

**GOVERNOR'S TASK FORCE ON INFANT MORTALITY
MEETING SUMMARY
June 20, 2011**

Members Present

Jeff Boyle, MD
Rodney Cuny, MD
Sara DeCoteau
Linda Daugaard, Chair
Janet Dutcher, CNP
Michael Elliot, MD
Gail Gray, EdD
Doneen Hollingsworth

Eugene Hoyme, MD
Jennifer Irving, MPH
Gail Jamison
Lon Kightlinger, PhD
Deb Kuehn, CNP
J.R. LaPlante
Laurie Landeen, MD
Pam Locken

Kimberlee McKay, MD
Cindy Morrison
Brad Randall, MD
Dennis Stevens, MD
Lynne Valenti
Toni VanderPol, MD
Dori Vojta, CNP, CNM

Members Absent:

Steven Benn, MD
Mary Carpenter, MD

Sophia Conroy
Deb Fischer-Clemens, RN

Bonny Specker, PhD
Angel Wilson, FNP

DOH Staff Present:

Darlene Bergeleen
Peg Seuer

Susan Sporrer
Colleen Winter

Welcome

First Lady Linda Daugaard opened the meeting of the Governor's Task Force on Infant Mortality. Twenty-three members were present.

The First Lady said the Governor wanted to make addressing infant mortality as one of his initiatives because South Dakota is losing too many babies before they reach their 1st birthday. Over the past decade, an average of 79 babies die each year before their 1st birthday and South Dakota's infant mortality rate is significantly higher than the neighboring states of North Dakota, Minnesota, Iowa, Nebraska, and Montana. While the infant mortality rate for American Indians in the state has improved, it is still twice as high as the White infant mortality rate. The Governor has made it a priority to reach out to the state's best experts to develop strategies to address this problem.

The first meeting will be used to lay the groundwork for the activities of the Task Force. The day's presentations are designed to help task force members better understand the extent of the infant mortality problem in the state and identify areas to focus efforts. At the second meeting in Rapid City in September, the task force will start looking at possible strategies, both community-based and clinical, to improve the infant mortality rate. The third meeting in Pierre on November 3rd will be where the task force develops and finalizes recommendations. The final report is due to the Governor by December 15th.

Infant Mortality in South Dakota

Lon Kightlinger, State Epidemiologist, presented data on infant mortality in South Dakota. Data comes from birth and death certificates filed with the Department of Health (DOH). Key points of the presentation included:

- South Dakota's infant mortality rate is 7.3 per 1,000 live births vs. 6.8 for the U.S.
- South Dakota ranks 21st in the nation for its neonatal mortality rate (4.3 per 1,000 live births) but 40th for its postneonatal rate (3.0 per 1,000 live births).
- The American Indian postneonatal mortality rate is higher than its neonatal mortality rate.

- American Indians accounted for 18% of all births but 32% of all infant deaths.
- Low early prenatal care correlates strongly with high infant mortality rates. The 2020 goal is to have 75% of pregnant women receive prenatal care in the first trimester. There are four counties in South Dakota that have less than 50% of pregnant women receiving prenatal care in the first trimester ; these same counties also have very high infant death rates.
- Diabetic mothers have higher rates of infant death (24.4) than non-diabetic mothers (6.8)
- South Dakota ranks fifth highest in the US for mothers smoking during pregnancy. 30% of American Indian women smoked during pregnancy vs. 16.6% for Whites.
- South Dakota has higher rates of congenital malformations, SIDS, and accidents than the US and lower rates of low birth weight and maternal complications.

Task force members were interested in seeing a comparison of South Dakota's infant mortality rate with other states if congenital malformation/abnormalities were removed to whether South Dakota rate would be comparable to other state. There was also interest at looking at a possible link between congenital malformations and diabetes as well as the impact of alcohol use during pregnancy. Members also expressed interest in hearing from Dr. Amy Elliott who is working on a grant to study and decrease the prevalence of births affected by prenatal alcohol exposure.

There was considerable discussion about the information collected on birth and death certificates as well as through the DOH Perinatal Health Risk Assessment Survey of new mothers. There was concern expressed by some task force members as to the accuracy of information on certificates, particularly death certificates. Task force members recommended looking at information on birth and death certificates more closely to better understand infant mortality trends in order to lead to better outcomes.

Review of 2006 Infant Mortality Project

Gail Gray gave a brief overview of the 2006 infant mortality project. The workgroup was made up of physicians, IHS, and DOH staff. The committee found that South Dakota infant deaths were more common among mothers who: (1) received no prenatal care; (2) smoked during pregnancy, (3) were younger than 19 years of age; (4) had not finished high school, (5) were American Indian; and (6) lived in a "frontier" county. As a result of the findings, the committee identified some key activities to reduce infant mortality:

- Develop a media campaign designed to help women know they were pregnant ("I Didn't Know" campaign) and the importance of not smoking and prenatal care;
- Work with the medical school to reinforce with physicians the importance of prenatal care and not smoking during pregnancy;
- Enhance of the relationship between Healthy Start and DOH programs;
- Strengthen service for teens and young mothers;
- Work with the Trauma System Steering Committee to improve medical response for sick and injured infants in rural and frontier area.

Gail noted that the recommendations resulted in messages and programs that did impact the state's infant mortality rate, there needed to be a focus on sustainability of messaging and programs to maintain successes. She said it was discouraging to see that there had been no impact on the percentage of pregnant women smoking despite targeted campaigns to address this population.

