Anna Wrigley Miller, Office of Planning and Budget

We have a member present on the phone, so please speak clearly and do your best to keep crosstalk to a minimum because, again, we're recording and it gets really complicated. Plus, we have a very large and full room today.

First of all, at our last meeting, we voted on the report for House Bill Four-Seventeen (417). Then we read through the findings and developed recommendations for Five-Sixteen (516) and Senate Bill Seventy-Five (75). Today, we are going to discuss those reports in detail in just a few minutes. And then we had our first introduction to House Bill Seven-Seventeen (717), and that lead to some robust conversation. Today, we have another presentation from Paige, Missi, and Tracey. They're going to answer some more questions. Then we have some other groups that are signed up to speak. We'll hear from them, and then I'll open it up for public comment.

I sent out the meeting minutes to everybody last Friday, so if I could have a motion to approve the minutes.

Alan Powell, Georgia House of Representatives

So move.

Gabriel Sterling, Office of the Secretary of State

Second

Anna Wrigley Miller, Office of Planning and Budget

All in favor?

On the motion to approve the minutes, nine (9) votes for aye were cast, zero (0) nays, and zero (0) Absences

Okay, great. We have a lot of papers on our desks, so I am going to try to orient you to everything. Basically, the packets that are not in folders are from OPB. We're hopefully going to go in order, so we're going to start with House Bill Five-Sixteen (516), and then behind that is a letter from Darren [Mickler, Executive Director of the Professional Licensing Boards Division of Secretary of State]. Basically what I want to do is read through, it's going to be really brief for you guys, I am going to read through kind of what we came up with in the findings.

We found that it is recognized that the practice of structural engineering requires specialized 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 that they have obtained and will 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 the proper education. 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 delineation through rulemaking; only a statutory change could create the structural engineering designation.

And then our recommendation is, after consideration of the findings above, the council recommends that House Bill Five-Sixteen (516) pass as currently written.

So, is everybody okay with how that is?

Gabriel Sterling, Office of the Secretary of State

Madam Chairwoman, I move we adopt the report for House Bill Five-Sixteen (516).

Anna Wrigley Miller, Office of Planning and Budget

Okay. Is there a second?

***Multiple seconds were offered ***

Okay, all in favor say, "Aye."

On the motion to approve the final report for HB 516, nine (9) votes for aye were cast (Kelly Dudley via conference call), zero (0) nays, and zero (0) Absences

Kelly Dudley, State Accounting Office via conference call

Aye.

Anna Wrigley Miller, Office of Planning and Budget

Thanks, Kelly. Okay. Thanks, you guys. I will have this posted on our website as soon as possible, probably today, but by tomorrow. We've just got to get it loaded online.

Ashley Jenkins, ACEC Georgia

Thank you. We appreciate it.

Anna Wrigley Miller, Office of Planning and Budget

Thank you, guys. Now, we are going to take Senate Bill Seventy-Five (75) the same way. The findings that we came up with were the profession of veterinary technician

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. The practice of veterinary medicine takes specialized skill, and 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 that they need without the cost burden being on the state.

Our recommendation is, after consideration of the findings above, the council recommends that Senate Bill Seventy-Five (75) pass as currently written.

Jonna West, Department of Agriculture

Madam Chair, I move to approve as written.

Anna Wrigley Miller, Office of Planning and Budget

Great. Second?

Multiple seconds were offered

All in favor say, "Aye."

***On the motion to approve the final report for SB 75, nine (9) votes for aye were cast (Kelly Dudley via conference call), zero (0) nays, and zero (0) Absences ***

All right. Thank you. And again, I will have this online as soon as we can get it online, so probably today but maybe tomorrow.

Katie Roberts, Fiveash-Stanley, Inc.

Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Okay, we just ran a marathon through that, so let's get to what the rest of the meeting today is for. How I'd like to handle this… And thank you, Chairman Powell.

Alan Powell, Georgia House of Representatives

I want to thank you, Madam Chairman. I'm gonna leave y'all to this body of constituents.

Anna Wrigley Miller, Office of Planning and Budget

Okay, so we have, again, several individuals here to speak to this bill, and as a statement, everybody please be respectful to the person who is speaking at the time. This is a large room. It can be easy to drown out somebody who is at the microphone. So, be respectful of whoever is speaking at the time. A note to the fiscal note, we do not have it because we are still waiting on Medicaid data. However, as I promised, we do have Secretary of State data. Gabe [Sterling] is going to talk about that in a minute. A note of that, the bill did not specify where exactly this board was going to be located, and it was defined as an advisory board, but the duties mirror a professional licensing board, so the estimate that Gabe put together is as a professional licensing board. Do you want to talk through that now?

Gabriel Sterling, Office of the Secretary of State

In fact, since it was listed as an advisory board, we took some assumptions that I am going to verbally put back in and walk you through it real quick. The numbers are based on estimates created for the recreational therapy licensing that we just did recently. We are estimating about fifty (50), or plus, non-nurse-midwives and about five hundred (500) nurse-midwives, we can see an estimated potential license of professional midwives at about one hundred (100) and as high as nurse-midwives at five hundred (500). Worst case, we used five hundred (500) for this estimate. Okay? The salaries include our normal F.T.E., full-price things. Based on the law, it doesn't look like inspections will be needed. We don't know that based on what the final version will be, so we left that blank for now, but understand that is a cost that could possibly be out there at some point. As another assumption that we had some vigorous debate over, for this particular thing, I am going to put out there as another cost. Since this would be a licensing board, not an advisory board as you guys constructed, I would assume there would need to be an executive director or somebody internally with the expertise on that and/or a licensing supervisor on those. Those costs are not included in here. That could add another two hundred thousand ($200,000) or so for this overall cost. We consider the overall workload and account for cases that if they are at capacity, putting fulltime people onto this. Attorney General time is included for the board meetings, startup, promulgating initial rules, the basics of the startup. Board members, staff, and others will need some training on that. That is in there, it's not a high cost, but it's a cost. There are going to be startup costs for interfacing with our licensing software through our vendor, SA, or whoever's vender it might be if this goes to some board. There is an IT vendor that is going to have to set up all this stuff. We are going to put in a contingency of say, twenty to twenty five percent (20%-25%) because often times there are things we don't know or expect. There will be shared server costs depending on where this information lives, and again, which board, or under which composite board, this might go under. We have some OSAH (Office of State

Administrative Hearings) hearing things because OSAH hearings seem to be a part of ever licensing community. We then spitballed the licensing revenue at fifty dollars ($50) a license since we didn't have anything else to go on. To start out, we are looking at system integration, support and maintenance, IT system, and rulemaking with the AG office is about $90,000 out of the gate. Now we are looking at overall operating costs, and I wont break all these things out, just the basics of it. It's licensing analysts, part of a F.T.E… With this, we have no full F.T.E.s, if it has to go to a full licensing board, there's going to be full-time F.T.E.s on this. That is just the way that it is going to be. So, this number is going to be low based on that. I am looking at closer to, with the fifty percent (50%) licensing analyst, fifty percent (50%) compliance analyst, forty percent (40%) intake support, forty percent (40%) call center, and a (50%) investigation support, that's of an F.T.E. My assumption is that these will actually run a little hire. I am trying to run a middle of the road estimate on these. That is one hundred and twenty-two thousand ($122,000) give or take. And then, other expenses, which include the training, shared server costs, OSAH hearings, AG fees for consistent maintenance, board member travel and per diem because there are always those attached, we are looking at about fifty thousand ($50,000). So, we are looking at annualized fees close to about one hundred and seventy thousand ($170,000), and to me, it is on the low-end. We are looking on the high end of licenses, of five hundred (500) licenses at fifty dollars ($50) a piece, at twenty-five thousand ($25,000). Obviously, we are running at a pretty large deficit, even at middle-of-the-road estimates. That is where we are at. Again, it's not defined in the law about where it's supposed to go. We don't know where it's going to land. These are rough estimates based on the law that's… As I mentioned before, the law is a little bit of a mess right now. It is hard for us to estimate how it this is actually going to function. Those are our best numbers. We are looking at a quarter of a million dollars ($250,000) to startup, and about one hundred and seventy to two hundred thousand ($170,000 to $200,000) a year to be continually functioning, and on the high-end, twenty-five thousand ($25,000) in revenue.

Anna Wrigley Miller, Office of Planning and Budget

Okay, thank you. Do we have question from the council to Gabe on that? And I want to clarify, how we came up with what the potential revenue would be is we looked at the current number of certified nurse-midwives, and there's about five hundred and ninety-five (595) as of last Tuesday (10/22/2019). So, we used five hundred, even though we know the estimate that you guys gave us was around thirty (30) or so people. We were trying to find a rational number to run off of. Any other questions on that? We will have a more formal fiscal note for you, Representative Mathiak. It takes time to run through all of this.

Karen Mathiak, House of Representatives

Thank you.

Gabriel Sterling, Office of the Secretary of State

And Secretary of State's office has been on the ball.

Anna Wrigley Miller, Office of Planning and Budget

That's right. Now, how I want to run the rest of the meeting. Cody, will you pull up her presentation? They have a short presentation they want to give us, and I am going to let you explain what these packets are. And then after you guys speak, I want to try to keep y'all's portion to about twenty (20) minutes because we have quite a lot of other people wanting to speak here today, and I'll give everybody the opportunity. So, if you guys want to come up. You'll have to tell us when to click to the next slide. We are having technical difficulties.

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

Missi is going to present for you guys, but let me tell you about the packets first. The first packet with a bunch of bullet points on there is just some supplemental information for you guys. It has got the MANA data. We had a little confusion last time where our data was coming from. That is all pulled from MANA, and that is the thing we talked about where everybody submits their stats to, starting during pregnancy and then submits after pregnancy. That is in there. There is an acronym cheat sheet because we were throwing around a lot of names and things. That tells us what they're about, and briefly, a little bit about them. We have talked a lot about US MERA (U.S. Midwifery Education, Regulation, and Association), so there is a handout on what US MERA is, all the players in US MERA, and things like that. Then there is more information; stuff from ACOG on licensure, there is stuff from NARM, our certifying organizations, on how they help states that are going through getting regulated, and things like that. There are labs in there. Last time, people asked about what labs Certified Professional Midwives would order, so there is something on labs. There is an ACOG committee update specifically on planned homebirth. Then, there is also a "Counties served by midwives;" there was some talk that we only serve Atlanta communities, so this is a quick polling that we put together this week of the certified professional midwives currently in Georgia and the counties that they serve. Then, the next column is their students and where they will serve upon graduation. The other packet is a physical copy of the homebirth safety briefing that we prepared and got emailed to you guys. It got emailed to you guys, so there is a hard copy if you guys want that, and please, if you guys want to give us that back at the end of these hearing processes, we'd love to recycle and use them again.

Anna Wrigley Miller, Office of Planning and Budget

And I forgot to mention to the council, in the packets that didn't have folders, we also provided the first three (3) pages of the homebirth safety packet. We didn't print all of it. We then updated the state-by-state review to include a little more information on the data that is collected and the states that require liability insurance, and I shared it with you, Representative Mathiak. We also printed out the directory of schools that are associated by MEAC, and then a letter from the Georgia Composite Medical Board on their stance on this bill, and we will actually hear from them later today.

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

Okay, our other thing is that we have a print out of all our support letters. I think you guys have been receiving them, some on the flash drive, more came in emailed to you too, and we had about one hundred (100) more turned in today.

Anna Wrigley Miller, Office of Planning and Budget

Okay, take it away.

Missi Burgess, Certified Professional Midwife (CPM)

Okay. I am Missi Burgess. I am a Certified Professional Midwife. I am also a mother of five (5) children, all born at home. Thank you so much for all the work that you guys are doing, all the information that you have compiled, all of that. It’s amazing and impressive. Paige [White] told all of the stuff that you were given. I wanted to highlight specifically the packet that you got on our briefing that we prepared for you on homebirth safety, and I wanted to explain why we picked the documents that we picked to go in there and to state clearly that we are not here to say that homebirth lacks risk. There are inherent risks to having your baby out of the hospital, and there are inherent risks of having your baby in the hospital, and we are aware of that. What it comes down to is the families in the state of Georgia continue to choose to have their babies out of the hospital. There’s a large representation of them here today, and we want that to be safe for them. That’s why we are asking for licensure. This was a part of one of our last slides, but it was really tiny and in the corner. What you are looking at here are homebirths by type of attendant, since we know that women are choosing homebirth regardless of whether or not the state is providing a way for that. These are the percentage of who is attending those homebirths. This is actually nationwide. This information came from the CDC. Two thousand and twelve (2012) was the most recent information available. We are trying to stick to a strict so that I don't go over our twenty (20) minutes, so pardon me for reading a little bit. We understand that the Georgia legislation is trying to make government less restrictive to businesses. Lack of licensure for the midwives who attend over forty percent (40%) of out-of-hospital births has meant that CPMs do not have access to order routine lab work that is within the scope of practice for a midwife, and cannot obtain emergency medication that are considered standard

provisions for providers attending birth in any setting. Again, these are not prescriptive medications. We are not asking for prescriptive authority.
Many of Georgia's CPMs are licensed in other states since Georgia does not provide recognition of our national certification. Some do that because they feel like that is one way that even though they cannot be licensed in Georgia, it's a way they can let consumers know that they're willing to give themselves to some oversight and regulation even if it's not in the state that they live in. As Paige said, there was confusion in our last meeting regarding where some of our stats came from. What we stated on that slide was correct. They all came from the MANA stats, and MANA is the Midwives Alliance of North America. They've been collecting data since the nineties (1990s). The really cool thing about this particular data set is, I don't know if you looked through the homebirth safety packet, but one of the first studies in there states the methodological problems with trying to research this. Because if you have somebody that was intending a homebirth, and they have their baby in the hospital, you're just using birth certificate data. That outcome gets assigned to hospital. Verses, sometimes you have people who have their baby at home but they weren't planning to have their baby at home, that outcome gets assigned to homebirth. So, the cool thing about the MANA stats collection of data is that you get assigned from the beginning based on where you plan to have your baby. Even if you have your baby in the hospital, that's still gets logged as an outcome for out-of-hospital birth if that makes sense. We were able to extract data for the state of Georgia.

