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FINAL REPORT OF THE WOMEN'S ADEQUATE HEALTH CARE SENATE STUDY COMMITTEE

COMMITTEE MEMBERS

Honorable Renee Unterman
Chair
Senator, District 45

Honorable Dean Burke
Senator, District 11

Honorable Greg Kirk
Senator, District 13

Honorable Nan Orrock
Senator, District 36

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I. INTRODUCTION

The Women’s Adequate Health Care Senate Study Committee (the “Committee”) was created with the adoption of Senate Resolution 560 during the 2015 Legislative Session. The Committee was charged with undertaking a study of the conditions, needs, issues, and problems related to women’s health care in Georgia.

The Senate members appointed to serve on this Committee include: Senator Dean Burke of the 11th; Senator Greg Kirk of the 13th; Senator Nan Orrock of the 36th; and Senator Renee Unterman of the 45th. Senator Unterman, Chair of the standing Senate Health and Human Services Committee, served as Chair of this Committee.

The Committee held five public hearings on the following dates and corresponding locations:

- Tuesday, September 14, 2015, at the State Capitol in Atlanta, Georgia;
- Tuesday, October 6, 2015, at Georgia Regents University (GRU) in Augusta, Georgia;
- Thursday, December 11, 2015, at Tift Regional Medical Center in Tifton, Georgia;
- Monday November 9, 2015, at the State Capitol in Atlanta Georgia; and
- Thursday December 3, 2015, at the State Capitol in Atlanta Georgia.

The following legislative staff members were assigned to this Committee: Ms. Jennifer Yarber and Ms. Gavriella Coffman of the Senate Press Office; Mr. Jared Evans and Mr. Elton Davis of the Senate Budget and Evaluation Office; Ms. Elizabeth Holcomb of the Senate Research Office; Ms. Lynn Whitten of the Office of Legislative Counsel; and Ms. Avi’el Bland, Senate Health and Human Services Committee Secretary and Legislative Assistant to Senator Unterman.

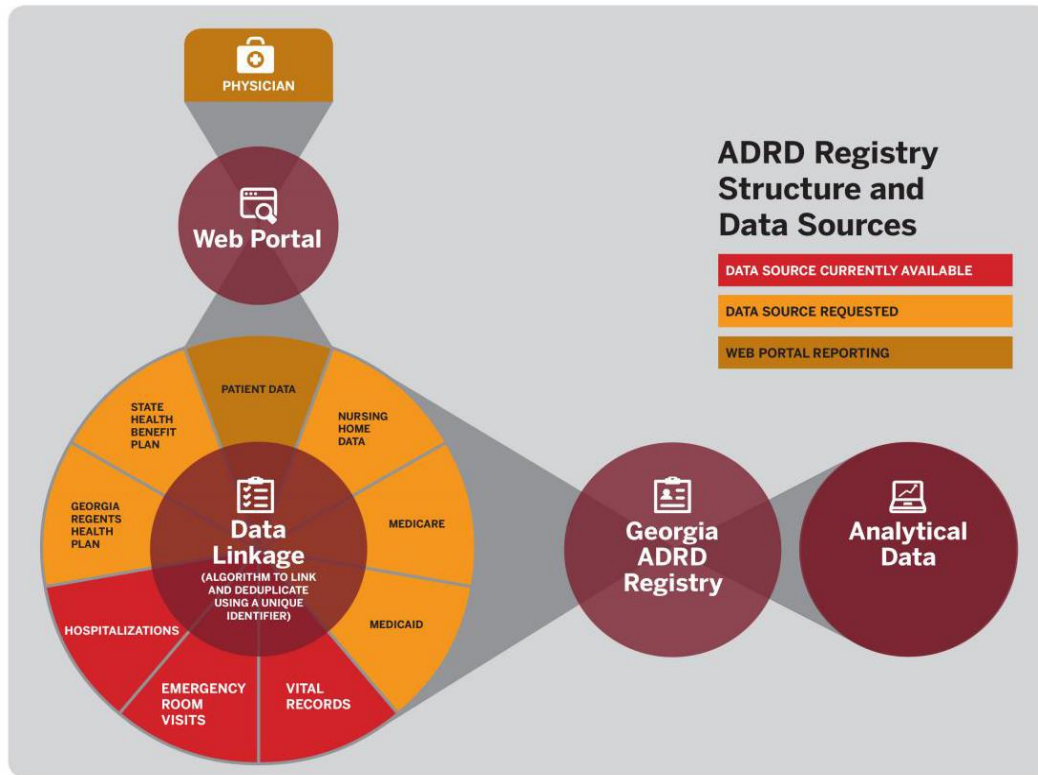
II. BACKGROUND

A number of health care initiatives were underway in Georgia when the Committee began this study. This section provides a brief history on topics discussed by the Committee and presented in testimony.

Georgia's **telemedicine** system is managed by the Georgia Partnership for TeleHealth (GPT), a non-profit and statewide collaboration between policymakers, health care providers, and patients. In January 2013, GPT reported 136,000 patient encounters and an increase from eight patient visits in 2006 to over 75,000 in 2012. GPT now has over 350 locations with 600 healthcare partners and providers and over 200 specialists that represent more than 40 specialties participating in network. Tift Regional Medical Center (host of Meeting 3) was an original partner in Georgia's telemedicine network. Now, the facility uses telemedicine to connect with patients in various cities across Georgia, including Atlanta, Macon, and Augusta. It also connects regional physicians to students in school-based health clinics.

