?

Tracey Cuneo, Certified Professional Midwife (CPM)

It could be the few nurse-midwives. I don't think any of them participate in MANA stats.

Missi Burgess, Certified Professional Midwife (CPM)

This one [Kay Johnson] did. I entered them for her.

Anna Wrigley Miller, Office of Planning and Budget

And one more question, what quantifies an out-of-hospital birth? If I don't make it to the hospital in time?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

No, homebirths that received prenatal care, signed an agreement, been screened to make sure they're low-risk women, seen prenatally just like they would be going to a hospital care provider.

Anna Wrigley Miller, Office of Planning and Budget

So, this number would include if I didn't make it in and had my baby on the bathroom floor?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

No.

Missi Burgess, Certified Professional Midwife (CPM)

This number does not include accidental home births.

Tracey Cuneo, Certified Professional Midwife (CPM)

The MANA stats are all reported home births…

There was indiscernible debate between the CPMs present in the room over the statistics.

Tracey Cuneo, Certified Professional Midwife (CPM)

It is important to distinguish when you look at studies, are these planned home births with skilled, trained [indistinguishable word], or are these accidental home births. Are we comparing apples to apples? Are these women that have been screened and had prenatal care and are low-risk, or are these people who just didn't make it to the hospital, right? And I think the MANA stats are just the skilled, trained midwives that are reporting.

Anna Wrigley Miller, Office of Planning and Budget

So, the ones in the applicant survey are MANA stats?

Missi Burgess, Certified Professional Midwife (CPM)

Apparently, that eight hundred and seventy-three (873) number is the only number that came from the CDC.

Anna Wrigley Miller, Office of Planning and Budget

Okay, so that could include anything not in a hospital.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And we can clarify through email if you need that. We can get that data straightened out.

Anna Wrigley Miller, Office of Planning and Budget

Now I want to get, rather than just specifics about the profession, I want to get into questions about the specific bill that's written. On line seventy-eight (78) of the bill, you guys refer to a midwifery assistant just in the definition, but that shows up nowhere else in the bill, and I haven't really seen that anywhere else. Is that something that is going to be licensed as well, and what capacity does a midwifery assistant have?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We are not currently asking a midwifery assistant to be licensed. They're more of just that, an assistant. There are some workshops and training that they can do to become assistants. More often, the certified professional midwife will train somebody in how they have an assistant done. So, we were just listing all definitions.

Anna Wrigley Miller, Office of Planning and Budget

Okay, do you want to go Gabe?

Gabriel Sterling, Office of the Secretary of State

First off, I think most people understand the thought process behind the need for something along these lines, especially in parts of rural Georgia and South Georgia where there is essentially a monopoly of one hospital of any kind, obstetrics, gynecology. I know Lee County got certified for another one that hasn't even been built yet. So, I applaud the direction this is going, but in my role in the Secretary of State's office and through our Professional Licensing Board, the bill as written has, what we would consider, issues definitionally and then the intent for some of these things. I just want to go over a couple of these things that have some problems that our staff discovered. Line fifty-four (54), you are creating an "advisory board." There is nothing about the powers given to this that make it an advisory board. An advisory board, we have a couples of those right now like lactation consultants and music therapy, and there set up very differently than how this bill is structured.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

I will say our bill looked a lot different when we turned it in, and it was changed a lot by legal in the state. We were told anything that seemed off or needed more fine tuning they would handle in committee. I will say that.

Gabriel Sterling, Office of the Secretary of State

Things written by committee makes camels. Line eighty-seven (87) with all of the other advisory boards, it is the Secretary of State that appoints the members and not the Governor. Essentially what you are doing here is making what is actually a complete licensing board and not an advisory board. It makes it a little different in structure and location. On lines one hundred and five (105) to one hundred and seventeen (117), for advisory boards, travel expenses and stuff are not covered. It provides that the advisory board chairperson approves all out-of-state travel, and there is no other PLB board that receives administrative support from SOS, such provision or practice. That is just not how things are structured. Again, doing by committee has created some new, different things that we're not used to seeing. We're trying to step towards rationalizing and making things the same, not making them a lot different. That's part of the reason GORRC exists. On line one hundred and twenty-six (126), our other advisory groups, the law requires the group meet once per year or otherwise called by SOS; this provision allows the advisory board chairperson to determine the meeting frequency. Again, these are structural things. Lines one hundred and thirty-one (131) to one hundred and fifty-one (151), the licensure requirements, to our way of looking at things, do seem a little complex. I mean, y'all walked us through part of that, but legal requirements when you're going to outside groups and stuff, we may have to have some language. It isn't quite as specific, but still meets the goals of that. Then you take care of some of that rule making as apposed to statutory rule itself. Lines one hundred and eight (180) to two hundred and nine (209), for other advisory groups the law provides the SOS's authority to take action against licensee. This section gives disciplinary authority solely to the advisory group yet making it even more of a licensing board. Line two hundred and ten (210) through two hundred and twelve (212), and this is a little one, it is supposed to start July of two thousand and nineteen (2019). We've kind of shot past that, so we will need to reword that. Line two hundred and ninety-one (291) to two hundred

and ninety-four (294) requires for the criminal acts to be taken care of, but under O.C.G.A. 43-1-19, as a licensing board, which is what this is essentially acting as, the criminal statutes are already existing. You are being redundant there in lines one hundred and eighty (180) to two hundred and nine (209) of that law. It also seems to give Public Health an idea to have to grant some extra authority for action which is sort of undefined right now in the way that our guys were looking at this bill. Just from the presentation, I had another question. Under the eligible for licensure, there's a section that says must be eighteen (18) years old and then had the educational program or pathway accredited by Midwifery Education Accreditation Council, your MEAC that you discussed, and NARM, or maintained a license in a state that does not require completion of such program or pathway which sounds like somebody can get in with no education.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

That was something that was not in our original bill. It should probably clarify if they were a certified professional midwife in another state and held the bridge certificate.

Gabriel Sterling, Office of the Secretary of State

But it doesn't say that in the law as written as we read it. That is another problem we have. Again, I think there are some ideas her that could meet where we are trying to get to, but this law as written right now has a lot. One of our guys called it a hot mess. But the intent is right, and like I said, when you write laws like this, they're laws. Rulemaking allows for a lot more flexibility moving forward when you see problems and changes. You put it in law, it's law. It is a real pain in the butt to change it, so we want to get it right the first time.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We definitely want to get it right the first time, so thank you.

Gabriel Sterling, Office of the Secretary of State

That is just some of the basics. If it is essentially a licensing board, which is what this reads, looks, and feels like, there are actually lots of costs attached to this. Is there a defined fee structure on this?

Anna Wrigley Miller, Office of Planning and Budget

There's not. To speak to that, they did request a fiscal note, but we are working on it. I reached out to SOS and they are working on it.

Gabriel Sterling, Office of the Secretary of State

I am assuming it is going to have a similar cost to what we've thrown in from the previous time we looked. That was an underlying license. This is a new license, which if memory serves, was approaching a half million ($500,000) to build and another three hundred thousand ($300,000) to run. So, this is now an inexpensive thing to do depending on the impact of it.

Anna Wrigley Miller, Office of Planning and Budget

Right, and I did want to address one thing in your applicant survey. The committee members did get your applicant survey this morning. I read through it yesterday, so they haven't read it. This is their introduction to it. You mentioned that this was supposed to go under Department of Health I think is how you had written it. So, there is a Department of Community Health, Department of Public Health. Department of Behavioral Health and Developmental Disabilities, and Department of Community Health. All four of those do not regulate things. Like Gabe said, the way that this read is professional licensing board. When I was actually reading through the applicant survey, I was confused by the reference to Department of Health.