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

That is in your packet. You have the official document reference last time.

Missi Burgess, Certified Professional Midwife (CPM)

The most recent period was two thousand and twelve to two thousand and seventeen (2012 to 2017). It included eight hundred and seventy-four (874) babies. Eight nine point five percent (89.5%) of those births occurred at home. Ten point five (10.5%) transferred to the hospital in labor, usually for labor augmentation, which means they required medications, like Pitocin to make their labor speed up because they weren't making progress, something like that, or for epidural and anesthesia. One point seven percent (1.7%) transferred after birth for postpartum issues. The mother could have been a hemorrhage or she needed fluids or something like that. Then one point four percent (1.4%) neonatal transfers. Sometimes that occurs because the babies respiration rate is too high, and you send them to the hospital because you want to have them observed, that type of thing. There were no maternal deaths and no intrapartum or neonatal deaths for the Georgia Midwives during that time period.

Gabriel Sterling, Office of the Secretary of State

What was the cutoff for the time period?

Missi Burgess, Certified Professional Midwife (CPM)

It was two thousand twelve to two thousand seventeen (2012 to 2017).

Jessica Simmons, Department of Revenue

One question just to clarify, and obviously I know it's in the packet too that sometimes trying to calculate the statistics is a little difficult because there are a lot of variables and outcomes, but just to confirm, when you are talking about the mortality rates, either infant mortality or maternal mortality, how is that calculated if somebody essentially wanted to do a homebirth but then did end up getting transferred to the hospital, but then, unfortunately, one of them did pass away? I am sure that the hospital, considering somebody passed away at the hospital, has to include that in their numbers, but does that also, based on what you said how the outcomes are reported in the MANA statistics, does that also get reported as an out-of-hospital?

Missi Burgess, Certified Professional Midwife (CPM)

No, it would be recorded as a planned homebirth outcome.

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

But when we would report it to MANA, we would report that.

Missi Burgess, Certified Professional Midwife (CPM)

We would report that they transferred, but that outcome would still get assigned to that midwife. MANA stats can be used to pull… As a midwife, you can pull your own stats for that to see how many first-time moms do I have, how many of my moms need an epidural, you know, that kind of thing, or you can look at nationwide and we had somebody pull out Georgia.

Jessica Simmons, Department of Revenue

So, it is getting included in MANA statistics, not just included in the hospitals statistics?

Missi Burgess, Certified Professional Midwife (CPM)

Right, yeah.

Anna Wrigley Miller, Office of Planning and Budget

Another clarifying point, the outcome would be transfer to hospital?

Missi Burgess, Certified Professional Midwife (CPM)

No.

Anna Wrigley Miller, Office of Planning and Budget

It would be what the actual outcome is?

Missi Burgess, Certified Professional Midwife (CPM)

Yes, the mortality would be recorded. Yeah. The elephant in the room that needs to be discussed is the one (1) perinatal mortality that has occurred this year in Georgia due to apparent negligence by a CPM. We know that the Secretary of State's office is investigating this, and we also know that we cannot and should not remain silent because it is an important part of the reason why we would like to be licensed. I cannot speak to the specifics of the case because I don't know them, but we did receive a question from someone on your board that wanted us to speak to the education and training of the midwife in question. What I can tell you is she would not be eligible for licensure under the requirements of our bill as it's currently stated because she did not meet the ICM qualifications for education. And ICM is the International Confederation of Midwives.

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

And also, licensing CPMs would make it that if a midwife did receive a license and was found to be practicing outside of the scope and outside of what the law mandated, there would be repercussions for her fellow CPMs to report such and for the state to handle that matter.

Missi Burgess, Certified Professional Midwife (CPM)

Again, we are grieved at the loss that that family suffered. The Georgia Midwifery Association has been completely self-regulated with its own standards and guidelines, and this tragic case is an example of why we are requesting oversight and help from the state of Georgia because this was a midwife that was… You know, what are we going to do? Tell her to stop? You know, we have guidelines, and she was acting outside of those guidelines.

Gabriel Sterling, Office of the Secretary of State

Just to clarify, the press reporting, which is all I specifically have as that's a separate part of the entity, reported that she was a CPM.

Missi Burgess, Certified Professional Midwife (CPM)

Yes.

Gabriel Sterling, Office of the Secretary of State

But under these rules, she wouldn't be because she didn't get the education or get enough education?

Missi Burgess, Certified Professional Midwife (CPM)

No, she'd be a CPM, but she wouldn't be eligible for licensure.

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

So, NARM is a credentialing board. That is our next slide.

Missi Burgess, Certified Professional Midwife (CPM)

Yes, NARM is our certifying organization. It is a two-step process. There is education and there is clinical experience, and you guys wanted more information on all of that so that is what we are doing and hope you don't get bored. Our nation credential is accredited by the same organization that accredits the national certification for nurse-midwives. That is the NCCA. We do not enter the field as nurses, we go directly into midwifery studies. So, one hundred percent (100%) of the time spent in education is focused on midwifery. You see there, it's three (3) to five (5) years, we have a national exam, we certification accredited…

Gabriel Sterling, Office of the Secretary of State

NCCA is not on your list of acronyms.

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

It's on the US MERA one. That's why.

Missi Burgess, Certified Professional Midwife (CPM)

National Commission for Certifying Agencies, I think it's a really redundant title. Our bill requires a MEAC accredited education or the midwifery bridge certificate offered by NARM. So, as you have read, MEAC, the Midwifery Education Accreditation Council, is approved by the U.S. Department of Education as a

nationally recognized accrediting agency. It is not required by NARM to get your CPM certification. The national exam is required, but it's not required that you go to a MEAC school.

Gabriel Sterling, Office of the Secretary of State

And to follow up, if you were licensed in another state, even if you didn't have the educational accreditations, you were allowed to get a license here. If I remember correctly, whether you wanted it in the bill originally, it was put in by somebody else?

Missi Burgess, Certified Professional Midwife (CPM)

Yeah, we are trying really hard to use the ICM language, and a lot of that was changed by legal when we gave them the bill.

Gabriel Sterling, Office of the Secretary of State

The currently bill does have that additional, available way in?

Missi Burgess, Certified Professional Midwife (CPM)

Yeah.

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

And we're working on fixing that.

Missi Burgess, Certified Professional Midwife (CPM)

I wonder if it states though that they also have to have the bridge certificate if they came from another state. MEAC provides criteria for developing a sound educational program for midwifery schools. Right now, it is the student's choice. Do I want to self-study, do I want to go to a non-accredited program, or do I want to get a MEAC education? Most students now are getting a MEAC education because that, in the most recent states, they have a twenty-twenty (2020) deadline, which we also put in our bill and legal took out, that if you were going to become a student, after twenty-twenty (2020) you better have a MEAC education is basically the standard that has been set. A lot of the newer midwives have MEAC education, and most of the current students are trying to get that right now.

Anna Wrigley Miller, Office of Planning and Budget

I have another question, sorry to interject. MEAC is accredited by U.S. DOE, the schools are then accredited by MEAC?

Missi Burgess, Certified Professional Midwife (CPM)

Yes. Do you want me to go into detail on the rigorous components that a school must meet to be accredited by MEAC?

Anna Wrigley Miller, Office of Planning and Budget

Sure.

Missi Burgess, Certified Professional Midwife (CPM)

You must measure student success with respect to the school's mission, must based its course of education on nationally recognized standards, must utilize qualified faculty for its didactic and clinical education. Yes, our pharmacology instructors have Ph.Ds. That was a question last time. Maintain appropriate facilities, equipment, supplies, and other resources, practice sound financial management, provide appropriate student services, establish policies and procedures regarding student affairs, include a minimum length of didactic and clinic education, have a mechanism for responding to complaints, and remain in compliance with Title IV of the Higher Education Act. The landscape of CPM education is changing. We think it's kind of exciting. Like I said, previously it was all self-study, and within the last ten (10) years it has been building, building, building to now it's a Bachelor's of Science in Midwifery. It's the lowest degree offered at most MEAC schools. There's also a Master's in Midwifery that students can go on to get. Then, if you haven't obtained the MEAC education… Oh, and I put up there that is the current major map from the Midwives College of Utah, which is where Tracey [Cuneo] and I graduated from, just breaking it down. It's broken into phases because there are three (3) phases to the clinical study for a student midwife, so their coursework goes along with the phases that they're in. The third (3rd) thing is the midwifery bridge certificate which is given by NARM, and that is for practicing midwives that did not obtain a MEAC education originally.

Gabriel Sterling, Office of the Secretary of State

To get that certificate, what do you have to do?

Missi Burgess, Certified Professional Midwife (CPM)

You have to obtain fifty (50) credit hours of continuing education in a five (5) year period of time, and those credit hours have to be granted by an accrediting organization, such as MEAC, ACOG, ACNM, AWON, AAFP, state health departments, nursing or perinatal associations. Those are all similar to the continuing education that a nurse-midwife would be required to get, basically the same requirements here for that. So it would be fifty (50) credit hours, and then there's required categories that must be met, including emergency skills and hands-on components.

Gabriel Sterling, Office of the Secretary of State

Is there a test to get to that point? Since some don't go through the MEAC education, is there a test to get that bridge certificate?

Missi Burgess, Certified Professional Midwife (CPM)

There's not another test, but usually, when you get continuing education, there are tests involved in that. So, sometimes you attend a class, a presentation, you take a test on the content in order to get the credits. Then some of these are also hands on components that they had to go get their skills checked off by someone.

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

And that's where the U.S. MERA agreement comes on, so that on a national level that they agreed on the bridge being sufficient.

Jessica Simmons, Department of Revenue

I know you mentioned it previously, but can you give us a little more information on the path… I understand the MEAC path, but more of the self-study path. I'm curious about that because I also think that getting into a licensure structure, there's obviously going to be stricter education requirements. I know you have some in the bill. I know we have a number of people here from the Secretary of State's office, but I also don't know if there are any current license types in the medical field that allow for self-study verses an accredited program. Can you walk us through the path right now, from the self-study route, how somebody would get their certification right now?

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

So, that's what we talked about. It's called the P.E.P., the Portfolio Evaluation, and that is what I did. I shadowed two (2) midwives pretty much day and night for four (4) years, and I did self-study. So, NARM does give you an outline of all the topics, not anything about them, but here are all the topics that will be on the national exam that I took. Same as they took, we all had to pass it. So, what I did is a long… all the prenatals and births and postpartum, I would study whatever came up, whatever happened. I would go by the NARM suggested study list and gathered all that information. I think I just had binders for all different phases full of information, and after my midwives signed off on all my skills, they also had to sign off that I could tell them all the medical stuff behind it. I could tell them why we were doing this, what was causing this. I couldn't just show them that I could the skill, I had to tell them the knowledge behind it too, and after I did all the skills that NARM said, I was cleared to take the exam.

Jessica Simmons, Department of Revenue

So, everybody ends up taking the same exam to get their current certification?

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

Yes.

Missi Burgess, Certified Professional Midwife (CPM)

Yeah, it's a seven (7) hour deal. You are there all day with a proctor. You don't sleep the night before. Does anyone else have question about education?

Christina Ferguson, Department of Public Health

I do. The list that you provided us for routine labs in pregnancy, it's pretty extensive. Are these the tests that you all are ordering, or are these the tests that certified nursing-midwives are ordering?

Missi Burgess, Certified Professional Midwife (CPM)

Those are just standard labs that anyone that's doing thorough prenatal care should get.

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

As a licensed Certified Professional Midwife, they would order those labs. In other states, they are ordering those labs.

Christina Ferguson, Department of Public Health

So, currently in Georgia, as a Certified Professional Midwife, are you all ordering these same labs?

Missi Burgess, Certified Professional Midwife (CPM)

No, we don't have any mechanism for ordering labs right now because we are not licensed in the state.

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

We'll help our clients. Maybe they'll get some labs ordered from a nurse-midwife, or a supportive OBGYN.

