

The Florida Senate
PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Policy Committee

BILL: SB 2120

INTRODUCER: Senator Joyner, Lawson and others

SUBJECT: Infant Mortality

DATE: March 19, 2007 REVISED: 03/22/07

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Garner</u>	<u>Wilson</u>	<u>HP</u>	<u>Fav/1 amendment</u>
2.	<u> </u>	<u> </u>	<u>HA</u>	<u> </u>
3.	<u> </u>	<u> </u>	<u> </u>	<u> </u>
4.	<u> </u>	<u> </u>	<u> </u>	<u> </u>
5.	<u> </u>	<u> </u>	<u> </u>	<u> </u>
6.	<u> </u>	<u> </u>	<u> </u>	<u> </u>

Please see last section for Summary of Amendments

Technical amendments were recommended
 Amendments were recommended
 Significant amendments were recommended

I. Summary:

This bill creates the black infant health practice initiative. The initiative will sponsor reviews of infant mortalities in select counties in Florida in order to identify factors in health and social services systems contributing to higher mortality rates among African-American infants. The initiative will produce recommendations on how to address the factors identified by the reviews as contributing to these higher infant mortality rates.

The initiative shall be administered through collaboration among the Department of Health (DOH or department), federal and state healthy start coalitions, and public universities or colleges having expertise in public health. The initiative will use both perinatal periods of risk (PPOR) and fetal and infant mortality reviews (FIMR) to examine racial disparities in infant mortality. Public universities or colleges are required to provide technical advice to the initiative for developing a standard research methodology for the reviews. The bill requires the DOH to distribute five grants to healthy start coalitions representing urban counties and five grants to coalitions representing rural counties, subject to specific appropriations. These funds will be used to conduct the reviews, develop recommendations, and produce reports to the Governor and the Florida Legislature on recommended system changes.

The bill provides immunity from liability for each participating coalition, its case review team members, and professional staff pursuant to s. 766.101, F.S. (which provides immunity from liability for medical review committees), for the purpose of implementing the initiative. The bill also provides an implementation timeline and an appropriation.

This bill creates two undesignated sections of law.

II. Present Situation:

Infant Mortality

Infant mortality, death during the first year of life, is used to compare the health and well-being of populations across and within countries. The infant mortality rate, the number of infant deaths per 1,000 live births, is related to the underlying health of the mother, public health practices, socioeconomic conditions, and availability and use of appropriate health care for infants and pregnant women. The infant mortality rate is usually tracked by age, race and ethnicity.

There are many causes of infant mortality. When reviewing infant mortalities, researchers usually examine the neonatal period (less than 28 days of life) and the postneonatal period (28 days through 11 months of life). Disorders related to short gestation and low birthweight, and congenital malformations are the leading causes of death during the neonatal period, while Sudden Infant Death Syndrome (SIDS) and congenital malformations rank as the leading causes of infant deaths during the postneonatal period.¹

Trends in Infant Mortality Rates

Infant mortality rates have dramatically decreased over the last 100 years. Prior to 1900, infant mortality rates of two and three hundred per 1,000 live births were common throughout the world. Infant mortality rates would fluctuate sharply according to the weather, the harvest, war, and epidemic disease. In severe times, a majority of infants would die within one year. So great was the pre-modern loss of children's lives that anthropologists claim to have found groups that would not name children until they had survived a year.²

The infant mortality rate in the United States has steadily declined over the past several decades, from 26.0 per 1,000 live births in 1960 to 6.9 per 1,000 live births in 2000. In fact, the 2003 infant mortality rate was 76 percent lower than in 1950. In recent years, it appeared that this declining trend had stabilized, until it went up in 2002 for the first time in 40 years. However, in 2003, the infant mortality rate began declining again, to 6.9 infant deaths per 1,000 live births. The United States ranked 28th in the world in infant mortality in 1998. This ranking is due to many factors including the different ways that countries define and count infant mortalities; but, this ranking is also due in large part to disparities which continue to exist among various racial and ethnic groups in this country, particularly African Americans.³