Gabriel Sterling, Office of the Secretary of State

It could be living in the wrong place.

Anna Wrigley Miller, Office of Planning and Budget

Right, and there is no specificity in the law as written to where it should go. It only mentions that it should be a subsection of the division but doesn't necessarily state what division which is why we assume secretary of state when I sent out everything for the fiscal note analysis on what this would cost.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Okay, my question for you, sir. I don't remember you name, I'm sorry. Are you advising us that we need to reword this so that it is an actual advisory board, and what does that look like?

Gabriel Sterling, Office of the Secretary of State

It depends on the outcomes that you want. It sounds like what you want is a full licensing board, so I would say using the term advisory board would screw up what you are trying to do or confuse people even more. I'm not one for making new licensing boards, generally speaking, because we are trying to reduce licensing boards and streamline things at lower costs, but for what you're trying to do I would recommend you do a licensing board. Also, there is a lot of stuff in here that needs to be cleaned up, and obviously we will have some recommendations, but I am sure there are several members here who were the sponsors and cosponsors of the bill that would like to clean it up as well. We all want to pass a good bill if we are going to do that.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Okay, to recap for Chairman Cooper who just got here, we haven't been talking about this very long. We just had an overview from Paige and her partners about the background of CPM. We've now opened it up to questioning about the differences between Certified Professional Midwives and Certified Nurse-Midwives, etc. We were talking about the bill right now. Any other questions?

Jessica Simmons, Department of Revenue

One question that I had, based on these statistics talking about, like highlighting postpartum for example, talking about hospital transfers. What timeframe do you determine is postpartum? Let's say, is that a day, a couple of days, a week? If someone is not transferred to the hospital, but two days later they need to go to the hospital, or if the baby did not immediately need to go to the hospital for a health issue but then at some point did a few days later due to a serious health issue.

Missi Burgess, Certified Professional Midwife (CPM)

Our statistics look at forty-two days.

Anna Wrigley Miller, Office of Planning and Budget

And that is what the CDC uses too?

Missi Burgess, Certified Professional Midwife (CPM)

Those are not CDC stats; those are from our MANA stats.

Jessica Simmons, Department of Revenue

And I apologies if I missed it somewhere in the presentation, but is there information on the infant mortality rate regarding home births verses hospital births?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Yes, there is a lot of information.

Jessica Simmons, Department of Revenue

Do we have it in our information?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

In the flash drive, there is the Lancet study that talks about it.

Jessica Simmons, Department of Revenue

Lancet?

Anna Wrigley Miller, Office of Planning and Budget

Go ahead.

Chairman Sharon Cooper, House of Representative

And what are those? What are they? Be specific about the mortality and complications.

And along with that question, I didn't mean to interrupt.

Jessica Simmons, Department of Revenue

Oh no, please.

Chairman Sharon Cooper, House of Representative

It’s just when they start talking about it. The last case that I had, twelve (12), thirteen (13), and fourteen (14), there were around one hundred and thirty thousand (130,00) births, or maybe that is a year. Anyways, there were six hundred (600) home births. It was a very small percentage of home births.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

One percent (1%) chooses.

Tracey Cuneo, Certified Professional Midwife (CPM)

Less than one percent, yes.

Missi Burgess, Certified Professional Midwife (CPM)

Also, that reminds me, somebody had a question earlier that I did not answer. I think it was about the cesarean rate. What the person was trying to figure out was whether we were comparing apples to oranges there because we only see low-risk women. It is important to note than ninety percent (90%) of women are low risk, so ninety percent (90%) of women having their baby in the hospital are also low risk. Then the one percent that have their baby at home are the lowest of the low risk for sure. When you compare those two, there have been multiple studies that have been done to compare outcomes for only low risk women in the hospital and only low risk women at home. The neonatal mortality rate is very similar between those two (2) groups.

Anna Wrigley Miller, Office of Planning and Budget

While she looks at that, I have another question that you prompted me. As part of the exam to be a CPM, is it part written and part practical? What is it like?

Missi Burgess, Certified Professional Midwife (CPM)

She doesn't have that slide up. So, there’s clinical and then there’s written. So, clinically… and it also goes back to our reference to the landscape is changing. So those of us that are like the old, older… we’re not old, we’re new midwives, all three (3) of us, but even since we became midwives it is changing. So, when I was going through my clinical program of study, I had a thick book, and the one CNM that’s here was one of the people that trained me and she often made comments about how often she had to sign, “Yes, she knows how to do blood pressure,” “Yes, she knows how to give oxygen,” “Yes, yes, yes.” You know, it was a very thick book of every little thing. It had to be demonstrated, and then it had to… most of them you actual have to see in the clinical setting. Which is why our training takes so long because most of the time people just have their babies. So, it takes a long time before your preceptor actually sees you administer oxygen. So, that’s part of it. That’s the years, and then the seven-hour (7-hour) exam is on a computer answering multiple-choice questions. That’s the big, national test.

Anna Wrigley Miller, Office of Planning and Budget

Just a follow up question to that, is there a chance that you could go through all of the births you're required to go through and all of your clinical stuff without… I don't want to say luck of the draw, but luck of the draw, not having experienced a situation where you have to transfer somebody to the hospital when it's not just a natural thing?

Missi Burgess, Certified Professional Midwife (CPM)

No, we have to turn in logs for our birth experiences. It's anonymous for the client. It's client numbers. Then, basically it goes to an applications committee with NARM, and they are specifically looking to see. There's a blank down the side where you have to write, "was this a normal, spontaneous vaginal delivery," "did it result in hospital transfer." You have to have some hospital births on there. It looks very skeptical.

Anna Wrigley Miller, Office of Planning and Budget

If they're all okay every time?

Missi Burgess, Certified Professional Midwife (CPM)

If they're all like, "yeah, this baby just came flying right on out," You know, that's not what they want to see. And then also, there was something else that I was going to say…

Tracey Cuneo, Certified Professional Midwife (CPM)

I just want to add that we are certified in neonatal resuscitation and CPR [cardio-pulmonary resuscitation], and there are requirements for continuing education and recertification at a national level every three (3) years. So, we are continuing to be educated and many of the local midwives participate in national workshops with practicing birth emergency skills for outside-of-the-home…out-side of the hospital.

Jessica Simmons, Department of Revenue

I have all got a couple of other questions. One question you mentioned that obviously if you are looking at potential candidate for home birth it's somebody that's low risk. Who makes the determination that it's low risk? Is that a determination that a midwife would make? Is that a determination that somebodies OBGYN would make? Who determines if somebody is a potential low risk candidate?

Tracey Cuneo, Certified Professional Midwife (CPM)

So, we have practice guidelines in our state group, the Georgia Midwifery Association, that we spent about two years hammering out with experienced midwives that have thirty (30) to forty (40) years' experience, and talking about on the committee, "what makes somebody low risk?" There are people who are professional midwives who can choose to not go by our guidelines because there is no recourse for them not adhering to what our recommendations are.

Jessica Simmons, Department of Revenue

So, meaning that they could actually still have somebody for a home birth that is high risk?

Tracey Cuneo, Certified Professional Midwife (CPM)

Right, so when there is a licensing board, that allows us to actually be able to get some administrative oversight. If we see a peer that is doing things that are dangerous, right now there's no recourse of than peer pressure to tell that person not to practice that way. They've been trained a certain way, they've been told… they've had the right training, but they're choosing just like some doctor's choose to be an outlier and practice outside of what is evidence-based.