Tracey Cuneo, Certified Professional Midwife (CPM)

My name is Tracey Cuneo. These are the labs that are suggested for good prenatal care. These are the labs that ACOG agrees with for prenatal care. This is, as a licensed midwife, the labs that I would be ordering as a licensed midwife for care.

Anna Wrigley Miller, Office of Planning and Budget

So, part of what this committee does is we look for cases of harm that if unlicensed you can't do this. So, are women who are currently delivering with you guys not getting routine lab work done?

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

Some of them, yes. They can't afford to do care with an OBGYN or a nurse-midwife because of the out-of-pocket being too great then they would go without those labs.

Anna Wrigley Miller, Office of Planning and Budget

That leads me to another question, and forgive me for being blunt, but I understand that since twenty-fifteen (2015) this hasn't been legal, but I also understand from doing anecdotal research myself online, I understand babies have been being delivered by Certified Professional Midwives in this state since twenty-fifteen (2015). So, knowing that you are unable to have any admitting permits with hospitals and you can't order routine labs that are routine for pregnancy and you all aren't licensed or even technically legal in the state right now, before you enter into an agreement with a woman to deliver her child, do you guys have a disclaimer that says all of those things?

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

Yes, there are a lot of informed disclosures and informed consents that are signed, and that is a part of NARM training is they actually make us turn that in with our application that says we have actually written these.

Anna Wrigley Miller, Office of Planning and Budget

Do you walk through line by line what it means that you may not be able to get some of these testing because you aren't licensed?

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

So, mine would have, by the highlights, initials in that section.

Anna Wrigley Miller, Office of Planning and Budget

Okay. We've all bought cars though. You just initial.

Missi Burgess, Certified Professional Midwife (CPM)

Yeah, no. A hallmark of midwifery care is informed consent, and there's issues like a Vitamin K shot that the baby should get after delivery that helps its blood clot. And, in our community, you get a lot of mothers, no disrespect guys, but they are like, "Yeah, don't want that. Read on Facebook it gives your baby leukemia. I don't want it." You know, and we are like, we have crafted this three (3)-page document that tells you the benefits and the risks involved, and I don't want you to sign it until you've read it. That is typical midwifery care on any issue. They're hour-long appointments. We have a long time to discuss things and go line by line because we work really hard to compile the information and we care, and we are working one-on-one with these families. I am supposed to say, "Certified Professional Midwives are working one-on-one with families."

Anna Wrigley Miller, Office of Planning and Budget

So, I want to keep everybody moving on time.

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

You guys have this in your stuff.

Anna Wrigley Miller, Office of Planning and Budget

Really I just want to make sure if there are any questions from the committee that they feel free to go ahead and ask.

Missi Burgess, Certified Professional Midwife (CPM)

Okay, our clinical training is so comprehensive that it is difficult to cover in a brief overview such as this one. This small chart doesn't even come close to demonstrating the experience of a student CPM. In addition to the number of births you see here, CPMs are also assessed on over seven hundred and fifty (750) individual clinical skills. As you can see, the student CPM is required to attend a minimum of fifty-five (55) total births. Most students will attend many more by the time they are done with their training. Detailed logs are submitted along with the application to take the national exam. On those logs, NARM is looking to see that the student demonstrated emergency skills in an appropriate number of challenging situations. So, a student couldn't just submit, "out of these fifty-five (55) births, they were all normal. Done." NARM is going to come back to them and say, "Well you haven't really demonstrated much skill, you've demonstrated that women are good

at having babies." You have in your binders the document that gives an exhaustive list of core competencies, the core competencies for basic midwifery practice. Our specialized skills are broken into four (4) basic categories: prenatal care intrapartum care, postpartum care, and newborn care.

Gabriel Sterling, Office of the Secretary of State

My brain jumps to these when I see asterisks. The birth attendant, I see two (2) asterisks and I see one (1) asterisk under two hundred (200) hours or two (2) months.

Missi Burgess, Certified Professional Midwife (CPM)

There are asterisks there, and that asterisk got cut off of this picture, but you have the document in your binder.

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

It's not in this binder; it's in the original application.

Missi Burgess, Certified Professional Midwife (CPM)

The asterisk next to fifty-five (55) is saying the typical student does way more than that because so many of your births do not, end up not counting because of things like you didn't deliver the placenta because it fell out on its own while the mom was on the way to the bathroom, or something like that. Things like that happen.

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

So, for example, my homebirths were in the one hundred and seventy (170) range when I turned in my application.

Anna Wrigley Miller, Office of Planning and Budget

I have a question: Family practice physicians are not normally the ones delivering and not really licensed to deliver, especially in Georgia. I am just interested by OBGYNs weren't on your comparison?

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

They don't do homebirth.

Missi Burgess, Certified Professional Midwife (CPM)

These are only out-of-hospital care providers. You guys had asked for more information for specific out-of-hospital specialists.

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

We can make her add it.

Anna Wrigley Miller, Office of Planning and Budget

No, there's an OB here that can talk.

Missi Burgess, Certified Professional Midwife (CPM)

This information comes from the twenty-nineteen (2019) Georgia Midwifery Association standards and guidelines document, and demonstrates the standard clinical skills required for prenatal care. So, we see clients for one (1)-hour visits monthly until around twenty-eight (28) to thirty-two (32) weeks, then every two (2) to (3) weeks until thirty-seven (37) weeks, then it's weekly until delivery. That is a standard prenatal care schedule. The midwife will provide an initial assessment of the general health and health history of the woman. Then there are the labs that you talk about for screening purposes, routine prenatal and postpartum laboratory analysis to look for abnormal findings that may require a referral. Basically, the Certified Professional Midwife at every step of the way, all of her clinical skills are geared toward risk assessment. Is she still low risk? Every moment that we are with a client, that is what we are assessing. Is she still low risk? Ongoing prenatal care provides an opportunity for routine assessment of blood pressure, pulse, weight, the abdomens; we measure the belly with a measuring tape, we listen to the baby's heart beat, assess how the baby is lying, is it head down, sideways, estimation of gestational age by physical findings, look at varicose veins, edema which means swelling, her reflexes, and then diagnosis and treatment for any common discomfort of pregnancy. So, the word diagnosis is a little misleading there because it might be that she is like, "Every time I roll around here, its discomfort here." We are like, that's your round ligament. We aren't actually diagnosing a disease, we're talking about like you're getting a headache every time you don't drink water all day. These are common pregnancy discomforts listed there. Any questions?

Christina Ferguson, Department of Public Health

Yes, because right now you all are not able to order these labs, you maybe mentioned that sometimes you encourage the client to work with an OBGYN to get the labs ordered. You also presented a letter from a director of nursing for a NICU, it seems like, from that one letter, that there is some support from people in the medical discipline. Why don't you all build that allied health group or cohort to work

with these clients, these pregnant moms, together to get through the process, especially since you can't order all the labs that are routine?

Missi Burgess, Certified Professional Midwife (CPM)

That is being done. It's not just OBs, there's also nurse-midwives who women can see during pregnancy for things like labs and ultrasounds and things like that.

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

Anything where it was more official, there has been hesitancy because of the lack of licensure. They've stated their insurance won't let them officially work with a CPM because of our status in the state, which is one of the reasons why we are looking towards licensure so that we could collaborate more effectively with those providers.

Jessica Simmons, Department of Revenue

One follow up question to that though is that obviously if these are some of the things that you go through in the screenings, obviously it is a pretty extensive list of labs here, and if it's something that, you mentioned, some clients don't get these labs done. Without getting these labs done, how are you able to still qualify somebody as low-risk when something might be flagging on these labs that you can't see because your patient has decided that, for various reasons, that they don't do the labs? Is it possible that somebody could actually be high-risk then end up going through with the homebirth because the labs weren't done and an issue wasn't indicated because the labs weren't done?

Missi Burgess, Certified Professional Midwife (CPM)

That would be a good question for a midwife that doesn't require her clients to get labs, and I don't know any.

Jessica Simmons, Department of Revenue

So, you require all of your clients to get labs?

Missi Burgess, Certified Professional Midwife (CPM)

Well, this document is the Georgia Midwifery Association's standards and guidelines, and anybody that is a member of GMA agrees to follow these guidelines. So, I can't say that there's not a midwife out there somewhere, which again, is one of the reasons that we want licensure because we want standards to be uniform.

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

And some CPMs may be looking for physical warning signs with the mom before insisting they get labs taken, so sometimes there are some physical things that are happening with that mom that would indicate that labs were definitely needed to continue.

Missi Burgess, Certified Professional Midwife (CPM)

Care during labor and birth emphasizes frequent monitoring of the fetal heart rate using a Doppler, and monitoring the vitals and well-being of the mother. Vitals include taking pulse and blood pressure and temperatures. Well-being is assessed by monitoring food intake, hydration, output, are they vomiting, are they urinating, coping mechanisms, is she coping well. That is a big deal. You are giving birth without pain medication, are you coping? Were you prepared for that? It's not unheard of for the Certified Professional Midwife to be the one to say, "I think you need to go get an epidural. Let's go do that." CPMs also assess the cervix with vaginal exams. That is all. Pretty much what is covered there. Certified Professional Midwives are trained in emergency birth skills, such as resolving shoulder dystocia. That is the one where the head comes out and the shoulders get stuck. How to deliver a baby with the cord around the neck, which happens frequently, but a lot of people think it is an emergency, so I mentioned it. Assisting the newborn with its first breathes with NRP, which is Neonatal Resuscitation. It's offered by the American Academy of Pediatrics, has to qualify which NRP program is good enough. So, Certified Professional Midwives are required to have NRP training, and then managing a postpartum hemorrhage would be part of the emergency skills that a Certified Professional Midwife would use at birth. That is pretty much the specialized skills.

Gabriel Sterling, Office of the Secretary of State

On the hemorrhage front, I remember you mentioned last time that in Utah, you have access to some of the drugs that would be necessary for that.

Missi Burgess, Certified Professional Midwife (CPM)

In many states, yes.

Gabriel Sterling, Office of the Secretary of State

In Utah specifically though, and I think Chairman pointed out that some of those drugs, given our pharmacology laws, even if you were licensed, I don't know if you could do that under our current structure. I just don't recall.

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

I think it needed researching.

Anna Wrigley Miller, Office of Planning and Budget

We've got the Georgia Drugs and Narcotics groups. They're going to talk once we are finished.

Tracey Cuneo, Certified Professional Midwife (CPM)

I will say that almost every state that has licensed Certified Professional Midwives… CPMs that are licensed, gives them access to emergency medicines, just a few of them, for life-saving situations.

Missi Burgess, Certified Professional Midwife (CPM)

Okay, postpartum care. The midwife remains with the postpartum mother during the postpartum period until the conditions of the mother and newborn are stabilized. That's typically two (2) to three (3) hours. Immediate postpartum care, again, we are looking at well-being, Is she bleeding? What are her vital signs? What's her uterus' fundal height? Get's real technical. Refers to how her uterus is after deliver. Has she had a bowel movement? Is her bladder functioning? Examining the perineum and vagina and assessing for lacerations and repairing those lacerations as needed. After that, there's ongoing postpartum care. Some midwives come back at one (1) day, some at two (2) some at three (3). Everybody comes back within three (3) days. Some do another visit in a week, some at two (2) weeks, there's a three (3) week visit, a six (6) week visit, and then all of these things are what are going on in the overall well-being. Breastfeeding, counseling, and support. We have a ninety-six (96%) breastfeeding rate for Georgia CPMs. We are also screening for postpartum depression and anxiety using the Edinburgh Postpartum Depression Scale, or something like that, which is the standard. Everybody uses that that comes in contact with postpartum women. Then an assessment of pelvic floor function, which would also result in a referral to a physical therapist if needed. Okay, newborn care, after the birth of the baby, the midwife will assess, monitor, and support the baby during the immediate postpartum. As mentioned before, midwives hold current certification in newborn resuscitation through the American Academy of Pediatrics. CPMs record Apgar's at one (1) and five (5) minutes. That is a question that comes up a lot. Do you do Apgars? Yes. A standard newborn exam is done. That's weight, measurements, temperatures, feeding, bowel and bladder function, reflexes, physical deviation from normal, clamping and cutting of the umbilical cord, eye prophylaxis as requested by the parents, the administration or referral for vitamin K is requested by the parents, and then addressing the concerns of the family. Then, most CPMS return to the home in one (1) to three (3) days, to again, assess vital signs, tone, reflexes, feeding, color, weight gain. CCHD stands for Critical

Congenital Heart Defect; that's a reading that's done with a pulse oximeter, and then referral or performance of newborn metabolic screening and hearing screenings. The state of Georgia requires three (3) screenings for all newborns, so CPMs self-require ourselves to inform the parents of that and ensure that it is done through follow-up.

Anna Wrigley Miller, Office of Planning and Budget

Okay, any questions on that? As I said on time, I want to get any last questions from the Council.

Jonna West, Department of Agriculture

I have one quick question. Are CPMs bound by HIPPA?

Missi Burgess, Certified Professional Midwife (CPM)

Yes, that was actually the slide that we just skipped.