Minnehaha County Infant Mortality Review

Dr. Brad Randall provided an overview of the Regional Infant and Child Mortality Review Committee. The review area covers Minnehaha, Lincoln, Moody, Hansen, McCook, Union, Brookings, Turner, Lake, and Miner counties. The committee reviews all infant and child deaths that had been discharged from a

hospital and the event/illness started in a county in the review area – about 25 cases a year. Dr. Randall explained the distinction between SUID (sudden unexpected infant deaths) which is any infant death that occurs suddenly and unexpectedly (i.e., suffocation, strangulation, neglect/homicide, etc.) and SIDS (sudden infant death syndrome) where the death remains unexplained after a thorough case investigation including performance of a complete autopsy, death scene investigation, and review of clinical history. Unfortunately, death scene investigations and autopsies are not routinely done. In addition, those certifying deaths have varied educational background and training with many county coroners having no medical background or training. Dr. Randall offered some suggestions for strategies to address infant mortality including better public and medical education about safe sleeping (i.e., back to sleep, safe surfaces, bed sharing) as well as better death investigations including autopsies and investigator training.

Pennington County Infant Mortality Review

Deb Kuehn provided an overview of the Pennington County Child Death Review Committee. The committee was established in March 1998 to reduce preventable child deaths through conducting a systematic, multidisciplinary review of child deaths in Pennington County. Reviews are done on deaths of children from birth to age 18 (not including stillbirths) for deaths occurring in Pennington County or the death of a Pennington County residents occurring elsewhere. The committee reviews about 40 deaths each year. The committee has led media efforts to talk about “safe sleep” as well as public service announcements about water safety. Efforts are now focused on improved postnatal education for parents about infant care such as safe sleep and care of the irritable infant.

Tribal Pregnancy Risk Assessment Monitoring System (PRAMS)

Jennifer Irving provided an overview of the South Dakota Tribal PRAMS project. The project is a CDC initiative to reduce infant mortality and low birth weight. The project surveyed women who gave birth to American Indian infants between June and November 2007 and monitors selected maternal experiences, attitudes and behaviors before, during, and after pregnancy. The response rate was 72.9% of the 1,300 eligible women. Key data included:

- 23% of respondents were less than 20 years of age and 36% had less than 12 years of education;
- 77% of respondents were not married;
- 55.8% of pregnancies were unintended (unwanted or mistimed);
- The most commonly reported barriers to prenatal care were having too many things going on, no transportation, and not wanting anyone to know she was pregnant;
- Topics most discussed at prenatal care visits included breastfeeding, postpartum birth control, smoking, alcohol, safe medicines during pregnancy, HIV testing, and illegal drugs; least discussed topics included physical abuse, seat belt use, early labor, and testing for birth defects;
- 19% reported emotional abuse, 13.3% reported physical abuse, and 4.8% reported sexual abuse by partner/husband during pregnancy;
- 66.9% of respondents breastfed or pumped breast milk at any point after deliver and 37.9% breastfed/pumped for at least 2 months;
- 52.5% of respondents reported any smoking before pregnancy, 31.4% reported any smoking during the last three months of pregnancy and 45.1% reported smoking after pregnancy;
- 85.2% of respondents reported the infant was regularly placed to sleep on back;
- 51.2% reported the infant co-slept with mother or someone else always or often while another 35.6% reported this occurred sometimes or rarely;

The DOH indicated they had applied for a grant to fund a statewide PRAMS project to replace the new mother survey. Although the grant was approved, it was not funded by CDC.

Public Testimony

Sandy Lown with the Teddy Bear Den in Sioux Falls talked to the Task Force about the services they offer to pregnant women and families. The Teddy Bear Den provides referrals, education, and incentives geared toward low-income pregnant women, pregnant immigrant women and pregnant teens as they are least likely to receive adequate care during pregnancy. The Teddy Bear Den encourages local low income pregnant women to make themselves and the health of their children a priority. Participants earn “Teddy Credits” by seeking healthy lifestyle such as attending health care provider appointments, not smoking, drinking or using drugs. Since the program includes the infant until he or she is 15 months old, it also includes all well baby check-ups and immunizations. The credits are then redeemed at the Den for new baby items such as diapers, sleepers, clothing, high chairs, cribs and infant necessities while in the program. Sandy indicated that 66% of participants make less than \$5,000 a year and one of the greatest needs they are seeing right now is assistance with gas/ transportation to appointments. The Teddy Bear Den is unique to Sioux Falls.

Ann Wilson spoke about the research she has done regarding birth outcomes and infant mortality. She shared concerns about continuing efforts to increase prenatal care, decrease low birth weight and preterm births which clearly impact infant mortality. She also talked about the implications of young women in making wise choices in relation to planning for pregnancy and addressing the intendedness of pregnancy by increasing access to contraception. Finally she touched on the need for better investigation of SIDS and greater awareness and education about safe sleep.

Task Force Discussion

Task force discussion focused on next steps. Members identified some areas for further consideration and review:

- Focus in on areas we can do something about (i.e., smoking, prenatal care, safe sleep, etc.);
- Need to work with American Indian populations;
- Need to develop recommendations that are sustainable;
- Look at intendeness of pregnancy, particularly in American Indian population;
- Develop standards for ultrasound;
- Younger generation communicates differently – pamphlets don’t work;
- Look at what other states with demographics similar to South Dakota have done;
- Need to address postneonatal rate – what happens after they go home; how many had been in ICU;
- Look at access to prenatal care and well-baby checkups – transportation is an issue; and
- Look at some models that are working in Indian county.

Subcommittees will be formed to look at some of these areas in more depth and bring recommendations to the full Task Force at the September meeting. Members will receive an e-mail with information about the subcommittees being formed and their willingness to participate on a subcommittee.

Next Meeting

Due to scheduling conflicts, the September 8th meeting will be rescheduled. The meeting will be in Rapid City.

NOTE: The next meeting will be held Thursday, September 15, 2011 in Rapid City.