Jessica Simmons, Department of Revenue

And then one other kind of follow up question on that, can you walk us through essentially what various kind of things you would see. At what point do you make the determination that somebody needs to be transferred? At what point do you say, "We need to change course. We need to get you or the baby to hospital as quickly as possible." And then at that point, what is the procedure, what is the turnaround time? Do you call and ambulance? How does that work?

Tracey Cuneo, Certified Professional Midwife (CPM)

So, we have a list of things that we look at a birth. So, looking at the fetal heart tones. We're taking heart tones every hour with Doppler's, seeing babies that have high heart rates, low hearts rates, mother's that are looking like they are dehydrated, mother's that are slow to progress. They're not making adequate progress on their labor. Mothers that have their water broken for several days. Mothers that have water broken with dark green, you know, or dark colored waters that make us aware the baby may have some fetal distress going on. It's a long list.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

It's definitely an ongoing process, even prenatally. What is going on prenatally even to risk them out.

Tracey Cuneo, Certified Professional Midwife (CPM)

And I will tell you what I do as a midwife; I am calling the hospital ahead of time and calling the charge nurse in labor and delivery. I am letting her know I am coming in with a mom. I have an electronic chart that I've kept with the mom. I have all prenatal care. I have her labs, I have her ultrasound, I have everything they would want, and I fax it over to the charge nurse. I walk in with my client and I give report for what's happened at home.

Jessica Simmons, Department of Revenue

Are you bringing them in? Is an ambulance transferring them?

Tracey Cuneo, Certified Professional Midwife (CPM)

They are driving in their own car, but if it was an emergency, I would call an ambulance, absolutely. Would not hesitate.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

But we're not waiting until there's a lot of red flags, you know, if there's something that's no longer low risk, we're going in, and most of those times the babies are born a few hours later. The mom may get an epidural, some sleep, some Pitocin, things like that. We're not coming in there at the last minute.

Chairman Sharon Cooper, House of Representative

Some things have been said that made me have some questions. First of all, you're doing that electronically, you're calling it, is that a requirement in writing for your other people to do?

Tracey Cuneo, Certified Professional Midwife (CPM)

No

Missi Burgess, Certified Professional Midwife (CPM)

No

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Well keeping charts is definitely. They can have paper charts, yes. It is how everything is moving towards, but having detailed charting is a part of the requirements, yes.

Chairman Sharon Cooper, House of Representative

Okay, and I think that, having talked with y'all, you know that one of my major concerns is what happens in an emergency because there are no pregnancies that are guaranteed low risk. No matter how well trained you are, you know, there's none an OBGYN can totally say is low risk, or a nurse with a midwifery degree can say is low risk. I get chill bumps from telling you this because years ago, a fourth (4th) year medical student came and interned here with me for a month, came back for two more weeks, and went on to do a fellowship in interventional cardiologist in Ann Harbor, Michigan. Normal pregnancy was in the hospital. Normal pregnancy, Lila was delivered. There is a rare, rare, rare thing, but it does occur, twenty pints of blood and blood fluids later and a hysterectomy, and she barely made it alive out of it. Perfect delivery, normal baby, full-size, everything like clockwork. I talked to her three (3) weeks before the delivery. She was so excited, and so there is… no. That is one of the things. I consider Jackie very special, and unfortunately, she came back to Georgia to practice and didn't like the groups she was with and just moved to Montgomery, Alabama. I'm not happy about that because I won't to get to see Lila grow up as much.

Anyways, they come to me, the ambulance people, because we are having trouble and people are complaining here in the metro area that when they call an ambulance for a heart attack that they are taking twenty (20) minutes and more to respond to that. The rural areas were already a problem, which I need to talk to you about. Sometimes they only have one ambulance in a rural area, and if that ambulance in out on another call, you are left with a mother hemorrhaging to death or having a stroke or going into eclampsia with no recourse. I mean, that has come up since you talked in my office with me. These people have come to me about the ambulance service, which comes under… I get everything in Health and Human Services. Now it's the ambulances.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We definitely hear that, and it is why that we have extensive training in birth emergency skills. We are actually working on bringing, yet again; it is called Best Birth Emergency Skills. It's emergency skills training in hemorrhage, shoulder dystocia, all of the common emergencies that would happen with birth. Nationally, we are trained to carry emergency drugs for hemorrhage, which are the first thing that they would do in a hospital, inner muscular Pitocin, and things like that. One of the reasons we also licensure is because we want access to be able to use those for our clients in the meantime while we are getting them to the hospital.

Tracey Cuneo, Certified Professional Midwife (CPM)

Because the ambulance, they don't carry Pitocin. They don't have it on there. It's a drug that costs less than a dollar, and they're not carrying it. So, all they're doing is driving really fast while a mom is hemorrhaging.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And if an ambulance told us they were going to be a little bit, we would drive them in our car before we waited twenty (20) minutes on an ambulance, for sure.

Kelly Dudley, State Accounting Office

I have a question about that. I'm not a physician, but how are you getting access to those drugs? Because from a layperson, I thought only a licensed M.D. (Doctor of Medicine) can actually prescribe a drug. So, how do you get access to the emergency medication for your client?

Tracey Cuneo, Certified Professional Midwife (CPM)

We do not have access right now, but these are not prescription drugs.

Kelly Dudley, State Accounting Office

They're over the counter?

Tracey Cuneo, Certified Professional Midwife (CPM)

They're not over the counter, but it's not as though you're writing a prescription for the patient. They're emergency medications that are kept on hand.

Chairman Sharon Cooper, House of Representative

But it has to have a prescription for it.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

You have to have a license to order, say, off the medical website if you wanted to order Pitocin, or Methergine, or something like that. You would have to have a license in your state for them to send it to you.

Chairman Sharon Cooper, House of Representative

A medical license?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

A midwifery license.

Tracey Cuneo, Certified Professional Midwife (CPM)

I am licensed in Utah, that is where I went to school, and if I am practicing in Utah it is regulated for me to be able to order those medications and to be able to carry them.

Chairman Sharon Cooper, House of Representative

I would have to check with the Pharmacy Board. I would say in Georgia there would be a pharmacy law against it, but I would have to check.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

For sure. We can look at other states and see if there's a pharmacy law. I haven't heard of it, but it's possible.

Chairman Sharon Cooper, House of Representative

Our pharmacy board is so restrictive in this state.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

You would know.

Chairman Sharon Cooper, House of Representative

Yes, I would know, and in the state of Georgia, I can tell you there's probably a law against you having those drugs.

Missi Burgess, Certified Professional Midwife (CPM)

Utah requires that you take a pharmacology course.

Tracey Cuneo, Certified Professional Midwife (CPM)

A semester pharmacology course.

Missi Burgess, Certified Professional Midwife (CPM)

But most states do not require that.

Chairman Sharon Cooper, House of Representative

Okay, and who teaches all these courses that you're taking?

Tracey Cuneo, Certified Professional Midwife (CPM)

The pharmacology course I took was at the MEAC accredited, the midwifery accredited, school that I went to as part of my Bachelor of Science program.

Chairman Sharon Cooper, House of Representative

Taught by whom?

Tracey Cuneo, Certified Professional Midwife (CPM)

Taught by a professor.

Chairman Sharon Cooper, House of Representative

A professor that was what? A Ph.D. in Pharmacology like they teach in the medical schools, or a midwifery degree?

Tracey Cuneo, Certified Professional Midwife (CPM)

I would have to research what degrees she had after her name. I don't know off the top of my head.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

The MEAC schools are… the MEAC agreement is something between ACOG, the World Health Organization, and ICM. So, I would go to guess that they have some pretty strict rules on who can teach a MEAC accredited class.