Jonna West, Department of Agriculture

If you can just talk about how you protect and secure data?

Missi Burgess, Certified Professional Midwife (CPM)

The informed disclosure is that form that everybody signs, and it must contain the midwife's education, training, and experience, conditions requiring consultations, transfer of care, and transport to a hospital, a medical consultation transfer and transport plan, the services provided by the midwife, the midwife's current credentials and legal status, the NARM accountability process, and HIPPA privacy and security disclosures. Most CPMs today have access to electronic charting software that is all HIPPA compliant. Any transferring of records is done via fax, just like everybody else does HIPPA compliant. We won't request somebody's records without permission, we won't send somebody's records without permission, written documentation of everything, and anything, like students have access to charts, the individual client has to approve that. Yes, the student can look at my chart, they can use my chart for the logs these students are submitting, so they have to give permission for the student to be able to do that.

Jonna West, Department of Agriculture

Thanks.

Missi Burgess, Certified Professional Midwife (CPM)

And this picture is from a celebration last week of a midwife that's practiced for thirty (30) years. All of her families got together to honor her.

Christina Ferguson, Department of Public Health

It says at one point in the legislation that oral informed consent is sufficient, and then at another point their written informed consent is required. That is sixty-four (64) verses line two hundred and twenty-five (252), why the inconsistency?

Missi Burgess, Certified Professional Midwife (CPM)

Sometimes you don't have time to get it in writing. There's also things like during labor, you might say, "Can I check your cervix?" and they will say yes or no. That would be an oral consent. It would be documented in the chart, but you wouldn't make someone sign something for that individual thing. It is a common part of having a vaginal delivery, and since they've already signed your informed disclosure and they're aware that's something that you do you wouldn't get a signature every time you offer that. The things that would require written documentation are the biggest informed disclosure that says this is my training, this is my experience, this is my legal status in this state, these are the services I offer, these are the things that I cannot provide you with, these are the reasons that we might go to the hospital, during your birth that is always signed. It should be upon initiation of care. Then there are things if somebody wanted to decline a lab or something like that, that would be written, like they didn't want an ultrasound. That would be documented in writing for sure.

Gabriel Sterling, Office of the Secretary of State

But to reflect my statements from the last meeting, this is something that when you make statutory, and they conflict, it is a part of that issue with the bill overall. If you did get licensed, then rulemaking may be a better outlet to do some of these things than statutory. One of the things that we're charged with at GORRC is we are not policy people necessarily. We are the regulatory side. We are the regulatory scheme. The bill, as I pointed out, is not ready. You've got a lot of work to do. I didn't even catch that one. Thank you for that. It is going to require a lot of work, and I have got to see that direction on that. We have stumbled on so many other regulatory hurdles here that even if you pass this bill, you've got other regulatory issues ahead of you. You've got a large serious of obstacles attached to this that I know you are in good faith trying to get through. That's why you are here today, but again, we are not policy, we're the regulatory side. The bill as written is not in good shape right now.

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

We are super appreciative, and we got the notes too on Friday. We are going to be working with Representative Mathiak fixing all these things you suggest.

Christina Ferguson, Department of Public Health

And one more question going back to that, lines twenty-four (24) through fifty-one (51) in the preamble of the bill. There are lots of claims being made. Where are y'all getting that data from? "Midwifery has always been a highly valued part of life in this state. Parents are entitled to freedom. The cost of hospital childbirth tends to more than… Planned out-of-hospital childbirth is safer when assisted by trained midwives." Where does… It is lots of claims. Lots of very bold statements about how you're going to move forward; where does that information come from? Where is that data supported?

Missi Burgess, Certified Professional Midwife (CPM)

The binder that you got at the last meeting contains a lot of that documentation.

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

It would be organizations like NARM and MANA that are stating that, and the safety stuff comes from the studies that are inside the briefing, and things like that. Then, of course, Georgia residents speaking to wanting to have their babies at home, and that Certified Professional Midwives have been around since nineteen eighty-four (1984). There have been some in the state of Georgia since that certification became available, and even before then, some of those midwives were practicing out-of-hospital birth.

Anna Wrigley Miller, Office of Planning and Budget

Any questions from this side of the table? No? Okay. Alright, thank you guys. I am going to start with the Department of Public Health. So, Megan, if you can come up, please.

Megan Andrews, Department of Public Health

For the record, my name is Megan Andrews. I am the director of government relations for the Department of Public Health. I thought it would be helpful for y'all to have a little historical background on how the state has regulated midwives, and where we are today. The original statute that this bill is amending was implemented in nineteen-fifty-five (1955). Public Health was called to have the regulatory authority to oversee the practice of midwifery. Beginning in nineteen-sixty-four (1964), DPH had administrative regulations that called for exams and the issuance

of a certificate to practice midwifery, and this was at a time before Certified Nurse-Midwives were really practicing in any significant numbers in Georgia. In nineteen-seventy-nine (1979), Public Health, this was when we were under DHR, adopted an internal policy to stop certifying non-nurse midwives. Our regulations state on the books, but as a matter of practice, anyone who appeared to our local health departments were not issued a license. An issue happened in nineteen-ninety-one (1991) in Cobb County. There was an infant death at a homebirth attended by a lay midwife, thus Cobb County Public Health began an investigation of that case. The situation that had happened was the child aspirated on meconium during delivery, so at that time that triggered the adoption of emergency rules by the Department of Public Health requiring that individuals be a Certified Nurse-Midwife in order to receive licensure from the Department to attend births. That was in nineteen-ninety-one (1991). I know there's rules on the books that were amended in twenty-fifteen (2015), what that rule change was at the time, Public Health required that the be Nurse Midwives but we also had our local health departments still issuing certificates for these individuals to practice. This was a part of a greater cleanup of DPH rules and regs, and we were just removing the requirement that the local public health department issue a certificate, so all that remains in current regulations is an individual must be a Certified Nurse Midwife in order to be authorized to deliver babies as they are regulated by the Board of Nursing. That is where we stand today.

Anna Wrigley Miller, Office of Planning and Budget

Okay. Any questions to Megan? Thank you

Megan Andrews, Department of Public Health

Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Okay, I have Bethany from the Medical Association of Georgia. Can you come up?

Bethany Sherrer, Medical Association of Georgia (MAG)

As I said last time, my name is Bethany Sherrer. I am with the Medical Association of Georgia. I am our legal counsel, but I also come down to the Capitol and do our health policy work. We have just over eight thousand (8,000) physician members across all the different practice areas you can be. That includes OBs, but it also includes all different types of specialties. Our policy states that we believe that lay midwifery should be prohibited, and that Certified Nurse Midwives or licensed physicians are the proper professionals to provide the delivery of prenatal services. More generally as a matter of patient safety, MAG opposes the performance of medical procedures by non-physician personnel who are not medically trained and

supervised. That includes the administration of vaccines and other injectables, so that would include injecting Pitocin or giving a Vitamin K shot or any of the other things that might go along with having a newborn or a woman in labor. Our concerns with regards to allowing CPMs to practice are made worse by lack of good data. The data we saw during the previous hearing came from self-reporting to a private organization supporting lay midwifery. If a bad outcome occurs during a homebirth, and the woman is brought to the hospital or emergency room, a resulting maternal or fetal death is likely to be attributed to the hospital and a physician or Nurse Midwife who attended the situation once they get into the hospital. For our purposes as a state, you know we take in data with regards to maternal and infant mortality and we review that data through a committee and there's a lot of work that's put into the data that comes into our state with regards to maternal mortality. Its not just a number that gets reported. Those things are investigated by a committee of professionals who truly care about maternal mortality and are trying to figure out how we can prevent things. So, one of the issues with what is brought up before is when we're trying to make thee comparisons between what is safer. We can't actually make a good comparison, so we may have this data from MANA, but we also have that data being reported by the hospital, the physician, whoever it might be, to their own various places you have to report a bad outcome, whether that's JCAHO or Public Health, or all of those things. We are essentially double counting. Every time we have a bad outcome that occurs, originally what started as a homebirth and then moves to the hospital, where fetal or maternal demise actually happens. We are double counting those deaths, so we are not getting a real picture of what's actually happening. According to a two thousand and sixteen (2016) study in the *American Journal of Obstetrics and Gynecology*, planned out-of-hospital birth is associated with a more than two-fold increased risk of perinatal death, and a three-fold increased risk of neonatal seizures or serious neurological dysfunction. A study published in the *Journal of Perinatal Medicine* in two thousand and seventeen (2017) found that there are significantly increased risks of neonatal deaths among midwife attended homebirths associated with three (3) underlying causes: labor and delivery issues, infections, and fetal malformations. That study sort of focused on why an infant death happens in different types of births, so in out-of-hospital births, those are the three (3) things where we see an increased risk over a death in the hospital. Where a death in the hospital, we'll see an increased risk of fetal demise due to a genetic defect, so you see those people who may be tested positive for possible genetic defects go to the hospital more likely and those deaths obviously still happen. This focused on singleton births, so non-twin pregnancies, and they were all considered low-risk. They kind of looked at the same population in theory across the board. Physician education is also an important counterpoint to the education required of CPMs in HB seven-one-seven (717). To become an obstetrician, a physician goes to four (4) years of undergraduate education, four (4) years of medical school, a one (1) year internship, and then three (3) to seven (7) years in residency. The U.S.M.L.E., the exam to obtain licensure, includes three (3) different steps that you have to go through in order to finally get your license as a physician. Then you are required to obtain C.M.E. hours, a lot more than fifty (50) in five (5) years, but a good number of

C.M.E. hours as you go through. And then, in addition to that, Board Certification as an Obstetrician requires a continuous maintenance of certification process, which includes study and testing. So, you're tested at regular intervals throughout your career as an obstetrician if you want to remain board certified. Now, I conclude that's not required for licensure, but in all practicality you have to be board certified in almost every hospital if not every hospital in order to have privileges there. So, to practice as an obstetrician, you're going to have to remain board certified, so you're going to have to continue to go through that certification process. It's important to note that when they're in residency, they don't just do births. You were right, but they do a lot of births as a part of that, but they also do things like rounds in an ICU. They're trained to deal with all sorts of issues that could come up surrounding a birth. And while yes, I would agree with some of the things that come up in this bill; that birth is not a disease or that pregnancy is not a disease, we cannot always anticipate what might happen, and we don't always know what is going to happen at week thirty (30) or thirty-five (35) or even thirty-nine (39) or forty-one (41). We just don't know, and that's why we have the continuous monitoring in place that we have when a woman is routinely seeing her OBGYN or Nurse Midwife, and that includes urine screens to make sure that pre-eclampsia is not coming up and regular checks with ultrasounds as you get into certain points in your pregnancy to make sure that if you're too far along that your placenta's not calcifying. There are lots of things that are done routinely as you get further along in your pregnancy that you cannot do right now under the rules the way they are. I do want to point out that Pitocin in our law is a drug, which means that ordering a drug is still prescribing that drug. In order for the person to get it, and order is written and it's a prescription drug order. It doesn't matter that you're not writing a prescription on a sheet of paper that somebody's going to a pharmacy to get. You're still prescribing the drug in the true sense of the word. This legislation would still allow CPMs to practice without a license, so if they just don't want to get a license, they can still practice unregulated. So, they way this is written it just says you can't call yourself a CPM now, but I don't really know in practicality what difference that would make if we are allowing unlicensed professionals to deliver babies now. If women are allowing an unlicensed person to deliver a baby now, I don't know why all of a sudden having this in place would change that perspective. We currently, in Georgia, only allow Nurse-Midwives to practice when they're under the supervision of a physician, so this is going beyond what we allow now for Nurse Midwives. So, the state of Georgia has essentially created healthcare teams where the physician is the head of the team so to speak, and we believe as an association that that's the safest way to provide care, and that having a physician as a part of the healthcare team is really important for providing evidence-based care and that would take this away. Finally, you brought up the rules that DPH does have. We're not practicing under those rules now, so I think it is scary to put in totally different rules and hope that we have a different result, but you know, as a state we haven't been enforcing rules that are already on the books and have been on the books for four (4) years now. The legislature has prioritized maternal and infant mortality and access to evidence based care. The state set up perinatal levels to standardize and demonstrate the levels of care that are provided at hospitals across the state. So, this would be a

contradiction to that. We've set up these levels so that we know what a hospital has, what capabilities do they have, what are they able to do in different situations, and we don't know what's in a woman's home. We don't know what's available; we don't know all of the things that are happening within a woman's home, yet we went through all of this work to set up different levels of different hospitals so that everybody is completely aware of the levels of care that are around the state so if an emergency happens, we know where that woman should go, or if a woman is going to give birth in a hospital, she knows that she has a specific type of condition, or is at risk for a specific type of issue, then she knows which hospital to go to. But we just don't have that anymore here, so this sort of contradicts what we've already done. The bottom line is that physicians want patients, moms and babies, to have access to high-quality, safe, evidence based care, and we don't believe that licensing CPMs is the way to accomplish that.

Anna Wrigley Miller, Office of Planning and Budget

Thank you, Bethany. Do we have any questions from the Council for Bethany?