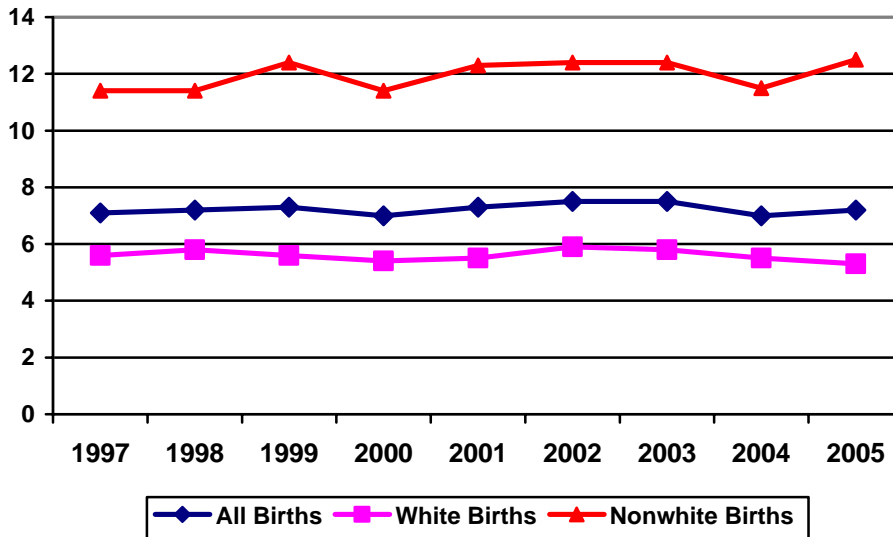
¹ Centers for Disease Control and Prevention. <http://www.cdc.gov/nchs/data/hus/06.pdf#chartbookontrends> (last visited on March 19, 2007)

² <http://www.pbs.org/fmc/timeline/dmortality.htm> (last visited on March 19, 2007)

³ Centers for Disease Control and Prevention. <http://www.cdc.gov/omh/AMH/factsheets/infant.htm> (last visited on March 19, 2007)

The substantial decline in infant mortality rates is also true for Florida. In 1920, the infant mortality rate for all births in Florida was 93.9 per 1,000 (76.1 per 1,000 for white births and 134 per 1,000 for nonwhite births). Infant mortality rates declined rapidly after 1950 and were at their lowest in 2000 (7.0 per 1,000 for all live births). However, since 2000, infant mortality rates have fluctuated, going up and down from year to year. In 2005 (the most recent year for which data are available), the infant mortality rate in Florida is 7.2 per 1,000 (5.3 per 1,000 for white births and 12.5 per 1,000 for nonwhite births).⁴

Figure 1: Infant Deaths Per 1,000 Live Births, 1997-2005



Racial Disparities

Infant mortality rates have declined for most racial and ethnic groups, but large disparities between the groups remain. During 2001-2003, the infant mortality rate was highest for infants of non-Hispanic black mothers. Infant mortality rates were also high among infants of American Indian or Alaska Native mothers and Puerto Rican mothers. Infants of mothers of Cuban origin had the lowest infant mortality rates.

Infant mortality among African Americans in 2000 in the U.S. occurred at a rate of 14.1 deaths per 1,000 live births. This is more than twice the national average of 6.9 deaths per 1,000 live births. The leading causes of infant death among African Americans include congenital abnormalities, pre-term/low birth weight, Sudden Infant Death Syndrome (SIDS), problems related to complications of pregnancy, and respiratory distress syndrome. SIDS deaths among American Indian and Alaska Natives is 2.3 times the rate for non-Hispanic white mothers.⁵

In Florida, racial disparities have been consistent with national statistics. Infant mortality rates for nonwhites have been between 1.5 and 2.5 times higher than rates for whites since 1900. However, in 2005, infant mortality rates for white births reached their lowest level ever recorded

⁴ Florida Department of Health. Vital Statistics. Found at: <http://www.flpublichealth.com/VSBOOK/pdf/2005/Fetal.pdf> (last visited on March 19, 2007)

⁵ Centers for Disease Control and Prevention. Found at: <http://www.cdc.gov/omh/AMH/factsheets/infant.htm> (last visited on March 19, 2007)

(5.3 per 1,000 live births), while infant mortality rates for nonwhite births increased to their highest level in over ten years (12.5 per 1,000 live births).⁶ While overall infant mortality rates are significantly lower than the early 1900s, the difference in mortality rates between white and nonwhite births in 2005 is the highest disparity percentage recorded in Florida since 1900.