Jessica Simmons, Department of Revenue

Who teaches the pharmacology courses for nurse-midwives?

Chairman Sharon Cooper, House of Representative

I don't have any idea. If they're taught at Emory, I would bet they would come over and a PhD. does or a pharmacist.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And a lot of the trainings that we're doing are also taught by either nurse-midwives or people that have taught at midwifery schools, and they're also accredited by the MEAC council saying that this is an approved out-of-hospital midwifery training emergency skills workshop. And then, NRP, our neonatal resuscitation is the same one. I've gone to Grady and taken it twice. We can take them at the local hospitals. Also, there is somebody who teaches on an international level, NRP then and additionally for out-of-hospital providers.

Chairman Sharon Cooper, House of Representative

Well, we're not regulated by the World Health Organization. Let's make that clear that we don't go by their standards because they can vary greatly on what our standards are. I mean, that's not good

or bad, we just don't use those. Going forward, I would like… If I remember, the bill grandfathers in all the people…

Paige White, Certified Professional Midwife (CPM) and Applicant Group

No, No. When we talked that was a very big sticking point with you. We agreed that that's not in our bill, at all.

Chairman Sharon Cooper, House of Representative

So, what you're going to do is, you would say that only people that had had this course would immediately be the only ones, and all other people who have been practicing home births would immediately be illegal.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We are saying that they could not get a license, and we have been working within the community to get all the midwives up to a national standard of care. So, that's where the bridge program, if you already have your Certified Professional Midwife, the MEAC has allowed a Bridge Program, which is all birth emergency skills. It is lots and lots of birth emergency skills trainings and workshops, and you must go do them to earn that bridge certificate so that you fall in line with how the other states are licensing. You don't have to go back to a midwifery school for four years, but you do have to work on that. So, most people are working towards that or have turned it in.

Chairman Sharon Cooper, House of Representative

Because if you do it that way, they would become, it would make them illegal immediately. As soon as it went into effect, they would be. Wouldn't it?

Jessica Simmons, Department of Revenue

And to clarify, I think it's currently illegal.

Anna Wrigley Miller, Office of Planning and Budget

They're currently illegal right now.

Chairman Sharon Cooper, House of Representative

They're currently illegal right now?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Due to the change, yes.

Anna Wrigley Miller, Office of Planning and Budget

In twenty-fifteen (2015), the Department of Public Health (DPH) had a rule change, because statute gives the Board of Public Health the ability to say what is and what is not a midwife. It was changed to only allow nurse-midwives to be the only legal type of midwife in the state.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We definitely didn't get any notification or say or “come talk about it with us.”

Anna Wrigley Miller, Office of Planning and Budget

They went through the normal open law practice. I have copies of the posting that went out.

Missi Burgess, Certified Professional Midwife (CPM)

I found your specific numbers for neonatal mortality and from Up-To-Date.

Chairman Sharon Cooper, House of Representative

Good.

Missi Burgess, Certified Professional Midwife (CPM)

It was 1.3 per 1000 births (one-point-three per one thousand) births for planned out-of-hospital, low risk deliveries verses 1.2 per 1000 (one-point-two per one thousand) births.

Anna Wrigley Miller, Office of Planning and Budget

So, 1.3 (one-point-three) verses 1.2 (one-point-two)?

Chairman Sharon Cooper, House of Representative

Thank you for looking that up.

Missi Burgess, Certified Professional Midwife (CPM)

And that was from Up-To-Date, so that’s currently.

Christina Ferguson, Department of Public Health

I have some questions. We’ve been talking about your… what’s needed for the accreditation process, and the course work and things like that, and I hear clinical requirements. Do those clinical requirements, are they teaching you how to insert IVs, how administer the drugs, and things like that? Is that what is included? How would that differ from nurse-midwife verses the programs you had described to us?

Tracey Cuneo, Certified Professional Midwife (CPM)

In Utah, I was taught those clinical skills, and that is a part of, there’s no nursing degree, but we are taught clinical skills that are nursing that are practical for birth. That is something that would be taught.

Christina Ferguson, Department of Public Health

So, that is for the baccalaureate degree. You all mentioned to us that there are two (2) pathways. The P.E. pathway that you mentioned, does that clinical component also include starting an IV and administering any types of meds?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

I did take workshops on those and then it is on the exam, but in Georgia I wouldn't have done any of those things.

Christina Ferguson, Department of Public Health

So, the workshops would have showed you how to start an IV?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

With practicing, yes. I had to travel, but yes.

Christina Ferguson, Department of Public Health

Then my second question is, currently DPH requires that pregnant women receive certain serological testing, specifically HIV and syphilis, to prevent prenatal transmission to the child. We also conduct newborn screening for all children born in Georgia for rare genetic conditions through specimens taken immediately after birth. Would the midwives that you are talking to us about today conduct these screenings as well?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Yes, we already offer our clients labs. We state what the Department of Health says, that it is regulated that these be done and give them options to get them.

Christina Ferguson, Department of Public Health

And those labs are reported voluntarily, how do y'all report?

Missi Burgess, Certified Professional Midwife (CPM)

Currently, they would have to be seeing a backup physician to be able to get those labs.

Christina Ferguson, Department of Public Health

So, now you're working as a part of a team? It's you and a doctor? You have oversight of a medical doctor?

Missi Burgess, Certified Professional Midwife (CPM)

No. No medical doctor is going to give us oversight as unlicensed care providers. Their liability would not allow them to do that. They don't oversee us; they oversee the patient.

Christina Ferguson, Department of Public Health

So, the patient is being cared for by two (2) people then?

Missi Burgess, Certified Professional Midwife (CPM)

That's what's required right now.

Christina Ferguson, Department of Public Health

Okay.

Chairman Sharon Cooper, House of Representative

As you talk, I have another question. Only because I have dealt with this over the years, I would say that this rises whether we would have to go back into the nurse practice act. The R.N.s (Registered Nurse) don't want anybody doing any other kind of nursing skills. To allow something to happen in the nursing home setting and the assisted living setting, we had to go back in and negotiate changes so that people that are going to give meds and everything like this and do some nursing things… I think we would have to go back, and I don't know that you would be allowed in the state of Georgia to do a nursing function. Starting an IV, drawing blood, and all would be considered a nursing function.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

But it was changed because I know there is some stuff being worked on for Certified Nurse Assistants to do some nursing skills.

Chairman Sharon Cooper, House of Representative

Right, but that was specifically for them and that was on giving meds, but that's what brought it up which was really, really a fight.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And we know what we are asking is not an easy wave the wand [sic] and it's done ask. We are just trying to bring Georgia up to the national standards and with the other states.

Chairman Sharon Cooper, House of Representative

Well, I am just trying to tell you that every complication that brings that up is a major roadblock having to go through.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And I do know the certified nurse-midwives, ACNM, and the advanced practicing nurses do have CNR bill and are supportive, and you're saying this is a different organization of nurses?

Chairman Sharon Cooper, House of Representative

This is a different organization, and I beg to disagree with you. The lobbyists for the nurses told me that that wasn't true, the ones that have master's degrees, that they were not in support of it.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

There are two (2) bills circulating. There's a senate bill [SB 267] that has nothing to do with us, and then our bill. I am open to having conversations if you wanted to facilitate.

Anna Wrigley Miller, Office of Planning and Budget

We will invite them to the next meeting.

Chairman Sharon Cooper, House of Representative

I think they were very specific. They were not talking about doulas, and as the nurses with master's degrees, they know the difference between the bill in the Senate, which is about doulas. Which wants to allow…

Paige White, Certified Professional Midwife (CPM) and Applicant Group

They're calling themselves midwives, and they're not midwives.