Gabriel Sterling, Office of the Secretary of State

I do. As you pointed out, we have standards now that reach the hospitals, but as has been discussed, there are large swaths of this state, Southwest Georgia comes to mind right now, where there is literally one (1) hospital and there's another one that's been certified to be built, and you say this isn't the way to provide the care, so I am curious, what is your organizations position as to what is the way to provide more access in those areas that are underserved right now? More so curious.

Bethany Sherrer, Medical Association of Georgia (MAG)

I think that's an important question, and I do want to say, when it comes to the rural idea, I think this is actually more concerning in rural areas because if something does go wrong and you're in a home, how do you get to a hospital? So, if something goes wrong and you have, as Chairman Cooper brought up, you have one (1) ambulance in the area and you're going to have to go forty-five (45) minutes to get to a hospital and a woman is hemorrhaging, that's just not enough time. You know, we always want a plan to go to a hospital, but things that we've looked at is trying to get more physicians to move to rural Georgia. It's hard. Unfortunately, the population just doesn't always support someone down there, but forming these sort of team-based healthcare can provide some of that. We have maternal and fetal medicine physicians that are sort of working with rural areas, and they're doing a lot of this through telemedicine. We're setting up, you know, you see hospitals setting up clinics, some of that is on a rotational basis. We have F.Q.H.C.s that are providing a lot of the prenatal care now.

Gabriel Sterling, Office of the Secretary of State

Okay, we don't have that acronym thing. F.Q.H.C.?

Bethany Sherrer, Medical Association of Georgia (MAG)

F.Q.H.C. is a Federally Qualified Health Center, so it is a health center that receives federal funding. Some of this, it's a complicated problem. We know that M.C.G. (Medical College of Georgia) is starting a program to help obstetricians re-enter into obstetrics, so obstetricians that may have pulled back and are maybe only doing gynecology or maybe doing something entirely different, but they want to get back into obstetrics work, and some of that requires that they stay within the state usually, within that program. So, trying to get more obstetricians to go back into performing or doing obstetrics is an important part of that. We also, as a state, put in some money through the Board for Health Care Workforce, LaSharn? That provides money for the medical malpractice insurance, which is an impediment for people providing obstetrics care because malpractice is more expensive as an obstetrician than it is in any other. That's one of the most expensive.

Gabriel Sterling, Office of the Secretary of State

So, maybe some more tort reform and maybe some C.O.N. here to there.

Bethany Sherrer, Medical Association of Georgia (MAG)

Yeah, that would be great. So, yes, it's a multifaceted problem and I think that we have bits and pieces that are picking at it right now. There's trying to figure out a way to leverage telemedicine to provide specialized maternity care especially. A lot of our family practice physicians are willing to fill in some of that stuff, but it may include, you know, back-filling some of the training to make sure that they have the understanding of prenatal care if they want to go to a rural area. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Dennis, do you want to come talk now… from Georgia Drugs and Narcotics Association.

Dennis Troughton, Georgia Drugs and Narcotics Agency

I am Dennis Troughton. I am director of Georgia Drugs and Narcotics Agency, which I am sure many of you haven't heard of, but we are the enforcement agency for the Georgia Board of Pharmacy. We do regulatory enforcement, as you mentioned. We're also criminal enforcement. I have been a pharmacist thirty-five (35) years and a cop for twenty (20). We are able to go into… So, I am not here to speak for or against.

Anna Wrigley Miller, Office of Planning and Budget

Yes, we just wanted some clarification at the last meeting on pharmacy rules, so that's why Dennis is here.

Dennis Troughton, Georgia Drugs and Narcotics Agency

We do have the authority anywhere in the state where there are prescription drugs. We have the authority to look at records and essentially do investigations and inspections. We do have a broad authority when it comes to prescription drugs. After reading the bill that we had gotten that you're speaking on today, you know, our concerns, and I am not speaking for the Board of Pharmacy, okay? I am their lead investigator, but we are a separate agency so I don't want to confuse you that I am speaking for the Board of Pharmacy, but from our perspective, again not for or against, your Certified Nurse-Midwives, P.A.s, Certified Nurse-Practitioners, none of them can order and prescribe unless they are under the authority of a physician. So, when it comes to the laws and if there's a problem with a P.A., you know those P.A.s can't just order certain drugs. So, that's what we would certainly just look for in that bill, and sir, you mentioned, and forgive me I don't have everybody's name, but you mentioned what needed to be cleaned up in the bill and all that, that certainly would be a concern of making sure who's responsible when drugs are, you know, are they prescribing, are they ordering, who is responsible then after that, because that's when we get called in when there are problems. And of course, in today's wonderful opioid crisis that has consumed so many of us. Just an example, line two hundred and fifty-one (251), "Purchase, possess, carry, or administer prescription supplies," I don't even know what that is, as long as I've been doing it, I'm not sure what that means exactly. The last sentence [Line two hundred and fifty-five (255) to two hundred and fifty-six (256)], "And other prescription medications or restricted medical items approved by the advisory board." So, I get that, but it sounds like it would also have to be in the law. We are talking about controlled substances, it doesn't make it clear, can they get any controlled substance, and any injectable product in the state of Georgia, I'm talking about saline, is a prescription drug. It's on the dangerous drug list in the state of Georgia, so it would require them to have the authority to order and to get those things, and right now, the only way that can happen is through a physician, vet [veterinarian], dentist, podiatrist, optometrist, very limited.

Gabriel Sterling, Office of the Secretary of State

Is there a separate line to be required for the administration for those drugs too? I don't think you were saying those things, to inject or do those things.

Dennis Troughton, Georgia Drugs and Narcotics Agency

You know, I'd have to let the Medical Board, as far as the administration part of it, I'd have to let… That's not my area. How they get it and what they do with it is ours, but the administration. Like today, P.A.s, we've probably all seen them in our visits to the doctors. P.A.s, the nurses, they can administer, but they couldn't get those things into their office without having a supervising physician and without having a current job description and protocol.

Jonna West, Department of Agriculture

Dennis, I have a question. Individuals that are allowed to possess those substances, prescription drugs, no matter what they are, they're prescription. Are there requirements for how they're secured? In a facility, where and how they're kept under lock and key, I mean, is there regulation on how drugs are possessed and kept?

Dennis Troughton, Georgia Drugs and Narcotics Agency

You see the word secure throughout the laws and throughout the regulations. There are no specifics. Even the D.E.A. doesn't say, below the wholesale level, you have to have a certain size cabinet that is this strength and this metal. That's very ambiguous as far as what is security, and what happens is though, the person that's responsible, let's say there's a sizable diversion somewhere. That happens every day. Those are the questions we're going to ask. Where were you keeping these? Then that's where it comes back to the regulatory part of the board to say, you kept your oxycodone bottom sitting with your prescription pads in the draw. That's not a good idea, but there's not in the law, no.

Jonna West, Department of Agriculture

Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Any other questions for Dennis? Thank you for the clarification on that. We have Dr. Al Scott from the OBGYNS. Are you ready?

Al Scott, M.D., President of the OBGYN Society

Good morning, Madam Chair and members of the committee. This shouldn't take very long. My name is Doctor Al Scott. I am currently president of the Georgia OBGYN Society. I have been in private practice for nearly thirty (30) years, and I currently have five (5) Certified Nurse-Midwives and four (4) physicians in my OBGYN practice. I have worked with [Nurse] Midwives for more than twenty-five

(25) years, and I understand their benefits as well as their limitations. HB seven-seventeen (717) proposes a separate new licensing board, which does not distinguish between a college, master-level educated Certified Nurse Midwife who currently practice legally in Georgia, and other types of midwives who can be eighteen (18) years of age, high school graduates, and trained in a lay system by attending only twenty (20) homebirths. Line two hundred and eighty-two (282) of the bill states, "Midwifery shall not constitute the practice of medicine in this state." Therefore, relieving them of the need for medical malpractice insurance or any liability for poor care, poor clinical judgment, or bad outcome from homebirthing. Although the bill classifies midwives as not practicing medicine, it allows the midwife to order lab work, ultrasounds, administer prescription drugs, give intravenous fluids, injections, oxygen, local anesthesia, perform surgical suturing, and prescription medications or restricted medical items as approved by the midwifery board. Per the bill, a midwife may terminate services to a client for any reason, provided that the client has reasonable access to other professional care, where as an OBGYN performing in the same manner would be accused of patient abandonment of a pregnant woman. The lay midwife is not required to have any agreement or relationship with an OBGYN for any patients, including those who may become high risk, and therefore, the midwife could be functioning outside the medical safety net in a state with a very high maternal mortality. As you know, Georgia is forty-eight (48) in maternal mortality. Women, many of whom become high-risk sometime during pregnancy, with the likelihood of having complications or dying in childbirth, should be in the collaborative medical care system and are not appropriate patients for a lay midwife. Midwives are unable to perform cesarean sections or emergency cesareans when unforeseen circumstances occur. The state has areas without close access to a hospital OB unit. Home deliveries without ready, emergency access to a birthing hospital for when dangerous situations occur during home delivery, will increase maternal mortality in Georgia. In labor, emergency situations such as abnormal fetal heart tracing, indicating the fetus in utero is in trouble, prolapsing umbilical cord, hemorrhage, placenta abruption, when the placenta detaches from the womb must be delivered immediately to save the mom and/or the newborn. Forty-five (45) minutes to the hospital means one (1) or both may die. The licensing board in the bill will be heavily weighted towards lay midwifery with three (3) lay midwives, one (1) consumer, one (1) CNM, and one (1) physician who is experienced in non-hospital birthing. Note that an OBGYN physician, the expert, is not specified in the bill. There is no proposal in the bill about how the board will be financially supported for travel, expense allowances, licensee misconduct investigations, office administrative staff, as well as specifics on where it will sit within the Georgia government structure. A fiscal note would be needed. I know we talked about that earlier. Currently in Georgia, specially trained, master-level Registered Nurses are licensed by the Georgia Board of Nursing to practice as Certified Nurse Midwives, CNMs. They practice jointly with physicians in my office, and in many OBGYN offices throughout Georgia, and deliver about fifteen percent (15%) of the births in the state. The are approved to deliver in most Georgia birthing hospitals, care for low-risk OB patients, and collaborate on women's healthcare as an integral and welcome part of the healthcare system. We support

the opening of an additional training program in South Georgia to train more college-level CNMs to work in a Georgia health system. Currently, there's only one training program in the state of Georgia at Emory. We also support other pilot projects proposed by the Georgia Department of Public Health to utilize college prepared CNMs to safely provide care to women in rural areas of Georgia under some type of supervision. The Georgia OBGYN society cannot in good conscience support his bill, which lessens the standards of clinical care and decreases the safety for women in Georgia. We are working cooperatively with the legislature on numerous efforts to improve women's care, including Representative Sharon Cooper's maternal mortality study committee. Thank you. Any questions for me there?

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Then our last scheduled speaker from the Composite Medical Board, Doctor Harbin. Then we will open it up for public comment.

Tom Harbin, M.D., Georgia Composite Medical Board

Good afternoon, I'm Doctor Tom Harbin. I am a member of the Georgia Composite Medical Board. We have a letter, I would just like to read it, and then any questions. The Georgia Composite Medical Board thanks the Committee for the opportunity to provide input on House Bill (Seven-One-Seven) 717. The Board stands in opposition to this legislation, in its current form, for the following reasons: The lack of supervisory provisions in the bill. The failure to define the type of direction that must be provided to midwifery assistants (who appear to require no training whatsoever). Lack of formal concrete medical or nursing training. Allows individuals to administer medications that are prescribed by licensed physicians and the ability to purchase and possess medications without limitation as determined solely by the advisory board. The rendering of medical care by less qualified or unqualified personnel. Concerns with the provision that the practice of midwifery is not the practice of medicine. And lastly, concerns regarding the lack of safeguards when there is a life or death situation. Liability concerns regarding the practice of midwifery. Although the bill stipulates that the practice of midwifery does not constitute the practice of medicine, the Board feels very strongly that the prospective authorized practice as described in the bill does indeed constitute the practice of medicine. In the event that the General Assembly decides to move forward with legislation, midwives should be required to have a documented relationship with a physician or hospital in case of a crisis situation.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Any questions for Dr. Harbin?

Gabriel Sterling, Office of the Secretary of State

I just want to make sure he's here for his role on the board, not individually, correct?

Tom Harbin, M.D., Georgia Composite Medical Board

I am here representing the Georgia Composite Medical Board.

Anna Wrigley Miller, Office of Planning and Budget

Okay, thank you. Everybody, thank you for bearing with us. I am going to move into the public comment side. We have nineteen (19) people signed up to speak, so I know it's lunch time for me and probably lunchtime for a lot of other little babies out there, so I am going to limit it to three (3) minutes per person, so I am going to call yall in the order of this. So, Victoria…I will butcher your name, so Victoria.