There are many theories that try to explain the reason for the racial disparity in infant mortality rates. Researchers examining these differences consider various factors that might differ by race/ethnicity. Such factors include infant age at death, cause of death, mother's age and health, multiple births, low birthweight, premature births, assisted reproductive technology, prenatal visits, and access to health-care services.⁷

When these factors are examined, researchers have identified some potential reasons for disparities in infant mortality.⁸ For example:

- Age - younger and older mothers have higher preterm birth rates.
- Cigarette smoking - smoking is a potential factor for low birth weight and growth retardation (Asian/Pacific Islanders smoke the least and American Indian/Alaska Natives smoke the most).
- Alcohol consumption - alcohol consumption is a potential factor in poor pregnancy outcomes (Whites and American Indian/Alaska Natives have the highest alcohol consumption and Asian/Pacific Islanders have the lowest).
- Unintended pregnancy - births resulting from unwanted conceptions may suffer from elevated risks of infant mortality and low birth weight (in one study, African-American women indicated 29 percent of their births in the previous five years were unintended as opposed to 9.2 percent of white women).
- Cultural - Mexican Americans reported more prenatal stress, less support from the baby's father, and more drug/alcohol use.
- Obesity - Asian/Pacific Islanders have the lowest obesity rate and African-Americans have the highest.
- Unequal Care – These are significant differences among the percentage of women receiving prenatal care in the first trimester by race and ethnicity, an important factor correlated with better birth outcomes.
 - 85 percent for whites.
 - 77 percent for Native Hawaiians/Pacific Islanders.
 - 75 percent for Hispanics.
 - 74 percent for African-Americans.
 - 69 percent for American Indians/Alaska Natives.

Education – pregnant women with more education have greater rates of prenatal care during the first trimester than less educated pregnant women.

⁶ Florida Department of Health. Vital Statistics. Found at: <http://www.flpublichealth.com/VSBOOK/pdf/2005/Fetal.pdf> (last visited on March 19, 2007)

⁷ Centers for Disease Control and Prevention. Found at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5422a1.htm> (last visited on March 19, 2007)

⁸ American Public Health Association. Found at: <http://www.medscape.com/viewarticle/472721?mpid=26886> (last visited on March 19, 2007)

Federal Healthy Start Programs

In 1991, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) funded 15 urban and rural sites in communities with infant mortality rates that were 1.5 - 2.5 times the national average to begin the Healthy Start Initiative. The program began with a five-year demonstration phase to identify and develop community-based systems approaches to reducing infant mortality by 50 percent over the five-year period and to improve the health and well-being of women, infants, children and their families.

Since its inception, the federal Healthy Start Program has been located in HRSA. The federal Healthy Start program is a component of the Maternal and Child Health Bureau and resides in the Division of Perinatal Systems and Women's Health. Originally funded under the authority of Section 301 of the Public Health Services Act, the federal Healthy Start program was reauthorized by Congress as part of the Children's Health Act of 2000.

The common principles underlying the federal Healthy Start program include: innovations in service delivery; community commitment and involvement; personal responsibility demonstrated by expectant parents; integration of health and social services; multi-agency participation; increased access to care; and public education.

The federal Healthy Start projects address multiple issues, including: providing adequate prenatal care; promoting positive prenatal health behaviors; meeting basic health needs (nutrition, housing, psychosocial support); reducing barriers to access; and enabling client empowerment.

Seven additional federal Healthy Start programs were funded in 1994 as special projects with the goal of significantly reducing infant mortality through more limited interventions. In the second, or "replication" phase, the federal Healthy Start program added 75 projects in 1998, 19 in 1999 and three more in 2000. In 2001, the federal Healthy Start program entered its third phase, and added nine new grantees. Twelve existing projects that were categorized as "approved, but not funded" in 2001 received new funding early in 2002. Presently, there are 95 federally-funded Healthy Start projects and five main types of Healthy Start grants: Perinatal Health, Border Health, Interconceptional Care, Perinatal Depression and Family Violence. Some projects have more than one grant type.⁹

Florida Healthy Start Program

The Florida Healthy Start program was signed into law on June 4, 1991.¹⁰ The Florida Healthy Start program is a statewide initiative designed to decrease the risk of pregnancy complications and poor birth outcomes for all pregnant women, and the risk of death or impairment in the health, intellectual or functional ability for all infants. The primary tasks of Healthy Start are to:

- Identify, through a screening process, those who are at high risk for poor perinatal outcomes;

⁹ National Healthy Start Association. Found at: <http://www.healthystartassoc.org/hswpp6.html> (last visited on March 19, 2007)

¹⁰ Ss. 383.216 and 383.2161, F.S.