Chairman Sharon Cooper, House of Representative

Right, but we know what they are and the nurse midwives because they're doulas. They want to be able to do everything you do and everything the doctor does and be paid what the doctor gets. They are talking it even further, and they are backing it off the fact of your bill.

Anna Wrigley Miller, Office of Planning and Budget

We do our due diligence to try to reach out to all groups, so we have reached out to the nursing board. I don't know if they are here to speak today, but they will. We have reached out to the OBGYN group, I don't know if they are here today, but they will hopefully speak at the next meeting. We will add the certified nurse midwives.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Sure. We are open to talking, you know, because we have had some conversations.

Chairman Sharon Cooper, House of Representative

Sometimes individuals may act like they're speaking for the board, so not that y'all are telling a different story, but you might get it from an individual or two (2) or three (3) individual nurse-midwives who are perfectly fine for you to do that, and then when you get collectively. That might be it.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Yeah, we might be. I was thinking it was from ACNM board members.

Chairman Sharon Cooper, House of Representative

As you begin to put a bill in, and since I've talked to you, these things come to me about every bill. It's not just this bill. When a bill comes, all of a sudden everybody that hasn't brought anything about anything is knocking on my door to talk to me about the pros and cons of the bill. So, I'm not picking on you, I'm just telling you the way it works down here, and Representative Mathiak can tell you that's what happens to people.

Anna Wrigley Miller, Office of Planning and Budget

I think we have a couple more questions, but I have one quick clarification. On the topic of things that nurses do as well, IVs we talked about. Suturing, you guys obviously do suturing?

Tracey Cuneo, Certified Professional Midwife (CPM)

It is within scope of practice.

Anna Wrigley Miller, Office of Planning and Budget

It is within scope of practice?

Chairman Sharon Cooper, House of Representative

It's within *your* scope of practice.

Tracey Cuneo, Certified Professional Midwife (CPM)

It is within the national certification for the Certified Professional Midwife. It is something that we're trained in. It's something that we're tested on, and it's something that we are evaluated on.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And the nurses wouldn't do stitching in a birth setting.

Chairman Sharon Cooper, House of Representative

But when you say that it's within your scope of practice, let me explain the scope of practice for you because if this bill makes it to my committee for a hearing, you're going to hear these kinds of things if it makes it. Any group can set up their own scope of practice. When there was some discussion about the certified lactation specialist, there was a company that does a course for a week where they never touch a mother or a baby. Turns them out. It's fine if they want to go out and talk about why breastfeeding is good and mothers should do it, that kind of thing, but they never touch a mother and baby. That company, because of this bill we had, wrote up and sent to us their scope of practice, and their scope of practice was an exact replica of what these lactation specialists did. Anybody can write a scope of practice. Because your group has written its scope of practice does not mean that we would honor that as a scope of practice, or that it would meet our standards as a scope of practice. I just want you to know that.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Sure.

Missi Burgess, Certified Professional Midwife (CPM)

If I can interject, an important thing that I don't think has been said but is in the information that you've received that the same organization that. I don't know if accredits is the right word, the CPM certification from NARM, North American Registry of Midwives, is the same organization that provides the accreditation for ACNM, which is the nurse-midwives, meaning all of the requirements have been

evaluated on both sides by the same people. I think you'll find there is never a case where you will attend weekend workshop for something, never touch a mother or a baby, and that would then be included…

Chairman Sharon Cooper, House of Representative

Oh, I wasn't implying, I was just using that as an example that they wrote their own scope of practice when they were giving a service that never touched a mother or baby.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We have taken on the scope of practice of NARM, which has been around since nineteen ninety-four (1994). So, we are definitely not creating ours inside of Georgia. We definitely want Georgia to approve our scope, so.

Chairman Sharon Cooper, House of Representative

Right, and Georgia reserves the right. We do on all of the specialties. We do change what they can do. We, as a state legislature, can make the regulations and the rules totally. We can say even if they said it's in your scope of practice that you cannot do it, and we do that across the board. We can tell Representative Mathiak that chiropractors can't do this, or they can do it. That's her profession. That stays with the Georgia law despite what your scope of practice is. The main thing that I was worried about is anybody can write a scope of practice.

Kelly Dudley, State Accounting Office

So, if everything was straightened out and this came to a licensure, and this might be more of a question for you, Gabe, I'm curious if you guys are aware if that were to come true what the cost for you is, as far as licensure, and then on the opposite side, does that also mean that that's reimbursable by either Medicare, Medicaid. How does that impact our larger programs? I think that is a multifaceted question for different answers.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We do understand that there would be a licensing fee for each midwife as they were applying for their license every two (2) years. I do have a handout that's from two thousand and eighteen (2018) that, every state that licenses, it listed the fee each year or every two (2) years, for that midwife individually. Then it also estimated the startup, first-year program cost for that. It is on your flash drive and in the application and the binder.

Anna Wrigley Miller, Office of Planning and Budget

And to the Medicaid thing, of the thirty-four (34) or thirty-something states that license professional midwives, about half of those allow for Medicaid reimbursement through a waiver process.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

It would definitely be a two (2) part issue. We are not saying license us and for sure give us Medicaid coverage. We understand it's a process…

Anna Wrigley Miller, Office of Planning and Budget

That's what the bill says now. As the bill is currently written, that's what it says now.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Yes, I think we're under the understanding that that would be a discussion in committee for a lot of things.

Chairman Sharon Cooper, House of Representative

Right, but that is your goal?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

It would be beneficial to the community. I hear a lot of people saying they wish they could have a home birth, but they have Medicaid, so they are having to stay within a hospital.

Chairman Sharon Cooper, House of Representative

But it is the goal, is to be paid by Medicaid?

Gabriel Sterling, Office of the Secretary of State

But you also listed that home birth was about what percent lower than hospital birth?

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Price? About one-third (1/3) the cost.

Gabriel Sterling, Office of the Secretary of State

So, for Medicaid, it could be a savings for the state.

Anna Wrigley Miller, Office of Planning and Budget

Right, so OPB is doing, with Audits, a fiscal note on it, right now. It takes a minute because we have several others in the docket that we are trying to work through right now. DCH is getting us that estimate. We may see a cost savings on the Medicaid side because it's less, but we do not know yet. I am hoping to have that fiscal note by our next meeting on the thirtieth (30th).

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Thank you.

Christina Ferguson, Department of Public Health

Are you all going to be required to maintain liability insurance? I think the bill addresses that?

Missi Burgess, Certified Professional Midwife (CPM)

Your application specifically asked a question that I thought was really interesting, "what parts of regulation would be prohibitive to people entering our profession," and that would be prohibitive. Because our practices are so small, most out-of-hospital providers cannot afford liability insurance. Currently, two (2) states out of the thirty-three (33) require it, and I wouldn't say there have been good outcomes from that for anyone, consumers or professionals.

Jessica Simmons, Department of Revenue

So, currently, you do not carry any insurance?

Missi Burgess, Certified Professional Midwife (CPM)

No.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

There are none available. [sic]

Chairman Sharon Cooper, House of Representative

What? How can two states require it?

Jessica Simmons, Department of Revenue

That is a great question. How can they require it if it's not available?

Missi Burgess, Certified Professional Midwife (CPM)

Oh, it is available.

Gabriel Sterling, Office of the Secretary of State

I think that was the point of bad outcomes; they don't have it.

Missi Burgess, Certified Professional Midwife (CPM)

Right, I imagine you'd have to be a licensed provider in order to get insurance.

Chairman Sharon Cooper, House of Representative

That's what she was asking, if you got the licensure.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

I don't know of any that write policies in Georgia for out-of-hospital work.