Victoria Knudsen, Consumer

I don't have anything prepared because I was just going to go with my heart, and I came here today in support of my midwives and my babies that I had at home, and I think the thing that is very difficult for her to listen to everybody here saying is that everybody else here knows what's best for my family, and that I don't have the knowledge or that I am not smart enough to make the decision that is best for me and my family, that I can research, that I can know the risks and the benefits to homebirth or hospital birth or whatever I choose, that I can't decide if this is safe, or if I should be transferred to a hospital while I am in my pregnancy. During my prenatal care with both of my midwives, it was very obvious that I was being taken care of and constantly assessed for the risks that could happen during my births. I was being taken care of in the best possible way. Just like these midwives said, which I am having a hard time understand how people are not seeing that just like in hospital births, they are constantly assessing the risks that an OB is doing, so are midwives. There is clearly training being done where they can assess the same risks. Thirty-three (33) other states in this country license midwives, so I am having a hard time understanding where, why we're not getting on board. What's the issue? There are plenty of other states and families in this country that support homebirth and believe in this, and clearly, women here and all the letters that you guys got, they support this, and they want this, and they should have this option. The legal stuff with the bill, the mumbo-jumbo, whatever. You guys need to fix it, great, but homebirth should be supported, midwives should be supported, and women's rights should be supported.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Dr. Joy Baker. Did she leave? Okay, she's not here. Allison Shetler? Nope. Okay, Crystal Bailey?

Crystal Bailey, Certified Nurse-Midwife (CNM)

Crystal Bailey, Nurse-Midwife. I have been a Nurse Midwife for twelve years. I was trained at Emory University. I worked with physicians in rural Tennessee. I have worked at birth centers. I have delivered thousands of babies in the United States, and I have worked in Malawi and South Sudan. I have lost mothers and babies, but not in this country, but I have been there. I have heard those cries, and I don't understand why Georgia has so many of those cries; the cry that you hear when a mother dies. It is not supposed to happen, and why in my thousands of deliveries in the United States have none of my mothers, none of my babies had any problems like that? It's because, as a midwife, we safely, and we practice within these protocols, and we have mothers do labs, we have them do testing, we use physicians, we use hospitals, we use interventions. As a nurse-midwife, we have access to care, so my patients don't have to, and I as a midwife don't have to, consider whether or not to do testing, to do intervention. I don't have to fear about am I unlicensed, should I not take this mother in? It's because I have a license, and to know that midwives who are trained, who are safe, who are needed, don't have that access to care. This is where mothers die; this is where babies die, when there's hesitation. When a mother says, my baby's not moving as much, and she hesitates to act, to monitor, she hesitates because she doesn't want to have to navigate something where she could be criminally prosecuted or that mother doesn't have a backup physician because a physician doesn't want to collaborate with her. When you hesitate, you don't have good outcomes, and so, in the state of Georgia, as nurse-midwives, we are not going to meet the need of these mothers. I currently work as, I teach at Emory University and I have a homebirth practice. But if I attend ten (10) homebirths this year, and there's only three (3) other nurse-midwives attending births, then who's going to attend all these other women? It's going to be these midwives. These midwives that are trained, that want to practice safely. They want to care the same meds I do, they want to have access to the same things I do, and if we don't create a way for them to be in the system, then we as nurse-midwives are quite upset that these mothers needs are not being met. I don't know any other faculty at Emory that oppose the licensure of midwives who meet the standards set forth by ICM, who are going to meet the needs of Georgia mothers and babies. We have midwives here in Georgia who have Ph.Ds. in midwifery, so I don't know why they weren't called to speak to this issue. But I just want you to know that you have to have midwives on the ground, and mothers trust us, so you have to give them access. So, please consider the importance of this issue.

Anna Wrigley Miller, Office of Planning and Budget

Thank you, Crystal. Katie Murrey? Katie Murrey?

Katie Murrey, CPM

My name is Katie Murrey. I am a Certified Professional Midwife. I am also licensed in the state of South Carolina. I work with supportive OBs. I work with supportive Certified Nurse-Midwives. I do order labs; all the things that were presented today that were concerning, I can do because of license, and I can offer those things to my clients. After three (3) years of training, one hundred and thirty (130) births, training overseas in a third-world country for four (4) weeks, training with three veteran midwives, and three (3) years of academic work, I sat for the biggest exam of my life, and I passed it. I worked with the department of health in a state in the Midwest for five (5) years who willingly licensed me to see low-risk women at home. When I moved here, I was astonished to find that the distasteful political environment that is dictating a woman's right to have a midwife of her choice attend her at the location of her choice for such a private event as birth. The reality is that I can practice legally in South Carolina, Florida, Alabama, Tennessee, Virginia, pretty much almost every state in the southeast, but not here. I can practice in thirty-three (33) other states, but not in Georgia. As the state, as you guys know, who has the most appalling maternal mortality rate in the entire country, I implore you to take notice of one of the greatest assets to the healthcare system serving our mothers and babies. The CPM midwife is on the ground in the community, in people's homes on a regular basis, she has eyes like a hawk watching over her mothers and babies, and with the ability to be integrated into the healthcare system, mothers and babies lives are forever benefited, and we don't lose mothers and babies. I have seen and caught life threatening disease, when other professionals did not. I have sent mothers to the ER in rural areas, and those professionals did not catch her condition. I have also seen the powerful impact that a friendly and supportive transfer can do for the health of my mothers, and we have all seen the detrimental affects when midwives are not properly licensed and trained and held to the correct standard. It's embarrassing. I could have a bachelors, master's, or even Ph.D. in midwifery, from an accredited school, but not be licensed to work in this state. Yes, Georgia is one of the worst states in the nation to give birth, but with your help, we can make it better. It's time Georgia supported its local mothers to have the right access to the right professional that is right for them and their decision making. There should be no question of our skill, education, or experience, but every question should be raised as to why there aren't more midwives serving these mothers, especially in the rural areas. We are out in the homes of these families, serving them, supporting them, and empowering them.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Valarie Regas?

Valerie Regas, consumer

Hi. My name is Valerie Regas. I'm a mother of three (3). My first was an unnecessary C-section that resulted in long-term health problems, the next two (2) were at home, and completely uneventful, so I'm a little passionate. However, it occurs to me that

nobody really cares about my personal thoughts or feelings or my birth experience. The two (2) biggest things as a consumer and a Georgia voter that I see, first is money. We talked about the startup cost of doing licensure, and that's about a quarter of a mill startup, buck seventy-eight (78) a year after that. Chump change. We have to think about the amount of money we are losing on every Medicaid recipient who goes to a hospital when they are low-risk and they don't want to be there, and through interventions that cause health problems that didn't have to exist in the first place. The state of Georgia is not spending twenty or thirty thousand ($20,000-$30,000) dollars on a birth that could have been three thousand ($3,000) dollars for a low-risk woman. We are going to recoup money by not shelling out for unnecessary C-section after unnecessary C-section that puts Georgia lives at risk. Perhaps part of why we have so many deaths and why it's so terrifying as a Georgia resident to have a baby in the hospital is the obstetricians have failed us time and time again. They want us on a schedule, they want our bodies to cooperate around their tee times and their family dinners, and so they will cut us open, and don't care that they can kill us, to suit their schedule. It's terrifying if you are low-risk and don't have a reason to be there. I think it is also important to point out that we are not asking for permission to have homebirths. We are not asking to start something new. It's going to happen no matter what. It should be licensed and regulated. There should be a chain of accountability, and the women who are already taking care of us should have more leeway to keep us even safer than they already do. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Hannah Yancey?

Hannah Yancey, Consumer

Hello. My name is Hannah Yancey, and I am the mother of a beautiful baby girl, right over here, who was born in the comfort of our home on May twenty-third (23) this year. I spent my first trimester at a practice in Atlanta where my family and I were not given adequate prenatal care. Our visits were treated as transactions, it was uncomfortable, appointments were rushed, our questions and concerns were left unaddressed, communication was severely lacking, and our last visit ended with us thinking that we lost our baby at thirteen (13) weeks. We then hired an Atlanta-based home midwife practice. I felt more cared for in my consultation alone than I did my entire time under the care of the former practice. My prenatal care with my homebirth midwives was in-depth, extensive, and personal. They took an hour of their time at every appointment, and addressed every aspect of my pregnancy. They checked in on me emotionally and physically. They checked both mine and my baby's vitals, and allowed me to hear the heartbeat for as long as I needed. They required a written and printed birth plan, a Plan B in the event of a non-emergency hospital transfer, and a Plan C in the event of emergency hospital transfer to cover all possible scenarios. They facilitated all routine prenatal tests and exams as required by the state of Georgia. My water broke the day before my due date. My

midwives guided me through every step to take to ensure both mine and my baby's safety. They stayed attentive and steadfast in their care, setting boundaries as to when a hospital transfer or induction would be in our best interest. We kept an eye for any indication of a fever or infection, as well as keeping track of my baby's constant movements to ensure she was not in distress. Almost seventy-two (72) hours later, which would be the deadline for a premature water break, I went into labor. I had my baby girl eight (8) hours after my labor started at home in a birthing pool in her nursery surrounded by my two (2) CPMs, my two (2) doulas, and my husband, which was the ultimate birth support system. After she was born, I hemorrhaged due to my uterus' loss of tone. My midwives noticed increasing blood loss and began to remedy the situation with grace and poise. They stabilized me quickly still at home and in my safe place. They stayed by my side for hours to make sure I was improving while also attending to our baby girl, performing routine infant and maternal exams. Not only did I not have to fear for my or my baby's safety, or have to question my midwives' capabilities. They were both incredible. Our midwives followed up with home visits and office visits to check in with our family afterwards to help with guidance, as we needed. My labor and delivery was not without complications. However, because of my amazing care that I received, I can't imagine ever having another child outside of the comfort of my own home. I am not against a hospital birth, as I understand the necessity in some birthing situations, however taking away the choice for out-of-hospital births, I don't believe is the answer. I believe the answer is licensing our midwives while giving them access to the resources they need to continue providing Georgia families the care they deserve. We need CPMs and HB seven-seventeen (717) to help expand birth options in Georgia. And on behalf of all Georgia moms and midwives, thank you.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Brenda Parrish.

Brenda Parrish, CPM

My name is Brenda Parrish, and I am a CPM with twenty-five (25) years of experience and practiced all of those here in Georgia. In those twenty-five (25) years, my clients have included families from many educational and professional backgrounds. From high school education to doctoral degrees, they have chosen homebirths. NICU nurses, police officers, deputy sheriffs, EMTs and paramedics, nurses, chiropractors, and even one (1) physician, and a silk aerialist. They have all had one thing in common, a safe birth in the privacy of their own home. They were not reckless. They chose to work towards this goal with someone who's training is specific to this environment. To that goal, each of my clients meet with me regularly. At each prenatal visit, I set aside a full hour to spend with them. I am very invested in helping the mothers maintain a healthy, low-risk pregnancy. My practice is based on a lot preventative measures. Our training heightens our awareness to when a birth can no longer be conducted at home, and by the way, I want to interject here.

We don't dislike OBs in the hospital, we very much appreciate what they do, and there are times when it is very appropriate for us to move the place of birth from home to the hospital, and when that happens, nothing is better than a good respectful transfer for our clients and for us also. It helps if there is really good communication between the transferring midwife and the hospital provider so that the needs of that client can be met more efficiently. Licensing can help facilitate those kinds of transfers because it increases respect for the profession of midwifery. And you may not realize that we all come back to the mother in her home, again, multiple times. They're seen at least three (3) times by me after the birth. No where in the obstetrics world does a mother get this kind of care and follow up after her baby's arrived. Only homebirth midwives do this. Perfectly intelligent families are choosing to utilize the services of a midwife. They want a professional that can provide that care in a more personalized way. Across the globe, trained midwives are considered a part of the professional community. Thirty-three (33) states here in the U.S., as you've heard multiple times today, have addressed this disparity and have made provision for CPMs to practice legally. We're the only birth professionals training specifically to provide out-of-institution care for mothers and babies up to six (6) weeks in a low-risk setting. Our job is made easier and safer when we can refer to other professionals when needed, and licensing makes that easier to happen. Our clients are made safer when we can order appropriate labs when needed and ultrasounds when needed. Our clients are made safer when we have legal access to the medications that are appropriate specifically to birth, not every medication out there, only the ones appropriate to birth and care. Families are going to continue to choose to have homebirths. Please help us make that option a very viable one and a very safe one here in Georgia by supporting HB seven-seventeen (717).

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Lydia McCoy?