The **Alzheimer's Disease and Related Dementia (ADRD) State Registry** was established within the Georgia Department of Public Health (DPH) in 2014 pursuant to House Bill 966. The purpose of the registry is to: (1) collect and disseminate usable data to inform programs and services for the aging population, (2) identify epidemiological trends, (3) bring awareness at the state level to issues that affect healthy aging, and (4) inform stakeholders for planning and for future registry needs. The ADRD Registry is a key component of the Georgia Alzheimer's and Related Dementias State Plan that was issued by a task force and supported by the Georgia legislature in 2013 and 2014.¹ Information on the ADRD

Figure 1



¹ Senate Bill 14 created the Alzheimer's and Related Dementia State Plan Task Force in 2013 to create a comprehensive state plan to address Alzheimer's disease and related dementias. Senate Resolution 746, sponsored by Senator Unterman of the 45th, was adopted during the 2014 Legislative Session in support of the state plan.

Registry is available online on DPH’s website, including instructions on how to access the ADRD web portal and the diagram provided above in Figure 1 on Page 3.²

The **Georgia Maternal Mortality Review Committee (MMRC)** is the result of a three-year process that involved coordination and collaboration with DPH, the Georgia OBGyn Society, and the Centers for Disease Control and Prevention (CDC). The General Assembly’s passage of Senate Bill 273 during the 2014 Legislative Session laid the foundation for the MMRC’s work following the release of a 2010 study that listed Georgia as the state with the highest maternal mortality rate in the nation.³ In addition to ensuring the confidentiality of the review process for maternal mortality in Georgia, Senate Bill 273 provided the MMRC with the authority and legal protection to collect data for case reviews. The Georgia MMRC’s mission is to “identify pregnancy-associated deaths, review those caused by pregnancy complications and other selected deaths, and identify problems contributing to these deaths and interventions that may reduce these deaths.”

During the 2015 Legislative Session, the Georgia legislature passed House Bill 436, “**The Georgia HIV/Syphilis Pregnancy Screening Act of 2015.**” This legislation updated the Georgia HIV Pregnancy Act of 2007 by requiring that physicians providing prenatal care are to offer HIV and syphilis testing to any pregnant woman during the third trimester of pregnancy. At the time of delivery, if there is no evidence of such testing having been performed during the third trimester of gestation, a physician may order HIV and syphilis testing of the mother. However, the pregnant woman or mother may refuse any of these offers to test for HIV and syphilis.

House Bill 72 was also passed during the 2015 Legislative Session, amending Georgia law to provide more tools to detect, report, and prosecute cases involving the **abuse, neglect, and/or exploitation of disabled or elder persons**. The enacted provisions of this legislation allow evidence obtained pursuant to an inspection warrant is to be admissible in a criminal case and offer preferred scheduling of court cases to preserve testimony of elderly or disabled victims.

Rural Hospital Stabilization Committee and Pilot Program

Rural hospital closures have been a topic of growing concern in our state for quite some time—between 2010 and 2014, five hospitals in rural Georgia closed. In response to Georgia’s rural health struggles, Governor Nathan Deal created the Rural Hospital Stabilization Committee in March of 2014 to identify the needs of the rural hospital community and provide potential solutions. In its Final Report to the Governor in February of 2015, the Rural Hospital Stabilization Committee recommended a four-site “Hub and Spoke” pilot program and designated the Georgia Department of Community Health (DCH) State Office of Rural Health as the oversight entity responsible for the program’s implementation and monitoring.⁴ The rural hospital stabilization pilot program was appropriated \$3 million in State General Funds for Fiscal Year 2016 and is scheduled to run for 18 months.⁵

Specifically, the pilot program seeks to build out an integrated “Hub and Spoke” model to prevent the over-utilization of the Emergency Department (ED) as a primary care access point. The goal of a “Hub

² See <https://dph.georgia.gov/alzheimers-registry>.

³ Senate Bill 273, 2014 Legislative Session, was sponsored by Senator Dean Burke of the 11th.

⁴ See Rural Hospital Stabilization Committee, Final Report to the Governor (February 23, 2015). Available online at: https://gov.georgia.gov/sites/gov.georgia.gov/files/related_files/document/Rural%20Hospital%20Stabilization%20Committee%20Report%20022315%20FINAL.pdf.

⁵ See House Bill 76, 2015 Legislative Session. Health Care Access and Improvement Line Item 84.6. Available online at: http://www.senate.ga.gov/sbeo/Documents/AppropriationsDocuments/FY2016/General/fy16g_fullbill_final.pdf.

and Spoke” model is to best use existing and new technology to ensure that patients receive treatment in the most appropriate setting and consequently relieving the cost pressures on small rural hospitals’ EDs. The “hubs” are four communities with nursing homes, home health, rural health clinics, and a regional hospital, while the “spokes” include smaller critical access hospitals, ambulances equipped with WiFi and telemedicine, school clinics equipped with telemedicine, Federally Qualified Health Centers (FQHCs), public health departments, and local physicians. The four hubs for the pilot program include:

- Union General in Blairesville, Georgia (Blue Ridge Mountains);
- Crisp Regional in Cordele, Georgia (South Georgia);
- Appling HealthCare System in Baxley, Georgia (South Georgia); and
- Emanuel Regional Medical Center in Swainsboro, Georgia (Middle Georgia).

III. MEETING TESTIMONY

All testimony reflected in this report is limited to the information that was provided to the Committee at its public meetings. This section provides a brief summary of each meeting, including the names and affiliations of individuals who were asked to provide testimony to the Committee. Although testimony has been condensed for the purpose of this report, a copy of all presentations and materials submitted to the Committee are kept on file in the Senate Research Office.