- Provide professional assessment of their needs and decide what resources are available to meet those needs; and,
- Provide timely and important linkages, referrals, or services to reduce the risk of having a poor birth outcome and poor infant development.

Healthy Start includes targeted support services that address identified risks. Healthy Start begins with preconceptional counseling and includes prenatal care, postpartum care, delivery, infant care and targeted support services that address identified risks. Healthy Start offers universal screening for all Florida pregnant women and infants to ensure that early care is targeted to those families where there is the best chance of preventing or minimizing adverse outcomes. During 2005, a total of 151,646 women and 164,203 infants were screened for the Florida Healthy Start program.¹¹

The range of Healthy Start services available to pregnant women, infants and children up to age three include:

- Information and referral;
- Comprehensive assessment of service needs in light of family and community resources;
- Ongoing care coordination and support to assure access to needed services;
- Psychosocial, nutritional and smoking cessation counseling;
- Childbirth, breastfeeding and parenting support and education;
- Home visiting; and,
- Interconceptional education and counseling.

The Florida Healthy Start program is administered through coalitions that represent between 1 and 12 counties each. Each coalition is structured as a 501(c)(3) nonprofit corporation and is supervised by the DOH. The Healthy Start coalitions must work in a coordinated, non-duplicative manner with local health planning councils established pursuant to s. 408.033, F.S. Coalitions' membership must represent health care providers, the recipient community, and the community at large and must represent the racial, ethnic, and gender composition of the community. Membership must include at least the following:

- Consumers of family planning, primary care, or prenatal care services, at least two of whom are low-income or Medicaid eligible.
- Health care providers, including county health departments, migrant and community health centers, hospitals, local medical societies, and local health planning organizations.
- Local health advocacy interest groups and community organizations.
- County and municipal governments.
- Social service organizations.
- Local education communities.

There are currently 32 Healthy Start coalitions that cover the state to ensure local leadership and planning for a system of care, to promote optimum health outcomes for pregnant women and infants.

¹¹ <http://www.doh.state.fl.us/family/mch/hs/hsfactsheet.pdf> (last visited on March 19, 2007)

Fetal and Infant Mortality Review (FIMR)

Fetal and Infant Mortality Review (FIMR) is a process by which a multi-disciplinary community team is brought together to examine individual cases of infant and fetal deaths in an effort to identify critical community strengths and weaknesses as well as unique health/social issues associated with poor outcomes. The FIMR case review team makes recommendations for new policies, practices, and/or programs to improve community systems, when appropriate. Community leaders representing government, consumers, key institutions, and health and human services organizations serve on the community action team, which reviews recommendations, prioritizes identified issues, and designs and implements interventions. The goal of the FIMR process is use the findings from the review process to improve community resources and health service delivery systems for women, infants, and families.

The National Fetal and Infant Mortality Review (NFIMR) Program is a collaborative effort between the HRSA's Maternal and Child Health Bureau and the American College of Obstetricians and Gynecologists that addresses the FIMR issues. It includes a resource center that provides information and advice about implementing the FIMR methods. Topics include confidentiality, liability, data collection, home interview techniques, coalition building, taking recommendations to action, coordinating with other local mortality reviews, and using local FIMR information for regional/state assessment and planning.

The Florida FIMR projects are usually conducted in coordination with the Healthy Start Coalitions. Eighteen of the 32 coalitions have a FIMR project. In Florida, the FIMRs involve:¹²

- Information reviewed by a qualified abstractor of: vital statistics data; hospital, autopsy, prenatal and pediatric records; social service reports; and Healthy Start screens.
- Interviews with the mother and family members who have suffered the loss. Professionals with training in grief counseling ascertain the needs of the family and refer to bereavement support and community resources.
- Reviews of summary abstracted case information conducted by a Technical Review Panel consisting of a team of experts from medicine, social services, and the community who make recommendations for community change, if appropriate.
- Meeting of a Community Action Group of community leaders, in cooperation with Healthy Start Coalitions, who review recommendations and design and implement strategies for change.