Lydia McCoy, Student Midwife

I also think its very provincial that that picture is posted for me for motivation. That is a group of people at an event that I was at this weekend with the homebirth midwife that delivered me thirty (30) years ago at home, and she is one of my mother's closest friends 'til this day. She is one of the reasons that I am a student midwife here in Georgia and an apprentice to her as well as another Nurse Midwife that practices out of Macon, Georgia. I will keep this very brief because I want y'all to hear from them. Y'all will know by the end of this why this is important to me, but they're the consumers. They're the ones I want you to hear from. To keep this brief, in two thousand and sixteen (2016), I moved back to Georgia from Mississippi. I am originally from Georgia, and as I already stated, was literally born here and really born in my parent's bedroom in nineteen-eighty-nine (1989). My mother had six (6) previous hospital births, and then when she was expecting with me, she began to

search for a different option for her mainly due to some trauma she experienced in the hospital, and that is when she was able to find a midwife. She went on to have a beautiful homebirth that all my siblings were a part of, and that particular midwife, you can't see her very well but she's in purple, she has now terminal cancer. Her and my father brought me into the world together. Now, here are some takeaways from that brief story. Does my mother love me more than my other siblings because she had me at home? Yes. Probably so. None of them are here to defend that, so I can say that statement. I didn't know it was recorded or I would have scratched that out of my paper. But y'all know that's not true, and any mother can tell you there is absolutely zero (0) love lost because of how your baby arrives. It doesn't matter if you have a planned C-section, an induced birth, a natural hospital birth, or a homebirth. We all love our babies the same. What I am discussing here is mother's options. My mother's option, The option that was taken away from me from my husband's state of Mississippi. It does not license and recognize Certified Professional Midwives. I was not given that choice with my two (2) children. Do I love them any less? Absolutely not, but as the seventy-five (75) homebirth deliveries I have attended in my studies, six (6) that were hospital births that had previously been planned that they were transfers of care, meaning they didn't transfer in actual birth and deliver but transferred for because they were identified as something that no longer maintained that category of low-risk. We transferred care. We felt like their best option, their safest option at that point because they had the option, was to have their baby in the hospital.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. That was three minutes, sorry.

Lydia McCoy, Student Midwife

Okay, that's fine. I want to stay in Georgia, that's the main thing. I don't want to have to go to Tennessee, South Carolina, or any of the other ones. I'm here for Georgia, and Georgia families, and Georgia moms, and I want to stay in a place where I can practice and do that and give those options for Georgia mothers.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Millie McWilliams?

Millie McWilliams, Student Midwife at Midwives College of Utah

I am also going to read. Dear Committee Members, my name is Melissa McWilliams, and I live in Norcross, Georgia with my husband and three (3) kids. I am also currently a Bachelor's of Science in Midwifery from Midwives College of Utah. Thank

you for the opportunity to talk with you about my experience as a consumer of homebirth midwifery care and why I believe licensing CPMs is important for birthing people in Georgia. During my first pregnancy six (6) years ago, I decided to give birth in my home because it was where I felt most safe. My midwife saw me prenatally at hour-long appointments throughout my pregnancy where my baby and I were monitored, and I was informed about all of my pregnancy and birth options. I gave birth to all my babies at home with midwives in attendance, and I received excellent, I repeat excellent, care through all three (3) pregnancies. Several of my midwives who provided my care are here today, and I am grateful to their dedication to me. My experience as a consumer is what led me to pursue midwifery in and out of hospital setting. I wanted to provide others with the same type of care that I received. I am in the observe phases, which is one of the phases that Missi put up here, of my midwifery program which by the way, only requires ten (10). Right now, I'm at about sixty (60) just observes; nothing else, just to give you an idea. I am in the observe phases of my midwifery program and I want to tell you that every day I observe these midwives demonstrate heart, soul, compassion, intelligence, skill, discernment, and at times pure grit as they care for each individual client. I consider it a privilege to learn the art of midwifery from them. Birthing people in Georgia deserve access to the type of care that they offer, and this is why I am asking you to vote yes to House Bill seven-one-seven (717) and help us join the thirty-three (33) states who have already recognized CPMs through licensure. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Abby Schulte?

Abby Schulte, Consumer

Good morning. My name is Abby Schulte. I have four (4) beautiful children all born at home under the care of a Certified Professional Midwife. I have been fortunate to have low-risk, routine pregnancies and beautiful births. I know that not all women are able to or desire to give birth at home, but for those of us who are good candidates and have the desire, I think the option and opportunity to license Professional Midwives should be available to all Georgia women. My dad is a retired medical doctor. He's actually a radiologist, but was on the track to be an OB before he switched over, so you can imagine how thrilled he was when I announced I was going to have my baby at home. And I say that very sarcastically. He was super nervous about my choice, but seeing that my mind had been made, he supported me nonetheless. After my son was born, he was able to hear firsthand from my mom of the excellent medical care that I received. My midwives not only delivered by baby and placenta, but also stitched me up and stayed for hours after the birth monitoring me and giving the baby a thorough exam, and only leaving when we were both stable and comfortable. Then they were available via text or phone call at all times, and returned in forty-eight (48) hours to monitor baby, and me, and to run the newborn screenings. I felt so safe both medically and emotionally in their care.

After my mom, relayed all this information to my physician dad, he was convinced and very supportive of my subsequent three (3) homebirths, and they have both been impressed with the care I've received each time. One memory that is seared in my mind forever happened when I was about thirty-seven (37) weeks pregnant with my second (2nd) son. One evening I realized I hadn't felt the baby move in quite a long time. Panicking, I texted my midwife, who immediately had me call her. She gave me some things to try and said to call her back in a bit. When I still didn't feel any movement, I called her back panicking even more than the time before. I offered to drive to her house so that she could listen with the Doppler, but she insisted on coming to my house. This precious lady met me on the porch at ten (10) P.M. on a weeknight. I welcomed her with a tear stained face and trembling hands. We quietly walked to my bedroom, where we all held our breath as she skillfully placed the Doppler on my belly. I think we all shed tears of relief when we heard that beautiful, most glorious sound of a beating heart. He was alive and well, just an excellent napper [sic]. Later, I asked my midwife why she insisted on coming to my house, and she said because I wanted you to be at your home with your family if I had to give you bad news tonight. This kind of care is priceless, and it just can't be replicated in a larger-scale, doctor's office setting. Although, I want to reiterate that there's nothing wrong with going the doctor route, and I am very, so thankful for Doctors who work hard to take care of women and babies, but on behalf of my family and the other women who desire safe, out-of-hospital birth options and the midwives who work tirelessly to make this happen, I urge you to please support the licensure of Certified Professional Midwives in Georgia.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Katherine Dearborn?

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

Is there any way I could get a minute, two (2) minutes just for some bullet point rebuttals? Just some points of clarifications…

Anna Wrigley Miller, Office of Planning and Budget

Okay, but it needs to be brief.

Katherine Dearborn, Consumer

Hello. My name is Katherine Dearborn, and I am the mother to these two (2) kids who were born at home. While I want to make sure everyone understands, I have

met wonderful nurses and wonderful OBs in the hospital. I don't know if everyone know, but when there's a group practice, you're kind of rolling the dice with who is going to be on-call when you actually go into labor, and there were some that I loved in the hospital, there were others that… For example, my husband got deployed to Iraq when I was nine (9) weeks pregnant with this one, so I was receiving care at a military hospital on base, and I was asking about the hospital's policies and if they were in line with ACOG policies, like am I allowed to intermittent fetal monitoring, am I allowed to push in any position, and the nurse said, "Oh, honey. If you bring in a birth plan like that, they're going to crumple it up and toss it over their shoulder and you're going to end up with a cesarean because you were too uptight." So, I am sure you can understand why I was not comfortable rolling the dice with just whoever was going to be on call. So, I switched to a CPM, and I think that that's something that happens a lot when women only have one (1) option, especially in rural places. When you only have one (1) option, those care providers are not pushed to do the very best that they can, and I know that all care providers want to do the very best that they can but if women are given more options, I really believe that, from a business standpoint, those care providers will be pushed to do the absolute best that they can. And those care providers at the military hospital, they really believed that I probably wasn't going to drive an hour away to go see a CPM, but I would. So, the care that I received from the midwives, I can't convey the amount of dignity and respect that I was given with full informed consent, just knowing all of my options, having complete support and respect. Midwifery care is safe. It is evidence-based. My human right for what medical care I should receive and what I am allowed to deny, my human right to do that should trump policy at ever turn. Okay? And no one cares for the health of babies more than their mothers. You can trust Georgia mothers to do their research, to know that they can choose a safe care provider for their babies.

Anna Wrigley Miller, Office of Planning and Budget

Thank you, Katherine. Libby Forrester.

Libby Forrester, Registered Nurse

Good afternoon. My name is Libby Forrester. I am the mother to four (4) children. I was blessed to carry them and birth them all. Two (2) of them were in the hospital with Certified Nurse Midwives, and two (2) of them were outside of the hospital with Certified Professional Midwives. Birth changed my life, professionally and personally. God used these beautiful, low-risk experiences to, in the most intimate ways, shape who I am, shape my soul, and light a torch within me that I am proud to carry and serve our community now. I have been a Registered Nurse in Georgia since two thousand and ten (2010). I have continued my education to become an IBCLC, Lactation Consultant, Certified Doula, and a childbirth educator. On a day-to-day basis, I see the importance of and the impact that birth has within the hospital setting, within the birth center setting, and within the homebirth setting. The

importance of the conversations that I have had with OBs and CNMs and CPMs... The House Bill Seven-one-seven (717) is really an opportunity to improve the birth experiences and outcomes within our home state. I am asking each of you to please look at this as a foundational building block of communication and collaboration. It needs to happen. There needs to be a bridge between homebirth and hospital birth. This will be a building block to facilitate communication and practices and standards between OBs and Certified Nurse Midwives and Certified Professional Midwives and nurses, where when women choose homebirth and they are transferred into hospital care it is seamless and is a system that can be trusted, and it's established. This bridge is also a bridge for safe birth experiences for moms, like myself and all of our Georgia moms. It's a bridge that many states around us are working on, and are facilitating, and it's beautiful. When I think of healthcare as a nurse, I think of collaboration. I think of communication. I think of family and patient-centered care. That's what I was taught. Those are foundational pieces. Like you said earlier, the allied healthcare, that's what this can bring to our state, our families. That is optimal care during pregnancy, labor, and postpartum. I hope you see this as an opportunity to serve our community well, to improve the birth experiences and birth outcomes within our state. Thank you for your time.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Breanne Loveridge

Breanna Loveridge, Consumer

Hi, my name is Breanna, and I drove two (2) hours to be here today with my four (4) children, I have another one (1) in the back, and my husband because this is something that I care deeply about. I live in rural Georgia, so I am one of those people that you were talking about. The closest hospital to me is about forty-five (45) minutes away. The closest hospital with birth options is forty-five (45) minutes away without traffic, and this is a big problem for me because my last two (2) births from start to finish were about sixty (60) minutes from wake me up in the middle of the night to baby being born. I have these kids that I need to get off safely to their childcare, and then I would have to drive the forty-five (45) minutes. I don't want to give birth in a car. I don't want to give birth by myself. I want the same things that most other moms want; it's to give birth with an experienced practitioner in a safe and calm environment in a supported environment. That for me, in rural Georgia, means that it is probably going to be at home. Three (3) of my four (4) kids, we were living at different spots, but three (3) of them were born at home with a Georgia midwife. Certified Professional Midwives are those people for people in rural communities like me. I know my story is not unique, and that a lot of our state is rural, and licensing CPMs gives safer and more accessible care for families like me. Rural families need CPMs like our sign says, and I firmly believe that licensing them is the best and safest option for Georgia moms and families.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Ruth Cox.

Ruth Cox, Consumer

Good afternoon. I am Ruth Cox. I obtained my Bachelors in Biology, and I am married to a Georgia Tech graduated engineer who practices in the state with his P.E. I am also a CPM who has finished the bridge certificate, which you heard about earlier, but primarily I am a mother of five (5). All of whom were planned home births. I am not a stranger to risk. My first-term pregnancy was identified as a breech with other complications, which was guided to an appropriate transfer of care for a planned but unscheduled cesarean section by one of our Georgia CPMs. I have had to maintain my CPM certification with ongoing education and testing. Community health is a worldwide, recognized answer to first line response in rural and understaffed areas. Midwifery licensure will deepen those options for us here in Georgia. Prior to my training, I had been surrounded by women and families choosing homebirths, including families that would leave their state to find qualified out-of-hospital practitioners. I too was willing to use an unlicensed maternity care provider to get the quality, individualized care of a practitioner who specializes in safeguarding normal birth. Due to families' recognition of the excellent care available through Certified Professional Midwives, I urge you on this committee to please support Home Birth seven-one-seven (717).

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Robin Lommori.

Robin Lommori, Doula

My name is Robin Lommori, and I wanted to give my story as a consumer. When I was pregnant with my first (1st) child, I followed my OB's recommendations and I was induced. There was no medical reason. It was sheerly for convenience. After an unnecessary induction, a cascade of interventions, and an unnecessary cesarean, and many complications requiring a six (6) day hospital stay, I developed postpartum depression and PTSD. Unfortunately, it is estimated that nine percent (9%) of women have PTSD. My second hospital delivery wasn't a whole lot better. Years later, no hospital would even allow me to attempt a VBAC, a vaginal birth after cesarean, even though ACOG says women should be offered a trial by labor, no hospital wanted to give me that choice. They said it was too risky. My argument was that risk is subjective, and that it should be my choice. I ended up birthing my daughter, right here, with the only person that believed my body was not a lemon, a Certified Professional Midwife. I call it my redeeming birth because it should be how beautiful birth can be when women are respected and offered choices. The two (2) experiences were so drastically different, I refer to my hospital birth as McDonalds

and my CPM birth as filet mignon at a five (5) star restaurant. Thirty-three (33) states as you heard have recognized and licensed CPMs, and they all have better maternal outcomes than Georgia. Georgia has the highest maternal death rate of any state in the entire country. In the United States, it ranks forty-sixth (46th) in maternity mortality. It is safer to give birth in Saudi Arabia, South Korea, Kazakhstan, Bosnia, and Kuwait to name a few. Studies show homebirth is just as safe as hospital birth with proper selection of low-risk women and trained attendants, like CPMs. Midwives are trained in normal birth, and their C-section rates are well below the World Health Organization's suggested ten to fifteen percent (10%-15%) which keeps women healthy and costs down. The hospital charged my insurance fifty thousand dollars ($50,000) for the birth of my son, the unnecessary induction, and my midwife charged me five thousand ($5,000) for my homebirth. Georgia women deserve the option of filet mignon if they want to make that choice, and Georgia women deserve CPMs. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. Kendra Yoder.