A. Meeting 1: September 14, 2015

The Committee’s first meeting consisted of an overview of women’s health care in Georgia and presentations were provided by the following individuals and entities:

- Commissioner Brenda Fitzgerald, MD, Georgia Department of Public Health (DPH).
- Melanie McNeil, Esq., State Long-Term Care Ombudsman Program.
- Catherine Bonk, MD, MPH, Georgia Obstetrics and Gynecology (OBGyn) Society.

Senator Unterman opened the first meeting by welcoming everyone and emphasizing the importance of this Committee. She went on to explain that the scope of the Committee’s study has been expanded to allow for the study of issues outside of the shortage of obstetric and gynecologic services in rural areas of Georgia.

Dr. Brenda Fitzgerald, Commissioner of DPH, provided an overview of the status of women’s health care in Georgia. Maternal mortality refers to the death of a woman during pregnancy or up to one year after delivery. This includes pregnancy-related death, which is a death during or within one year of pregnancy caused by a complication of pregnancy; and pregnancy-associated death, a death of a woman from any cause while she is pregnant or within one year of pregnancy. Ranking 50th on a national scale, Georgia has one of highest maternal mortality rates in the nation. Georgia’s MMRC released a report of its findings in June of 2015 after it completed its first year (2012) of case reviews for 122 maternal mortality cases. Although the MMRC’s review of these cases concluded that 60 were pregnancy-associated deaths and 25 were pregnancy-related deaths, 37 cases were discovered to have been incorrectly designated as maternal mortalities. These 37 deaths were attributed to mistakes on death certificates where a check box used to indicate a pregnancy had been incorrectly marked. The review of medical charts and coroner’s certificates revealed cases where it was not possible for the deceased to have been

pregnant at the time or within a year of death. For example, it would be implicit in a review of a male who died of prostate cancer that the deceased was not pregnant. Dr. Fitzgerald informed the Committee that the standard coroner's certificate used in Georgia has since been changed to help reduce the occurrence of such mistakes.

Dr. Fitzgerald also provided the Committee with information on infant mortality in Georgia. Between 2002 and 2006, the infant mortality rate in Georgia was 8.4 deaths per 1,000 live births, 15 to 20 percent higher than the national average. Her presentation also highlighted: the self-management and treatment of diabetes; risk factors for cardiovascular disease (CVD); the importance of screening services for the early detection of breast cancer; and the creation of the ADRD State Registry within DPH. More detailed testimony on each of these items was provided to the Committee at Meeting 2, discussed below.

Next, the Committee heard from Melanie McNeil, Esq., the State Ombudsman for the Long-Term Care Ombudsman (LTCO) Program within Georgia's Department of Human Services (DHS). Ms. McNeil shared with the Committee that evidence based disease prevention and health promotion programs are under way across the state to support the health care of older women. The Chronic Disease Self-Management Program (CDSMP) is a statewide workshop offered through the Area Agencies on Aging (AAA). The program serves to empower its participants to become part of their own health care team through various techniques including problem solving, communication with family and health care providers, and teaching basic health promotion and behavior skills. Covering chronic conditions such as arthritis, heart disease, and diabetes, the CDSMP aims to reduce health care utilization by encouraging patient autonomy and improved engagement in one's health care. At least 3,000 individuals have completed this program.

Ms. McNeil explained the Hospital Transitions program, an evidence based program aimed at reducing hospital readmission rates and improving health outcomes that can be implemented using either the "Bridge model" or the "Coleman model." The Bridge model emphasizes collaboration among hospitals, community-based providers, and the Aging Network to ensure a seamless continuum of health and community care across settings. Instead of adding another silo of care, it connects existing silos to assist older adults and caregivers transition across the continuum of care. In contrast, the Coleman model is a four-week program where patients with complex care needs and their family caregivers receive specific tools. Such tools include working with a "Transition Coach" to learn self-management skills that can be used during a patient's transition from hospital to home. The four pillars of the Coleman model include: (1) medication self-management; (2) the use of a dynamic patient-centered Personal Health Record (PHR); (3) primary care and specialist follow-up visits; and (4) knowledge of red flags that signal to a patient that his or her condition is worsening and how to respond. Ms. McNeil briefly mentioned the Grandparents Raising Grandchildren Program and explained how it provides respite for those who are acting as caregivers, many of which are women.

Finally, Dr. Catherine Bonk, President of the Georgia OBGyn Society, provided testimony to the Committee. Dr. Bonk is a practicing obstetrician and gynecologist (OB/GYN) in Decatur, Georgia, and has been in practice for 25 years since completing her residency training. Dr. Bonk informed the Committee that the OB/GYN workforce is dwindling and that the aggregate debt for an OB/GYN amounts to about \$250,000 after completing the requisite four years of undergraduate education, four years of medical school education, and four years of residency training. In Georgia, there are five OB/GYN residency training programs that collectively produce about 23 graduates per year; of these graduates, only half choose to stay in Georgia. Dr. Bonk emphasized to the Committee that Georgia

needs focus on graduating more residents from these programs as well as keeping them in the state after completing training. Other Georgia OB/GYNs provided testimony regarding this issue on behalf of the Georgia OBGyn Society at Meetings 2, 3, and 4.

B. Meeting 2: Tuesday, October 6, 2015

The Committee held its second meeting on October 6, 2015, at Georgia Regents University (GRU) in Augusta Georgia.⁶ Three panels of experts in women’s health provided testimony to the Committee on the following topics: (1) oncology; (2) the aging population; and (3) cardiovascular disease and preventative health.

