F I S C A L I M P A C T R E P O R T

SPONSOR Ortiz y Pino **ORIGINAL DATE** 02/01/14 **LAST UPDATED** **HB**

SHORT TITLE Sudden Unexpected Infant Death Task Force **SM** 6

ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY14	FY15	FY16	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$8.0			Nonrecurring	General Fund/Federal Medicaid Match

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Human Services Department (HSD)
Department of Health (DOH)
University of New Mexico Health Sciences Center (UNMHSC)

SUMMARY

Synopsis of Bill

Senate Memorial 6 (SM 6) proposes to establish a Sudden Infant Death Risk Task Force to evaluate the state's approach to community-based sudden unexpected infant death prevention and recommend effective changes to the state's approach. The memorial further proposes the Department of Health (DOH) invite specific state agencies, universities and colleges, federal Indian Health Services (IHS) and tribal infant health and injury prevention programs, interested members of the public, other health care delivery organizations, and the New Mexico Pediatric Society to participate in the task force.

The task force is to meet regularly to examine community awareness of the risks of unsafe infant sleeping conditions, examine approaches to supporting families and care providers in protecting young infants from sudden unexpected infant death, and to explore issues related to families' access to and use of safe sleeping equipment.

If enacted, the task force would be required to report:

1. Current approaches to raising awareness of sudden unexpected infant death for professionals and families;

2. Provide a detailed list of expenditures in raising awareness;
3. Information on outreach and education practices and recommendations for the raising of awareness of sudden unexpected infant death;
4. The current and recommended statewide and local public outreach and education on sudden unexpected infant death;
5. The currently available community-based sudden unexpected infant death prevention programming at the state and local level;
6. Access to and participation in current programming;
7. An evaluation of this programming's effectiveness;
8. Local and statewide needs assessment;
9. Recommendations for effective change;
10. Evaluation measures for sudden unexpected infant death prevention programs tracked by DOH and other state agencies, with public accessibility to data that may assist in obtaining funds and recommendations for effective change.

The task force would place special emphasis in its report to raising the awareness about risks of unsafe sleeping arrangements, increasing access to evidence-based community programming and establishing short and long-term recommendations to reduce sudden unexpected infant deaths by implementing cost-effective measures.

FISCAL IMPLICATIONS

SM 6 contains no appropriation.

The Human Services Department (HSD) indicates SM 6 would require that a representative from HSD be invited to regular meetings of the task force, and it is estimated this would require 10 percent of a Medical Assistance Division (MAD) full-time equivalent (FTE), which would cost approximately $8 thousand per year.

TECHNICAL ISSUES

The University of New Mexico Health Sciences Center (UNMHSC) indicates SM 6 does not include the Office of the Medical Investigator, and a representative from the Office of the Medical Investigator should be included on this task force as the office investigates 100 percent of these sudden unexpected infant deaths.

OTHER SUBSTANTIVE ISSUES

The Department of Health (DOH) indicates that between 2010 and 2013 there were 108 deaths categorized as sudden unexpected infant deaths in New Mexico. Ninety-one (91) infant deaths were reviewed by the Office of the Medical Investigator (OMI) and found to include unsafe sleeping environments or practices, involving hazards which if removed, may have prevented the deaths. The American Academy of Pediatrics released a position paper and a set of recommendations to prevent these types of deaths in 2011. http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284.full.pdf+html

DOH was awarded a Centers for Disease Control and Prevention grant to operate and maintain a registry of these deaths. Many sudden unexpected infant deaths are preventable, and by reducing risk factors such as bedsharing (co-sleeping), plush or heavy blankets, bumper pads, cigarette

smoke exposure, and other environmental or modifiable factors, New Mexico could reduce these deaths. SM 6 proposes to convene a statewide taskforce to evaluate New Mexico's current efforts to prevent sudden unexpected infant deaths. The current approach to prevention includes a data registry housed in the Office of Injury Prevention of DOH. That office coordinates with the Office of the Medical Investigator to conduct field investigations in a comprehensive and standardized way. The Office of the Medical Investigator collaborates with the Office of Injury Prevention to assure best practices and evidence-based field investigations, data collection and analysis.

SM 6 would expand this process to include a greater representation of state agencies to support prevention of sudden unexpected infant deaths through home visiting programs, and it would serve to unify resources, strategies and knowledge throughout the state.

ALTERNATIVES

The Human Services Department indicates the information requested in SM 6 is currently found in both recent and long-term national studies. The Centers for Disease Control has established a Sudden, Unexpected Infant Death Initiative that includes a workgroup of national experts in fields relating to sudden infant death risks whose goals include the prevention of sudden infant death through the use of improved data (http://www.cdc.gov/sids/). There is also a federal Sudden Unexpected/Unexplained Infant Death (SUID) Sudden Infant Death Syndrome (SIDS) Workgroup housed in the U.S. Department of Health and Human Services that works with a number of stakeholders including the American Academy of Pediatrics to establish infant health and safety initiatives (http://www.nichd.nih.gov/news/releases/Pages/092613-infant-mortality-awareness.aspx).

RAE/jll:svb