Kendra Yoder, Home Birth Advocate

Good afternoon, everybody. Thank you for listening to all of us talk. I'm a former teacher, and my husband is a firefighter paramedic, and I'd like to start off by saying nobody cares more about mothers, children, or safety than the pair of us. This committee is here to assess whether CPMs are safe for Georgia mothers and babies. Regardless of personal ideology, the research is clear. When looking at research that has been updated to contain data that isn't without bias, the data that isn't including unassisted homebirths or accidental homebirths, i.e. the baby was born on the side of the road, then it's clear that the outcomes for mothers and babies for low-risk women in a homebirth setting with a trained midwife is substantially greater when women are given that option. To restrict that option isn't keeping anyone safe, and on the contrary, the decision to withhold licensure is a violation of our rights to choose the care that we find suitable, safe care that is backed by evidence, and that is available to women throughout the country and many others. Georgia currently has one of the worst maternal death rates in the U.S. and our neonatal stats aren't any better. While other states have been making safe choices for their citizens, including licensing CPMs, they have allowed mothers and babies to thrive, and we are sadly behind and women are being harmed rather than helped by keeping them [CPMs] out of the field legally. These midwives need the licensure to serve our mothers. They need access to these lifesaving drugs. I know that there's hiccups in that, and that needs to be worked out, but that's something that they need access to. They can access these rural communities where people aren't going to make it to the hospital. They can access communities where moms can't afford to have those kinds of services without using their insurance. I was one of those moms. I had to cash out, and it cost me a pretty penny, but I was determined to have that kind of care. Sorry, I

am getting jumbled in all of my cursive. Most importantly, we need access to them. My midwife saved my baby's life, this one right here. I planned a homebirth for the second (2nd) baby. My first (1st) was intentionally had at the hospital because my paramedic husband just wasn't sure, and I wasn't willing to push that because I wanted him to be comfortable as well. They're also his children. We decided to go with a CPM this time. Because of her expertise, she realized I had a rare, a very, very rare liver disorder that I am convinced someone else probably would have missed, but because her care was so in-depth, she immediately recognized something was wrong, transferred me to care, someone that she knew that was a CPM at a local hospital, was with me every step of the way, and they made sure that I got the care that I needed. I ended up delivering in the hospital, which is totally fine, but the care I received from her, the level of expertise that she had to recognize something so rare. She noticed even though my symptoms were not textbook; because of her in-depth care, she saw something that someone else might not have seen. And not only that, again, we don't dislike hospitals, I am so grateful that I was allowed and had the opportunity to go see the wonderful Nurse Midwife that took care of us and that everyone was safe, and that my midwife was still allowed to be there, and that she got me the care that I needed that was outside of her scope of practice that she realized, this needs something else and I will get it for you. She took care of us. Thank you so very much.

Anna Wrigley Miller, Office of Planning and Budget

Thank you for being here. Last on the list, Mary Cowan

Mary Cowan, Consumer

My name is Mary Cowan. I wanted to thank you today for listening to all of us and doing the work to understand and evaluate the topics we're discussing. You all have asked questions that show that you care about your responsibility here, and that you want to do the right thing for Georgia families. I am a Georgia voter. I am not anti-OB. I'm not anti-hospital-birth. I am thankful for the professionals that work through excruciating and expensive process so that they can care for birthing people, and I want to tell you, CPMs are that caliber of professional. They need to be included in the healthcare system, and quickly for the sake of Georgia families. I understand there are questions that you've asked, and gaps that you see that don't seem sufficient to approve. I am asking you to help us work on those gaps and help be a part of the solution for Georgia families. I had a wonderful homebirth, anecdotally, but I highly recommend it. Part of my birth story is that my mom is an RN and four (4) very traumatic births and an unnecessary C-section. They told her my brother was five (5) pounds larger than he ended up being. He was as large as one of my other siblings who she had delivered vaginally. Her birth with my youngest brother was her best birth, and it was attended by a laywife, not a CPM, who helped her labor at home and then transfer to the hospital because she was not a low-risk mother. She did not need to have a homebirth. Because of her positive

experience, I was also drawn to that path. I had my son, who is very cute over there. I am particularly interested in homebirths being covered by insurance. I, personally, have women who wanted to have a homebirth and could not afford it. I'm also interested in protection for Georgia families in choosing a CPM, and for the wonderful CPMs that I have met that want to spend their most precious commodity, time, helping birthing people in low-risk homebirths. Thank you.

Anna Wrigley Miller, Office of Planning and Budget

Thank you.

Mellissa Martello, Consumer

Do you mind if I speak? I was on the original list but my name wasn't called.

Anna Wrigley Miller, Office of Planning and Budget

What's your name?

Melissa Martello, Consumer

Mellissa Martello, I'm a consumer.

Anna Wrigley Miller, Office of Planning and Budget

I don't see you on here, but go ahead.

Melissa Martello, Consumer

Thank you so much. I appreciate it.

Anna Wrigley Miller, Office of Planning and Budget

Can you say your name one more time?

Melissa Martello, Consumer

My name is Mellissa Martello. I am speaking for the segment of Georgia women that the medical profession does not see very often. I am speaking of health women who are in control of their own health. We are powerful beings, and we have the ability to heal ourselves on so many levels, all of which are crucial to the healing process. We are capable of so much more than our society, including the medical system realizes. Our bodies are designed to give birth flawlessly. Ultimately, it is my body, my choice, and my baby, and where I choose to give birth to my children. If CPMs are not available to us, we will become less supported. They are our inspiration. They

empower us to do our powerful work. Birth is a miracle and it is a sacred experience for us Georgia women. All three (3) of my home births were sacred and beautiful. I was allowed to find strength within myself to birth my babies. It was a great growth opportunity, a rite of passage into the hard work of motherhood. My birth was fun at times. I laughed. I cried. I missed my father who passed away on the same day one (1) year before I was giving birth to his grandson. This experience gave me exactly what I needed to be the absolute best mom that I can be to encourage my children that they can overcome anything life brings to them. I don't tell my birth stories often because the majority of women who have birth in hospitals are robbed of this experience. My mother, sister both have traumatic birth experiences. Both capable, healthy, and strong women. When I became pregnant with my first (1st) child, I knew that I would have to go out of my way to avoid trauma, and I did just that. It became clear to me during my prenatal care with Kaiser Permanente that my baby and I would be robbed of anything sacred. There's not enough time to share those details, so I will spare that, but the lack of information regarding procedures was crippling and pointed towards every intervention in the arsenal whether medically necessary or not. Therefore, I chose not to go into Northside Hospital where statistically I'd have a one in three (1/3) chance of having a major stomach surgery. Please do not limit our choices. Please do not limit our supporters. Thank you so much.

Anna Wrigley Miller, Office of Planning and Budget

Thank you. I am going to give you five (5) minutes because we still have some wrap up business we have to take care of.

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

Sure. In the binder that you guys got, section seven (7), you're going to see that we have some of the other thirty-three (33) states that have reported their start up costs for what our bill what we really want, so we are going to work on that to make the bill right, but you can also see the cost analysis they did.

Anna Wrigley Miller, Office of Planning and Budget

Where did you get that from? Were they from the secretary of state offices or specific offices? I looked at that, and some of those boards have been established for a while. Establishing a board…

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

We are going to switch our bill so that we don't establish a board. We just want to be like the IBCLC bill where they're under a department. That was our intention. Since our bill got an interesting makeover in legal, we're going to work on it

Anna Wrigley Miller, Office of Planning and Budget

IBCLC?

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

IBCLC. The lactation people and the music therapists, yeah. That's kind of more of what we're wanting. We see those numbers should be more compatible with what's in section seven (7). Then, this has been updated [licensure across the U.S. graphic map] where it is showing the newest states of Kentucky and Hawaii. Now, thirty-three (33) states that use the CPM as their benchmark for certification. Less than five minutes.

Anna Wrigley Miller, Office of Planning and Budget

Okay, great. Thank you. I want to briefly explain to everybody again, we are not policy; we are from agencies. We are not legislators, so our role in the process, what GORRC's role is to look at a piece of legislation specifically as it's currently written and has been set in front of us. We make recommendations based off of the five (5) different criteria that I read out earlier. I'll briefly go through them again: whether the occupation or the unregulated practice cause harm or health to the citizens of this state, whether it requires specialized skill, whether citizens are currently being protected by other means, what the cost effectiveness/economic impact is going to be, and then whether there are means other than regulation to protect the interests of this state. That's the lens that we work from with this, and it is specifically of the bill that is in front of us. We are tied to what the bill is in front of us. Our recommendations are going to be along those lines. To everyone in the room, we're not policymakers. That will be a separate step that happens during the legislative process. We review what is set in front of us, specifically as drafted, House Bill Seven-Seventeen (717). So, our next meeting is going to be next Wednesday, November 6, 2019. It's not going to be in this room, it's going to be on the fourth floor, but over there. It is room four-zero-three (403) from eleven to twelve (11AM to 12PM), and what we are going to be doing is draft a report between now and then and we are going to vote on that report. We will have recommendations and findings like you've seen me read for other bills that we have had to evaluate. Again, eleven to twelve (11 to 12). What I want to do now with the council is get an idea of how we want to move forward with this. We've brought up, no surprise to any of you, some concerns with the bills, specifically as written, with the way it is placed, different aspects.

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

We are definitely committed to fixing that.

Gabriel Sterling, Office of the Secretary of State

Like she said, we are tied to this bill in front of us.

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

So us making amendments now won't matter?

Anna Wrigley Miller, Office of Planning and Budget

It won't matter.

Gabriel Sterling, Office of the Secretary of State

We are not policy. There are people who run for office, there are two hundred and fifty six (256) of them, you know who they all are. They're the ones that you're going to have to talk to after we talk. Specifically, on this bill, it wasn't my characterization, but I did explain it to you that this is sort of a hot mess right now. Other people came in, and it became a camel instead of the horse you wanted it to be. You have several things; I wont review it because it was in the minutes. Several lines were pointed out. You had other things pointed out today. This thing is not in the condition were we can just say let's pass this. I think you heard some of our statements of what you need to do. My suggestion is that you go back and work with you sponsors and skinny it down, follow a different path than you're doing right now to get to outcome you're coming towards. That said, you still have many regulatory hurdles ahead of you having to do with the other boards and other laws in place that are in the way of some of these things right now. The recommendation right now is House Bill Seven-Seventeen (717) cannot move forward as drafted. That is going to be the main thing. That is where I stand right now. I don't want to speak for everybody else of the committee.

Anna Wrigley Miller, Office of Planning and Budget

It is because of the rules of what this Council does. We are tied to a specific LC draft number of the bill, so we can't in good faith put a stamp of move-this-along in the process if we see specific issues with it.

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

So, if we fix it and drop it for changes, do we have to come back to you guys?

Anna Wrigley Miller, Office of Planning and Budget

So, Representative Cooper is the one who submitted the bill to GORRC. It would be up to her whether or not she resubmits it to us at a future date. So, we don't convene for everything. Music therapists were not recommended to us, so we don't write a report on music therapists. It is up to the legislator to whether or not it comes back to us.

Gabriel Sterling, Office of the Secretary of State

Or in the other way, the Governor had a specific couple things that he had after it was passed. We don't get to choose what comes to us.

Anna Wrigley Miller, Office of Planning and Budget

We don't choose what bills we review or don't review.

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

And your recommendations will point out the problems in the bill to fix officially?

Anna Wrigley Miller, Office of Planning and Budget

We will point out some recommendations. What ends up being put in, what other legislators want, but we will…our recommendation will be fifteen or so pages. You can look online to see what other reports have looked like in the past. We put suggestions out. It wont be point-by-point or line-by-line everything that needs to change. It will probably be broad things we feel, having looked at regulatory bills before, should potentially be looked at being added.

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

Thank you guys for listening to us and all of our wonderful families.

Anna Wrigley Miller, Office of Planning and Budget

Y'all can look for me to share a draft, and it will take a hot minute for us to do these minutes, so don't look for them tomorrow.

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

Sorry, Cody.

Anna Wrigley Miller, Office of Planning and Budget

Thank you, everybody. Do we move to adjourn?

All councilmembers approved adjournment