Oncology Panel

- Sharad Ghamande, MD, Interim Associate Clinical Cancer Center Director, Section Chief for Gynecologic Oncology and Professor in the Department of Obstetrics and Gynecology at GRU.
- Nancy Paris, MPA, President of Georgia CORE (Center for Oncology Research and Education).
- Angie Patterson, Vice President of Georgia CORE.
- David McIntosh, MD, Professor of Gynecologic Oncology, Mercer University School of Medicine; Georgia OBGyn Society.

The oncology panel provided information on cancer incidence in women and issues related to cancer treatment costs in Georgia. Dr. David McIntosh, a gynecologic oncologist and professor at Mercer University School of Medicine in Macon, Georgia, provided testimony on three topics: (1) Cancer State Aid Program funding shortfalls; (2) secondary school education on cancer; and (3) issues with high insurance deductibles. Formed in 1937, the Cancer State Aid (CSA) Program within DPH provides funding for diagnostic and cancer treatment services for uninsured and under-insured Georgia adults with limited annual household income. While the Georgia legislature designates state funds to the CSA Program to support the payment of cancer-related services, Dr. McIntosh told the Committee that the CSA Program runs out of money about two months early each year. This delays diagnostic imaging, the first step in detecting and treating cancer, and contributes to uncompensated care costs in Georgia. Dr. McIntosh also told the Committee that many middle school and high school students are misinformed about cancer facts and that an organized curriculum geared toward dispelling common cancer myths would be extremely helpful.

Dr. Sharad Ghamande, Professor and Director of Gynecologic Oncology at GRU’s Cancer Center, provided the Committee with information on cervical cancer and related risk factors, such as the human papillomavirus (HPV). Dr. Ghamande told the Committee that if HPV vaccinations in Georgia increased by 80 percent, as many as 53,000 new cases of cervical cancer could be prevented in the lifetime of those aged younger than 12 years old.

Next, the Committee heard from the Georgia Center for Oncology Research and Education (CORE). Angie Patterson, Vice President of Georgia CORE, presented information on hereditary breast and ovarian cancer. When the Georgia Cancer Coalition was dissolved in 2011, Georgia CORE continued to operate the statewide research network and maintained programs for cancer survivors. Georgia CORE informed the Committee that one-fourth of female deaths in Georgia are attributed to breast cancer

⁶ While Georgia Regents University (GRU) is “soon to be Augusta University,” this report refers to the institution as “GRU” during this transition period.

and ovarian cancer is the fifth leading cause of death in females in our state. Nancy Paris, President and CEO of Georgia CORE, emphasized the importance of detecting breast cancer at earlier stages by partnering with non-profits, public health centers, clinics, and hospitals to deliver mammography, genomic screening, and genetic testing to underserved women. She asked the Committee to consider recommending \$200,000 in funding to support such efforts to provide more cost effective care.

Panel on Georgia's Aging Population

- Carlos Isales, MD, FACP, Department of Neuroscience and Regenerative Medicine, Department of Orthopaedic Surgery, Medicine and Cellular Biology and Anatomy, Medical College of Georgia (MCG) at GRU.
- Debra Minor, RN, Area Agency on Aging, Augusta.
- Diana Cutright, RN, CSRA Regional Commission Nursing Supervisor Augusta, Aiken, Workers Comp for CSRA Division, ResCare HomeCare.
- Sheila Humberstone, Alzheimer's Association, Georgia Chapter.

Dr. Carlos Isales, a professor of medicine for MCG at GRU and physician specialized in orthopedics and endocrinology, provided the Committee with testimony specific to Georgia's aging population.⁷ He explained that aging often results in a decline in function of various physiological systems, including the: cardiorespiratory; musculoskeletal; neuroendocrine; immune; gastrointestinal; and auditory, visual, and vestibular systems. "Frailty," or musculoskeletal aging, is a relatively modern concept or syndrome that is used to describe musculoskeletal aging, which can be prevented through exercise. Frailty is considered to be present when a patient experiences three or more of the following characteristics: self-reported exhaustion; reduced physical activity; slow walking speed; reduced grip strength; and unintentional weight loss. In terms of strength, it is a normal part of the aging process for individuals to experience sarcopenia or a loss of skeletal muscle. Dr. Isales spoke on how sarcopenia begins around age 45, when muscle mass starts to decline at a rate of roughly 1 percent per year. He reported that a majority of women will lose about 40 percent of muscle strength by age 75; without exercise and training, strength levels will fall rapidly after age 60 due to the atrophy of muscle fibers.

Dr. Isales went on to describe the aging effects on bone density and bone quality, explaining that women experience accelerated bone loss due to decreases in estrogen levels. He reported that, over a lifetime, females lose approximately 42 percent of their spinal bone mass and 58 percent of their femoral bone mass. Compared to men, women have a higher risk of osteoporosis, a systemic skeletal disease characterized by low bone mass and deterioration of bone tissue. Dr. Isales explained that osteoporosis results in increased bone fragility and susceptibility to fracture that is often a "silent disease and will not be detected until a fracture occurs." Acknowledging the significant health care costs associated with osteoporosis-related fractures, he informed the Committee that the best predictor for fracture risk is the history of a previous fracture. However, he reported that of the patients seen in orthopedics for a fracture: only 6 to 10 percent are screened for osteoporosis; and only 10 to 20 percent prescribed any treatment for osteoporosis. Dr. Isales concluded his presentation by emphasizing that "aging is not a disease" and Georgia needs a comprehensive approach to treating its rapidly growing aging population. Although the National Institute of Health (NIH) provides funding to aging centers, there are no NIH-funded centers in our state.