Chairman Sharon Cooper, House of Representative

Well, they probably wouldn't if you are illegal. We're talking about should the bill pass, and it become a licensure thing, then we are discussing it. I can tell you, Georgia has one of the worst litigious,

apologies to all the lawyers in the state and here. We are one of the most litigious states in the country. It is one of the problems in this state. I believe that would probably be a requirement from the committee that you carry. I know what it costs obstetricians to carry it, but they carry it because it's a patient protection, sometimes misused when an act of God gets a baby here that has a problem. But there are times when there are reasons that a family should be compensated. I believe in all equity that would be something that would be required of you despite what every it cost, and to show that proof every year and that it be kept up and all. I missed this, but what board are they thinking about being put under? I've forgotten.

Anna Wrigley Miller, Office of Planning and Budget

The bill is vague and does not actually specify a board, so what we have been doing the cost estimates as is SOS. Secretary of State.

Chairman Sharon Cooper, House of Representative

I think that is probably a little inappropriate. This is a medical; I mean, I don't know, not anything against them.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

That document from two thousand and eighteen (2018) lists all the different boards. The states vary, you're right. There are some states that do other boards.

Anna Wrigley Miller, Office of Planning and Budget

But the bill is not specific at all right now.

Gabriel Sterling, Office of the Secretary of State

It said Department of Health, that's which one.

Anna Wrigley Miller, Office of Planning and Budget

Yes, the applicant survey says Department of Health right now. That could be four (4) different things, so there's not a specific one that we were looking at.

Chairman Sharon Cooper, House of Representative

I've read the bill, but it's been a while and had a few bills since then.

Jessica Simmons, Department of Revenue

Quick question, I think you almost hit the nail on the head. You were going through who accredits these different groups, who accredits MEAC?

Missi Burgess, Certified Professional Midwife (CPM)

The Federal Department of Education.

Gabriel Sterling, Office of the Secretary of State

You're getting to see the sausage making process that goes along with these things. To put not too fine a point on it, in May there was an issue with a CPM in Dearing, Georgia. I am sure you all are aware of it. Last month, our office took over the investigation, so I can't go into too many details, but the woman came in, it was an immigrant family, and had a sixty (60) hour labor. The child died in utero about ten (10) hours before actually coming out. It was a CPM. A licensing board could have settled some of these things like you said; you'd want to look at those things. With your certification alone doesn't do it; it requires good people trying to do good things at the right time to get the best outcomes. I think everybody here wants to see that. I think everyone wants to see an expanded group of people who can give this kind of service, especially in rural areas like where I said. In southwest Georgia, we have one hospital, so it's hundreds of miles for some people to have to go. There's a lot of work to still be done on this. Chairman Cooper has brought up several issues that are going to come up even if you get this bill passed. She is right, I can about guarantee you, this legislature will make you have liability insurance to do this for some of these cases. I don't think this is going to be a fast process, but I think you're doing the right things and the people up here are trying to ask the right questions. I want to say from our office, we look forward to continue having these conversations and bringing in some of the other outside groups and the other nursing groups to say what can and can't be done. You're right, there's real world and then there's rules, so I like the flexibility of rulemaking over statutory oftentimes, and I think some of this stuff is a little clunky right now. We can probably work to make it a little better moving forward.

Anna Wrigley Miller, Office of Planning and Budget

Representative Mathiak, are you wanting to speak briefly to this?

Karen Mathiak, House of Representative

If you don't mind.

Anna Wrigley Miller, Office of Planning and Budget

I don't know how many people are here today from the public to speak to this. There are a lot to speak? Okay. We will try to keep everyone to their time. Briefly tell us, and then we will have everyone else come speak that would like to.

Karen Mathiak, House of Representative

Thank you so much for allowing me just to speak. A lot of what they talked about brought up some questions that I wanted to talk about. I think with the insurance liability if it moves into that, the insurance companies are going to want somebody to be licensed. If you're not licensed, you can't buy liability insurance, so I think that's gonna take care of itself, especially if it ends up with a Medicaid waiver, they're gonna want that. I believe O.C.G.A law will, when you talked about specifics, I think they're gonna want the midwives to keep files for ten (10) years rather than six (6), just a little thing like that. E.M.T.s (Emergency Medical Technician), are they allowed to do sticks? I think they are. Then, in Lab Corp and some of the other labs, those are phlebotomists that do the sticks there, is that correct?

So, we can kind of look at that licensure. You talked about reviews, and how long are those kept and where do those go? Do those go to CDC? Some of the reviews, I was interested in that.

Cassie Scoggins, Office of Planning and Budget

It varies by state. At the next meeting, I can bring a more in-depth review of it, but basically, it's going to their department of public health or wherever they release them for.

Karen Mathiak, House of Representative

I think that's gonna help secretary of state with some of the statistics.

Gabriel Sterling, Office of the Secretary of State

Or whomever gets this at the end of the day. I am making no predictions one way or the other on that.

Karen Mathiak, House of Representative

Another thing, when a CPM delivers a baby, that birth registration goes through that county. I think that's where a lot of information, Paige, when you were trying to find that, I am assuming and we know what that does, those statistics go to CDC also,

Chairman Sharon Cooper, House of Representative

Which ones?

Karen Mathiak, House of Representative

When they certify a birth because it's the midwife that signs the birth certificate that goes to the Department of Health locally, correct?

Chairman Sharon Cooper, House of Representative

I don't know that it goes to CDC.

Karen Mathiak, House of Representative

Where does that information go from the county?

Chairman Sharon Cooper, House of Representative

I think it's kept in the counties

Karen Mathiak, House of Representative

Okay, so CDC never sees any of that?

Chairman Sharon Cooper, House of Representative

It goes Vital Records, but it doesn't go to CDC.

Karen Mathiak, House of Representative

So, we can get some statistics…

Missi Burgess, Certified Professional Midwife (CPM)

It is listed as home birth intended.

Karen Mathiak, House of Representative

Right, Missi, when we were trying to distinguish between intended home birth and accidental home birth.

Missi Burgess, Certified Professional Midwife (CPM)

That is why I feel very confident that that number is intended home birth because in the state of Georgia, that is how it is reported. In some states, it's not reported that way. It gets kind of confusing, but for a while and definitely for that time period that we stated, it has been reported as intended home birth.

Karen Mathiak, House of Representative

When we talked about the formulary, Chairmen Cooper with the medications, the schools that specifically Tracey went to in Utah, there is statutes formats, and I would like to revisit that also. You were asking about the formularies…

Chairman Sharon Cooper, House of Representative

What they left them do? Yes. I imagine that Utah is very generous. Utah is a little different because of the Mormon faith, the multiple wives, and few things that have gone on in the past. I mean, they tend to be an outlier. Not that they're not good, I don't mean that. The Mormon faith is a wonderful faith, not to be so careful, but I have good Mormon friends. They have been, because of their beliefs, being self-sufficient, and that kind of thing, have been more open and generous with what they have allowed to occur.

Gabriel Sterling, Office of the Secretary of State

Are you saying that Georgians aren't open and generous?

Chairman Sharon Cooper, House of Representative

I doubt, do you have a stockpile of food where you can take care of your family for a year.

Gabriel Sterling, Office of the Secretary of State

I do not.

Chairman Sharon Cooper, House of Representative

Okay, that is the kind of thing that the Mormon faith believes and would probably be good for all of us to have for our families. But because of that, I think there's been a little bit more openness, and

certainly not saying it's bad, or good, or otherwise. I am just saying it is the way it is, so they have been more open to.