Perinatal Periods of Risk (PPOR)

The Perinatal Periods of Risk (PPOR) for examining fetal and infant mortality was developed to address perceived gaps in other methods communities were using to examine the issue. Advocates of the PPOR state that no simple, standardized, widely accepted approach for communities to examine infant mortality exists. They also state current approaches don't readily identify potential gaps in the community for further reductions and that current approaches don't directly lead to action to targeted studies, investigations or prevention activities. Finally, they

¹² <http://www.uwf.edu/hlsd/fimr.htm> (last visited on March 19, 2007)

state that current approaches are not simply and easily communicated to community partners, which can inhibit mobilization.

The overall intent of the PPOR approach is to develop a simple method that can be used by communities to mobilize and prioritize prevention efforts for addressing fetal-infant mortality. The six-steps of the PPOR approach include:

- Assure analytic and community readiness;
- Conduct analytic phases of PPOR;
- Develop strategic actions for targeted prevention;
- Strengthen existing and/or launch new prevention initiatives;
- Monitor and evaluate approach; and
- Sustain stakeholder investment and political will.

Each of these steps is an essential building block, with each building upon the previous. The approach divides fetal-infant mortality into four strategic prevention areas: maternal health/prematurity, maternal care, newborn care, and infant health. The PPOR mapping of fetal-infant mortality enables communities to identify and further investigate areas in which there are the greatest opportunities for local impact. Follow-up investigations provide in-depth information and strategic direction for targeted prevention of fetal and infant mortality.

III. Effect of Proposed Changes:

Section 1. Creates an undesignated section of law establishing the black infant health practice initiative.

Subsection (1) specifies that it is the intent of the Legislature to create a black infant health practice initiative that shall include reviews of infant mortalities in order to identify factors contributing to higher mortality rates among African-American infants. The initiative shall also produce recommendations on how to address the factors.

Subsection (2) defines: "Coalition" to mean a federal or local healthy start coalition or consortium; "Department" to mean the Department of Health; "FIMR" to mean a fetal and infant mortality review committee; "Infant mortality" to mean the death of a live-born infant within 364 days after the infant's birth; and, "Infant mortality rate" to mean the number of infant deaths per 1,000 annual live births.

Subsection (3) specifies the objectives of the initiative, including determining the factors that are associated with racial disparities in infant mortality rates, developing interventions and policies to address these factors, and participating in community-based interventions and policies that address racial disparities in infant mortality rates.

Subsection (4) specifies that the black infant health practice initiative shall be administered through a collaboration among the department, federal and state healthy start coalitions, and public universities or colleges having expertise in public health. Participating healthy start coalitions are required to conduct case reviews, with assistance from public colleges and

universities in the development of research methodologies. Participating local coalitions are to be funded through annual grants, subject to specific appropriations by the Legislature.

Subsection (5) specifies that each participating coalition in the initiative shall: develop an interdisciplinary team to oversee the process in its local community; use the PPOR methodology when appropriate to examine infant deaths in its community; use a modified FIMR approach to examine infant deaths in its community; and develop findings and recommendations for interventions and policy changes to reduce racial disparities in infant mortality.

Subsection (6) specifies that the department shall award annual grants through a request-for-proposal process that is subject to specific appropriations by the Legislature. The department shall award five grants to coalitions representing urban counties and five grants to coalitions representing rural counties with priority given to coalitions representing counties with the highest nonwhite infant mortality rates.

Subsection (7) specifies that the department must conduct an annual evaluation of the implementation of the initiative describing which areas are participating in the initiative, the number of reviews conducted by each participating coalition, grant balances, and recommendations for modifying the initiative. A participating coalition shall produce a report on its collective findings and recommendations by January 1, 2010, to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of Health.

Subsection (8) specifies that each participating coalition, its case review team members, and professional staff are immune from liability pursuant to s. 766.101, F.S.

Subsection (9) specifies the department shall adopt rules necessary to implement this section.

Subsection (10) specifies that the department shall release a request for proposals in a manner that will allow each participating coalition to begin reviewing cases no later than January 1, 2008.

Section 2. Creates an undesignated section of law appropriating the sum of \$1 million from the General Revenue Fund to the DOH for the purpose of implementing the black infant health practice initiative and for one full-time equivalent position for the purpose of implementing this act.

Section 3. Provides that the act shall take effect July 1, 2007.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

There will be a \$1 million appropriation for grants for the project and 1 FTE authorized to the DOH to administer the grant program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

Barcode 780390 by Health Policy:

Removes the number of grants awarded to coalitions representing urban and rural counties and specifies that grants are to go to a coalition in Hillsborough County and a coalition in Gadsden County.

This Senate Professional Staff Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.