⁷ Dr. Isales is a professor of medicine at MCG's Department of Neuroscience and Regenerative Medicine and Department of Orthopaedic Surgery, Medicine, and Cellular Biology and Anatomy.

Ms. Debra Minor of Augusta's Area Agency of Agency added to Dr. Isale's testimony on how aging affects estrogen levels in women by stating the importance of providing patient education as estrogen levels decrease; information on hormone replacement therapy is especially needed.

Ms. Diana Cutright presented information on the prevalence of Alzheimer's disease and related dementia (ADRD) within the female population on behalf of the CSRA Regional Commission of Augusta. Because people are living longer, ADRD has surpassed heart disease and cancer as the leading cause of death in the aging population. Of the 5.3 million cases of ADRD in America, two-thirds of those cases are women. Ms. Cutright reported that women, when compared to men, are more prone to develop ADRD disease than cancer. Ms. Cutright told the Committee that caregivers, who are most often female, are dying faster than the persons with Alzheimer's disease because of the stress related to caretaking. She added that roughly 40 percent of caregivers in a survey felt like they had no choice but to quit their former job in order to continue caretaking. In closing, Ms. Cutright told the Committee that additional funding for ADRD research would be beneficial, especially in treating Georgia's growing aging population.

Ms. Sheila Humberstone of the Alzheimer's Association echoed the comments made by Ms. Cutright and agreed that there is a need for more home and community-based services for ADRD patients and caregivers. The cost to Medicare for individuals with ADRD already nears half a billion dollars in Georgia. Ms. Humberstone thanked the Committee and the Georgia legislature for its past support of ADRD in 2013 and 2014 as well as the increase in funding for adult protective services (APS) for the emergency relocation of abused adults from unlicensed personal care homes in 2015, discussed above in Section II. On behalf of the Alzheimer's Association, she asked the Committee for its support in working to make guardianship across state lines more transferable, referencing pending legislation that supports this very goal.⁸ She also recommended that the Committee continue focusing on ramping up APS services and criminal justice reform.

Panel on Cardiovascular Disease and Preventative Health

- Stephen Goggans, MD, MPH, District Health Director for the East Central Health District, District 6, Department of Public Health.
- Lucy Marion, PhD, RN, FAAN, FAANP, Dean and Professor, GRU College of Nursing.
- Selina Smith, PhD, MDiv, Director, GRU Institute of Public & Preventive Health .
- Pascha E. Schafer, MD, FACC; Assistant Professor of Medicine, MCG at GRU; Medical Director, Cardiac Care Unit; Associate Program Director, Internal Medicine Residency.

Dr. Stephen Goggans of DPH presented information on cardiovascular disease (CVD), which includes the following: heart attacks and angina (heart failure); stroke and transient ischemic attacks; and peripheral or aortic artery disease. For women, key risk factors for CVD include: being over 55 years old; having a family history of early CVD; abnormal lipids; diabetes mellitus; smoking; high blood pressure; and obesity. According to DPH, 59 percent of women and 71 percent of men in Georgia are either overweight or obese. Additionally, diabetes mellitus (DM) in Georgia women brings a higher risk of coronary heart disease than in men. Dr. Goggans relayed to the Committee that DPH's hotline for smoking cessation has been very effective, achieving impressive cessation rates that are higher than the national rates.

⁸ Senate Bill 270, sponsored by Senator Josh McKoon during the 2015 Legislative Session, is currently pending in the Senate Judiciary Committee.

Lucy Marion, Dean of GRU's College of Nursing, gave a presentation on addressing chronic health conditions in women through the utilization of the nursing workforce.⁹ This presentation included information on basic nursing care for women, advanced nursing for women, and the role of advanced practice nurses in Georgia. Dean Marion reported that the University System of Georgia has been very active in implementing APRN training programs and that Augusta's program has served as the flagship for other schools in Georgia. Her recommendations for improving the Georgia's nursing workforce included the following suggestions: creating strong incentives for rural nurse practitioners; removing APRN practice barriers in Georgia; and creating new nurse practitioner and nurse midwifery programs.

Dr. Selina Smith of GRU added to the discussion by summarizing chronic disease trends and their link to human behaviors. She told the Committee that six out of seven leading causes of death are chronic diseases related to behaviors individuals can modify. She noted the "phenomenal work" done through legislation on student health and posed the question of "how do you legislate behavior without being too invasive on adult level?"

Dr. Schafer of GRU closed the discussion with a presentation that included information on women's awareness of CVD risk and barriers to heart health. While 90 percent of women have more than one risk factor of CVD, their perception of risk is low. For example, women are less likely to call 9-1-1 if experiencing the symptoms of a heart attack than if someone else was exhibiting similar symptoms. Dr. Schafer stated that while CVD is the leading cause of death in Georgia, there is still a disparity in health care for CVD in women. However, she is optimistic that we can promote equitable care through investment in education, prevention, and research to support evidenced based practice.