Missi Burgess, Certified Professional Midwife (CPM)

They actually utilize their midwives really well. They give them the equipment to do the newborn hearing screenings. They give them the equipment to do the newborn critical congenital heart defect screenings. They pay for the newborn metabolic screening, which is the one you were referring to.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

We're all nationally trained to do those skills and would love to be able to do them.

Chairman Sharon Cooper, House of Representative

You better stop because in Georgia, they'll think that's gonna be down the road and it's a nose under the camel. You better stop.

Missi Burgess, Certified Professional Midwife (CPM)

In Georgia, our unique needs are we have women who face barriers to access to care. They cannot physically get to where they need to be. We are mobile healthcare providers for those women.

Chairman Sharon Cooper, House of Representative

You didn't come I don't think, have you been to my office? I just don't recognize you with your clothes on. With nurses, I can say I didn't recognize you with your clothes on.

Karen Mathiak, House of Representative

Can I corral all of this and then I'm done? NARM seems to be the big umbrella to help us to make sure we have academia, clinic, and hands-on. I want us to really look at NARM, the other thing I would like to encourage you, as I got involved with nurse-midwives and CPMs and home birth and all of that, Chairman Cooper said I was a chiropractor, I've dealt with home births for almost thirty-five (35) years. Tracey was the one that kind of interviewed me many years ago because it is such an outlier, like you said Chairman Cooper. I think that with the temperature of Georgia, and us loosing mothers almost a year after birth, some of the statistics we've looked at, they go as far as a year. We cited forty-two (42) days, I think that's what you said. I think that as we as citizens really look at what we're trying to do to help healthy babies and healthy mothers, especially in our rural areas, I am hoping that this is gonna help put some CPMs in our rural areas where we don't have the hospitals and we don't have the prenatal care. I'm in Griffin, Georgia. I am only forty (40) minutes away from Atlanta, and I am amazed at the women that don't have prenatal care. That is another conversation for another day, but the waivers and some of the things that we're looking at down the road are gonna help. That's one of the reasons I wanted to tell you why I got involved in this specific bill. I agree, we do have some tweaking to look at.

Chairman Sharon Cooper, House of Representative

Representative Mathiak, I want to respond to that. You know, I'm the co-chair for the maternal mortality committee that is going on now, and in preparing for that… and Georgia's numbers that are out on the website are not correct. We did not, for the years they put out, we did not have two hundred and five (205), we had one hundred and one (101) after they were reviewed. Part of our problem and a part of the problem that's leading to an increase in maternal mortality is the general poor health of the country and of mothers and late deliveries, and it's affecting women of color more so, about three (3) times more, than Caucasians. One of the problems is that especially in our outlying areas, we are seeing more problems with diabetes, high blood pressure, so that they are not normal deliveries and where we are more likely to have complications. So, in trying to make sure we have as few mortality deaths as possible, we are dealing with people who need more expert care. It seems like it's continuing with the obesity problem. I mean, I have read so much about this and we are getting into it. It's changing, and it's changing across the country because of the poor health of Americans. It is a real problem. And mothers waiting later, the later you wait to have a baby, the more complications. So, we are moving from more, what we would consider normal, to people who have more complications, and those complications are coming very late, when they are stroking and the delivery process, or the eclampsia is occurring. It's occurring at the last minute when there was no tremendous warning that they're having problems. I mean, this is a very complex problem trying to make sure that we are very careful about this. That has added to the complexity of this discussion with what's going on with the maternal… and it's rising across the country and it's rising here. It came down from the nineteen hundreds (1900s) when most deliveries were at home and almost bought them out on loosing mothers. Now, as we got medical care and they bottomed out, we are seeing it start to go up all across the country. I think it is because of the poor health. This makes it much more difficult as we consider these kinds of changes.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

I think we are pretty much done. I just wanted to say, our hope is that the low risk women, we can care for to give the OBs that need to be focusing on helping women with these complications that we can take some off their plates.

Chairman Sharon Cooper, House of Representative

That was the other thing. When you came to me, you said that the ones that you have now, that you know are doing this, that you know offer basically in the Metro area.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

There are some in other counties.

Chairman Sharon Cooper, House of Representative

But you told me they were mainly, there were not many in the rural areas.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And that is because of the lack of licensure. To practice in a rural area, where you don't have a super close hospital, if you were to have to drive a distance to get women help…

Missi Burgess, Certified Professional Midwife (CPM)

And you don't have access to emergency medication, for example.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

There is more of a risk for a negative outcome because of that, so doing that unlicensed without the state understanding what we're working with is very risky for us.

Tracey Cuneo, Certified Professional Midwife (CPM)

There are women who want to become CPMs in rural areas, but because of the lack of licensure, they are waiting to have that happen.

Chairman Sharon Cooper, House of Representative

But they are still going to have emergency situations and lack of a hospital, lack of quick medical care, lack of assets.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

And most of the time, emergency saving medication would help or get them to the hospital.

Missi Burgess, Certified Professional Midwife (CPM)

To stabilize them for the hospital care.

Anna Wrigley Miller, Office of Planning and Budget

Okay, thank you, guys. We'll have, probably, another robust discussion. Our next October thirtieth (30th) from eleven (11) to twelve (12), and we're going to do the final votes on those other two (2) bills. Then it will just be you guys for the entirety. Like I said, we are going to do our best to have the fiscal note done by then, if not, I will have some cost estimates, if it's not done. We'll try to reach out to other groups that we were talking about, but that will be how we will move forward.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Thank you.

Anna Wrigley Miller, Office of Planning and Budget

For those of you that signed up to speak, can you come up and briefly do that. I have Kay Johnson. Oh, it is our certified nurse-midwife. Because we are pushing on time, I am going to limit you to two (2) minutes.

Kay Johnson, Certified Nurse-Midwife

My name is Kay Johnson. I am an Emory grad. I worked since nineteen eighty-four (1984) in midwifery, and until ten (10) years ago, I was in the hospital for all of those times. I started doing home births with CPMs in twenty eleven (2011). I have never questioned the skills of the CPMs that I worked with. They clearly have the same midwifery training that I have, and they have much better clinical skills

starting up than I did as a nurse-midwife. I saw twenty (20) births. I did twenty (20) births. I think it's a shame to waste the passion and the education and the experience that these women have that we need so badly in Georgia because they not only take care of low risk women, they know how to keep them low risk. So, midwives in general, as a nurse-midwife that was a part of my training too. You set up a situation where I lose a patient if she gets sick instead of a doctor who makes more money if you get sick. So, the incentives for the midwives to keep the patient normal, to make sure that her diet is good, to make sure her lifestyle is right, that she's self-regulating things so that she doesn't, if her blood pressure… And we see them often enough, we spend an hour with them in a home birth. We talk about their family's involvement. We have a very good idea of what their medical history is, it's not just something that the tech put on a piece of paper that we look at in the five (5) minute visit that we have with them, so I think we are wasting these women. They are passionate, and they want to take care of pregnant women, and they love what they're doing, and they're willing to drive.

Anna Wrigley Miller, Office of Planning and Budget

Sorry, that was your time. Thank you, Kay. I am terrible at reading handwriting. Crystal Hanner?

Crystal Hanner, Certified Professional Midwife (CPM)

It's funny because I misunderstood what I was signing up for, but it's okay because I'll be happy to. I thought it was a sign-in, let us know you're here. I just followed Kay and blindly did it. I am Crystal Hanner. I am a CPM. I live in East Point, Georgia. I certified in two thousand and eighteen (2018). I too attended the same school that Missi and Tracey did. I just want to speak a little to our job, we are constantly triaging through prenatal care, through labor, through delivery. It's when you are one on one with a client or patient, whatever you want to call them. We really do, we've gone over every detail of their health history. We are not caring for three hundred (300) women at a time, you know, we have these few women within their dates. It is a simple set of skills that we are really good at to maintain that we are caring for the low risk women. Women are going to have babies at home, whether they have a trained, skilled provider or not. We want to fill that gap to assure that those women do have someone with them that has been very specifically trained to keep them in a safe space while they are having their babies at home.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Next, Bethany Sherrer?