C. Meeting 3: Monday, October 26, 2015

The Committee's third meeting was hosted by Tift Regional Medical Center on its campus in Tifton, Georgia. At this meeting, the Committee heard testimony on three topics: (1) obstetrical manpower shortages in Georgia; (2) practicing obstetrics in rural Georgia; and (3) rural health stabilization initiatives. The following individuals provided testimony and participated in panel discussions:

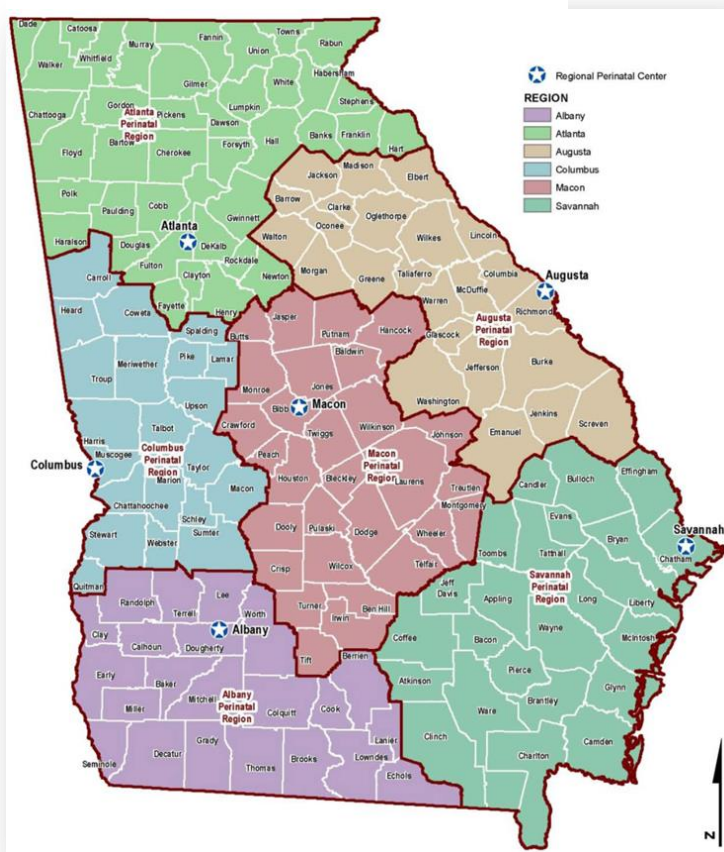
- Adrienne Zertuche, MD, MPH, Emory Department of Gynecology & Obstetrics; Founder and President, Georgia Maternal and Infant Health Research Group (GMIHRG); Georgia OBGyn Society.
- Hugh Smith, MD, OB/GYN at Upson Regional Medical Center, Thomaston, Georgia; Georgia OBGyn Society.
- Sandra Reed, MD, OB/GYN at Shaw Center for Women's Health, Thomasville, Georgia; Georgia OBGyn Society.
- Mary Trescot, OB Practice Manager, Tifton, Georgia; Georgia OBGyn Society.
- Paul Browne, MD, Section Chief, Associate Professor of Maternal Fetal Medicine, GRU.
- Chadburn Ray, MD, RPh, Associate Professor and Residency Program Director, Department of Obstetrics and Gynecology, GRU.
- Anne Patterson, MD, Maternal Fetal Medicine Specialist, Women's Telehealth, Atlanta, Georgia; Georgia OBGyn Society.

⁹ Dean Marion provided additional testimony on APRN training programs at Meeting 4.

Dr. Zertuche delivered a presentation on behalf of the Georgia OBGyn Society titled “Georgia’s Obstetric Crisis: Origins, Consequences, and Potential Solutions.”¹⁰ She explained that Primary Care Service Areas (PCSAs) are a collection of counties in which less than 30 percent of the residents receive primary care. According to Dr. Zertuche, 43 of the 82 Georgia PCSAs outside the Atlanta metro service area have either an “overburdening or a complete absence of obstetric providers.” Of Georgia’s PCSAs, she reported that 31 have no obstetricians; 73 have no delivering family practitioners; and 57 have no certified nurse midwives (CNMs). Noting that the average age of retirement for rural obstetricians is age 52 for men and age 44 for women, she forecasted that 58 of 77 rural PCSAs will lack obstetric services by year 2020. Dr. Zertuche discussed potential solutions to address Georgia’s rural areas and improve maternal and infant health outcomes, which included: exploring financial incentive programs for physicians and extenders that provide obstetric services; improving perinatal regionalization; and expanding the use and access to telemedicine in Georgia.

Ms. Mary Trescot manages a practice specializing in obstetrical care in Tifton, Georgia. She joined two OB/GYN physicians, Drs. Sandra Reed and Hugh Smith, to discuss the challenges of practicing obstetrics in rural Georgia. They were in agreement that it is difficult to recruit OB/GYN physicians to practice in rural Georgia where they work long hours and tend to be paid less than if they were to practice in a metro area. The panel also reported that most patients in rural Georgia have to travel long distances for perinatal care.

Figure 2



Referencing the Rural Hospital Stabilization Pilot Program, they are optimistic about the concept of using telemedicine to help provide more fluid prenatal and obstetrical care. The Committee learned that Georgia’s Regional Perinatal Centers map was last drawn in 1971 and the regions have not been redrawn due to lack of funding. The map provided in Figure 2 (left) and available on DPH’s website was referenced numerous times throughout this hearing and again at Meeting 4.¹¹ There are six Regional Perinatal Centers where hospitals are designated to provide maternal and infant care for high risk patients in specific geographic regions in the state.

¹⁰ Dr. Zertuche is completing her specialty training at the Emory Department of Gynecology and Obstetrics and is the Founder and President of the Georgia Maternal and Infant Health Research Group (GMIHRG).

¹¹ Available online at <https://dph.georgia.gov/regional-perinatal-centers>.

Dr. Paul Browne, an associate professor of maternal fetal medicine at GRU, provided testimony on the importance of prenatal care in rural areas and MCG's "Partners in Prenatal Care" program. The program helps primary care providers re-start OB outpatient care by using hospitalists at MCG to provide hospital care for obstetric patients. Patients can be seen locally for prenatal and postpartum visits, while only needing to travel for hospital care. This program has expanded within the region surrounding Augusta and Dr. Browne believes it could easily be scaled to the entire state. He also spoke about the imbalance in funding for women in the Maternal and Infant Care funded through DPH. Funding for the support of newborns and neonatal intensive care units is significant, while only 3 percent is directed to care of the pregnant woman. Therefore, Dr. Browne urged the Committee to recommend that funding to the Maternal and Infant Care grant be increased to help equalize funding for maternal and fetal care.¹²

Dr. Chadburn Ray gave a presentation on workforce re-entry programs for physicians. As the Residency Program Director for GRU's Department of Obstetrics and Gynecology, Dr. Ray focused primarily on re-entry for obstetric providers in Georgia. He indicated that there is no single panacea for solving the issues related to the obstetrics workforce. Changes in practice patterns and demographics contribute dramatically to workforce shortages and it is estimated that there will be a shortage of more than 15,000 obstetric providers nationally by 2050. Dr. Ray told the Committee that there will be an increased demand for women's health services of 9 percent by 2020, which is concerning given Georgia's population is growing at a greater rate than most southeastern states. Moreover, Dr. Ray shared concerns that the lack of federal funding for graduate medical education (GME) over the past several decades will negatively impact our health care delivery system. According to Dr. Ray, the Georgia Center for Obstetrics Re-entry Program ("Georgia CORP") has the potential to provide a better return on investment than federal dollars for GME by educating more providers in less time. Start-up costs for this program are estimated to be upwards of \$200,000.00 for the first year; this includes funding for a program director, program coordinator, program faculty, office space, and supplies while training at MCG's academic medical center.

Dr. Anne Patterson closed the meeting by providing testimony on the use of telemedicine to expand prenatal and high risk OB care. The Committee briefly commented on the use of telemedicine in the recently implemented Rural Hospital Stabilization Pilot Program.

D. Meeting 4: Monday, November 9, 2015

The fourth meeting, held at the State Capitol in Atlanta, Georgia, focused on physician and nurse workforce issues, certified nurse midwifery (CNM) programs, and perinatal regionalization. Testimony was provided by the following individuals:

- Cherri Tucker, Executive Director, Georgia Board for Physician Workforce.
- James R. Zaidan, MD, MBA, Associate Dean, Graduate Medical Education, Emory University.
- Chadburn Ray, MD, RPh, Associate Professor and Residency Program Director, Department of Obstetrics and Gynecology, GRU.
- Lucy Marion, PhD, RN, FAAN, FAANP, Dean and Professor, College of Nursing, GRU.
- MaryJane Lewitt, PhD, CNM, FACNM, Director, Nurse-Midwifery Program, Nell Hodgson Woodruff School of Nursing, Emory University.

¹² The source of this funding is the Health Resources and Services Administration and requires matching state funds.

- Nicole Carlson, PhD, CNM, Assistant Professor, Nell Hodgson Woodruff School of Nursing, Emory University; President, Georgia Affiliate of the American College of Nurse Midwives.
- Pat Cota, RN, MS, Executive Director, Georgia OBGyn Society.
- Seema Csukas, MD, PhD, Medical Director, Maternal and Child Programs, DPH.

Ms. Cherri Tucker of Georgia Board for Physician Workforce (GBPW) provided a brief presentation to the Committee on physician workforce data in Georgia. She informed the Committee that Governor Deal has committed to adding 400 new Graduate Medical Education (GME) residency slots in Georgia to bring our state up to the per capita rate of medical residents for southeastern states. Currently, GBPW offers the Physicians for Rural Areas Assistance Program, which can help with loan repayment amounts up to \$100,000. She also reminded the Committee of the Georgia Rural Physician Tax Credit incentive program, which is provided under O.C.G.A. § 48-7-29 and administered by the Georgia Department of Revenue. The Committee asked Ms. Tucker for additional data on the number of new GME position and related costs for State Fiscal Year (SFY) 2016, which is discussed below at Meeting 5. The Committee also heard testimony on GME programs in Georgia from Dr. Zaidan, Associate Dean of GME at Emory University. Dr. Zaidan told the Committee that while Emory is known for its sub-specialty programs, it is focusing on expanding its family medicine, internal medicine, and gerontology programs. Dr. Ray of GRU commented that MCG's program faces funding challenges of absorbing the cost of previous residents; currently, three residency slots must be funded through partnerships with regional hospitals. Dr. Zaidan and Dr. Ray mentioned the prohibitive nature of student loan debt and agreed that it would be beneficial to explore tax credits and loan forgiveness programs to incentivize residents to stay in Georgia after completing training.

Dean Lucy Marion of GRU's College of Nursing presented information on APRN training programs, a continuation of the testimony she provided at Meeting 2 in Augusta, Georgia. At this hearing, Dean Marion discussed the lack of incentives for preceptors for APRNs in training programs in Georgia. She identified that Georgia is not currently a "destination state for APRNs" and suggested strategies to address this. Suggestions included: starting a faculty practice that maximizes student learning and provides salary incentives to faculty for maintaining competence in the field; forgiving education debt; and implementing inter-professional team assignments between APRNs and other medical professionals.