Bethany Sherrer, Medical Association of Georgia

Hi. I am Bethany Sherrer with the Medical Association of Georgia. We are the largest physician organization in the state. We have just over eight thousand (8,000) physician members. We cover physicians across all specialty areas and all practice settings. I will be brief, and I am happy to speak more next week or bring in an OBGYN. I do take a little issue with the idea that physicians are happy that their patients might get sicker. I just had a baby last year, and my OB got paid exactly the same amount no matter what happened. Okay? So, for her, it didn't matter if I got sick. She got a lump sum for taking care of me, and that is how most OBs set up their delivery practices. So, they don't get more money if they have a sick patient. They do get more money when they have a cesarean, but there's nothing wrong with women having cesarean births. If that is what's safest for a woman, then there is nothing

wrong with a woman having a cesarean birth. I think that we need to be careful about the language we use around inductions, or cesareans, that doesn't make a birth bad or less safe. I do want to point out that there is recent research that also states, that was in the journal of perinatal medicine, that talked about the difference in infant mortality. I will, granted it is difficult if you are a data person, you know, when infant mortality is so low, sometimes the data gets skewed, right? So, we don't always have good data. This is the same problem we have when we discuss maternal mortality. I do think it's an important thing, and this said that there were, for midwife attended home births, there were thirteen (13) fatalities for every ten thousand (10,000) deliveries, whereas there were six (6) deaths for every ten thousand (10,000) hospital deliveries by a doctor. So, I just think it's really important that we look at all of the research and we're happy to share more of our information that we have and bring in a physician if you like.

Anna Wrigley Miller, Office of Planning and Budget

So, the next meeting is the thirtieth (30th), bring them.

Bethany Sherrer, Medical Association of Georgia

Absolutely, thank you.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

Are the comments a part of the notes and the recordings?

Anna Wrigley Miller, Office of Planning and Budget

Yes, it is all.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

I just want to be able to reference that website. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Next, Lindsay Lammers?

Lindsay Lammers, Ph.D. in Biochemistry and home birth client

Hello, my name is Lindsay Lammers, and I have a Ph.D. in Biochemistry. I first wanted to share that women should have the option to have a hospital or a home birth. If a woman has a healthy pregnancy, there is no reason why having their baby at home under the care of a midwife trained in out-of-hospital births should be prohibited. I'll share the story of my son's birth that happened just seven short months ago. I planned to have a home birth with a Certified Professional Midwife in Athens-Clarke County. Like many people, being in a hospital is not a particular restful or enjoyable place to be, so I was looking forward to going through labor in the comfort of my home. Additionally, the prenatal care I received from my midwife was wonderful and made me feel informed and confident in what my body was going through. She was extremely well-trained and had experienced so many births that I had no question of whether she could handle any situation. As it would happen, during my labor the heart rate of my baby dropped, and my midwife immediately made the decision that we should go to the hospital.

I had been seeing the Certified Nurse Midwife associated with the hospital as backup just in case of an emergency. They met us there and were ready to help. Fortunately, my son was just a little bit stuck, and he was born healthy and screaming in forty-five (45) minutes after arriving. My home birth midwife accompanied us to the hospital, and there was great collaboration between the midwives at the hospital and the OB that assisted me. The hospital midwife was impressed with the professionalism and experience my home birth midwife had. Ultimately, I had a great experience and was glad that I was able to labor at home and was also happy with the hospital care that I received. If I have another healthy pregnancy, I will definitely choose home birth again. I share this story with you because I want to highlight how home births and hospitals can coexist. It is important for a woman to have the option of home birth, but it also needs to be in a safe space where there is mutual respect between all licensed, trained medical professionals. This can only happen if Georgia recognizes and licenses Certified Professional Midwives. All births are beautiful and should be honored by licensing professionals who ensure babies are born in supportive and safe environments.

Chairman Sharon Cooper, House of Representative

I have a question. Okay, you said you delivered in forty-five (45) minutes after getting to the hospital. How long did it take you to get to the hospital?

Lindsay Lammers, Ph.D. in Biochemistry and home birth client

We only live ten (10) minutes from the hospital, so it probably only took five (5). My husband drove us, and the midwife was in the car with us.

Chairman Sharon Cooper, House of Representative

I figure he probably flew. How long had you been in labor?

Lindsay Lammers, Ph.D. in Biochemistry and home birth client

I had been in labor for seven (7) or eight (8) hours. I had been pushing for one (1) hour until the baby had been dropping through, and I was probably pretty close. I could see the hair on his head, and at that point, he came out with his arms like this. [sic] He was pinching the cord when he was first…

Chairman Sharon Cooper, House of Representative

How low did the baby's heartbeat drop?

Lindsay Lammers, Ph.D. in Biochemistry and home birth client

I don't know. I wasn't paying attention, but because we went to the hospital, the hospital was able to let the baby's heart rate drop much lower than we were comfortable doing at home. So, they were monitoring things and let things go.

Chairman Sharon Cooper, House of Representative

For forty-five minutes?

Lindsay Lammers, Ph.D. in Biochemistry and home birth client

Yes.

Chairman Sharon Cooper, House of Representative

Weren't they prepping you for delivery in the delivery room during that time?

Lindsay Lammers, Ph.D. in Biochemistry and home birth client

I was pushing for forty-five (45) minutes at the hospital and they used the suction cup to pull him out.

Paige White, Certified Professional Midwife (CPM) and Applicant Group

I will say, I was not her midwife, so I don't know about her story, but when we have a heart rate that's dropping below the normal range and moving the mom does not fix that, we are quick to go in. That is the early stages.

Chairman Sharon Cooper, House of Representative

Would her next birth be considered a normal birth? She's had a problem. I know the cord doesn't always get wrapped, I taught OB, so I know a little bit about it. I am asking the midwives.

Missi Burgess, Certified Professional Midwife (CPM)

I think any care provider, hospital or out-of-hospital, would still consider her low risk because it was a position problem. There are things that make someone a higher risk that are more likely to occur again, like preeclampsia, something like that.

Chairman Sharon Cooper, House of Representative

Okay, just asking.

Missi Burgess, Certified Professional Midwife (CPM)

Also, first (1st) time moms push for a really long time, and so her next baby is probably going to come out a lot faster.

Anna Wrigley Miller, Office of Planning and Budget

Well, thank you guys, everybody, for being here. This is a something people have very strong emotions about, so I appreciate everybody's decorum during this. Again, our next meeting is the thirtieth (30th) here in this room from eleven (11) to twelve (12). If you didn't get a chance to sign up to speak this time, please sign up next time and I will be sure to allow you time to speak. There is a piece of paper at the front. It will be there.

Chairman Sharon Cooper, House of Representative

I know people are emotional about it, just like Lauren's new mother from the Medical Association [sic] is passionate about it, but you have to realize when we make these kinds of decisions,

we are making them for all Georgians. When we vote on bills, that’s a very big responsibility. We have to look at all the sides, not for just the group of mothers that want to deliver at home, but we have to look at everybody. Even though the questions to you may seem that we are against you, that's not the way it is. We take in extreme responsibility in making the decisions we make down here on many, many issues. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Thank you.