Drs. MaryJane Lewitt and Nicole Carlson of Emory presented information on the need for additional Certified Nurse-Midwifery (CNM) programs and preceptor sites in Georgia. Currently, the only school in Georgia with a CNM program is Emory University. Dr. Lewitt, Director of Emory's CNM program, told the Committee that 85 percent of student clinical experience for a CNM degree must take place with midwifery preceptors and there is lack of community-based preceptors in Georgia. She recommended that CNMs be included in the rural physician tax credit program that is administered by the Georgia Department of Revenue. In conclusion, Emory asked for the Committee's support to expand the practice authority for CNMs in Georgia.

Testimony on the Georgia's regional perinatal system and centers was provided by Dr. Seema Csukas of DPH and Ms. Pat Cota of the Georgia OBGyn Society. Dr. Csukas explained Georgia's six Regional Perinatal Centers are designated to specific geographic regions that provide advanced care for high risk mothers and infants.

Services Provided by Regional Perinatal Centers include:

- Comprehensive perinatal health care for pregnant women, their fetuses and infants of all risk categories;
- Medical consultation;
- Assistance with transport/transfers of high-risk mothers and infants; and
- Outreach education to providers and staff of hospitals within the specific region.

Ms. Cota then provided suggestions for preserving and updating Georgia's regional perinatal system. The Committee previously learned at Meeting 3 that the perinatal regions were last drawn in 1971 and therefore do not account for telemedicine services. Ms. Cota asked the Committee to consider a state level perinatal health collaborative to evaluate and coordinate all Georgia's efforts to improve obstetrical and newborn services by reorganizing and updating the regional perinatal system. This collaborative body would also be responsible for developing a plan for monitoring the levels of care in OB hospitals and submitting a report on the preservation of rural obstetric services.

E. Meeting 5: Thursday, December 3, 2015

The Committee was briefed with follow-up information that was submitted by Emory University's CNM program and GBPW. At Meeting 4, the Committee heard from GBPW about the Governor's plan to create new GME residency positions in the following years. The roll-out schedule for SFY 2016 includes adding 20 new GME positions in Georgia hospitals. The total cost for these new GME slots in SFY 2016 is \$352,755.85.

Dr. Lewitt of Emory reiterated her testimony from Meeting 4, stating that full practice authority for CNMs in Georgia would improve access to care, especially in rural areas. Currently, Georgia is one of two states that have not passed legislation expanding full practice authority for CNMs. Many states have made use of the model statutes and rule language in the National Council for State Boards of Nursing Model Act, which was provided to the Committee.

In conclusion, the Committee discussed its findings and recommendations based on the testimony heard at Meetings 1-5. The Committee's recommendations are summarized below in Section IV.

IV. COMMITTEE RECOMMENDATIONS

Based on the foregoing findings, the Committee makes the following recommendations:

1. The Committee was encouraged by the findings of the Maternal Mortality Review Committee's (MMRC's) first year of case reviews following the passage of Senate Bill 27 in 2014. It strongly supports the ongoing efforts of the MMRC and anticipates Georgia will see an improvement in its national ranking for maternal mortality rate.
2. As the ADRD Registry within DPH continues to collect data on Alzheimer's disease, the Committee will continue to monitor its status and explore ways to enhance resources for Georgia's patients and caregivers. The MMRC and ADRD Registry are important initiatives that collect data for the purpose of monitoring and improving health outcomes in Georgia. Similar initiatives to learn about Georgia's population should be explored.
3. The Committee agrees that it is imperative to preserve care for women across the state and supports increasing obstetric, certified nurse midwife (CNM), and public health practice in Georgia's rural areas. In addition to workforce re-entry programs, incentives such as loan forgiveness, tax credits, adequate reimbursement rates, and bonus plans are options that should be explored in the future. Additionally, the Committee supports the Governor's work to increase GME residency slots in Georgia.
4. The Committee will continue to monitor the status of the Rural Hospital Stabilization Pilot Program and is optimistic about future opportunities to emphasize the concept of patient-centered medical homes and increase the utilization of telemedicine in rural Georgia.
5. The Committee supports efforts to strengthen Georgia's regional perinatal system for high risk women's health care and agrees it would be worthwhile to outline a detailed plan for a state level perinatal health collaborative.
6. After hearing testimony on Certified Nurse Midwifery, the Committee supports establishing additional CNM programs in Georgia and would like to explore options for increasing the Medicaid reimbursement rate for CNM services.
7. As it supports the ongoing work of nurse training programs, the Committee will continue to examine issues related to expanding the scope of practice for advanced practice nurses and CNMs in Georgia.
8. The Committee recommends a continuance of the state funds appropriated to Elder Abuse Investigations and Prevention under DHS for State Fiscal Year 2016, including funds for temporary emergency respite and APS services.
9. The Committee recommends a continuance of state funds appropriated to the Cancer State Aid (CSA) Program and further recommends that such funding be increased to prevent the CSA Program from running out of money two months early each year. It is important that the CSA Program have access to funds that allow diagnostic imaging year-round. This is crucial since the first step in detecting and treating cancer is diagnostic imaging, and delays in diagnostic imaging contribute to the uncompensated costs for care in Georgia. The Committee also supports efforts to increase awareness of risk factors and screening services for breast, ovarian, and cervical cancers.

Respectfully Submitted,

FINAL REPORT OF THE WOMEN'S ADEQUATE HEALTH CARE SENATE STUDY COMMITTEE

Renee S. Unterman

Honorable Renee Unterman, Chair
Senator, District 45