



# Department of Public Health and Human Services

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444-0303

PUBLIC HEALTH, WELFARE & SAFETY

Exhibit No. 4

Date 1/30/2015

Bill No. SB 217

Testimony in opposition to SB 217 "An act revising vital statistics law; requiring an intervening legislative session between the adoption of rule related to vital statistics and the rule's implementation; requiring that forms for the collection of vital statistics clearly state which information is required and which information is optional; clarifying that certain information on birth certificates is optional and requiring a parent's consent before that information is provided on the parent's behalf; and amending sections 50-15-103, 50-15-124, AND 50-15-221, MCA."

Presented to the Senate Public Health, Welfare, and Safety Committee, Friday, January 30, 2015

The Department of Public Health and Human Services opposes Senate Bill 217. The Department's primary concern is that this Bill would compromise a system which has played a key role in improving the health of Montana mothers and babies for many decades. This Bill would make optional the collection of essential health-related information on Montana birth certificates. Optional recording of essential health information would increase the risk of public health and medical professionals (a) not recognizing important population health needs, and (b) drawing inaccurate conclusions from incomplete vital records data.

The current system has a long accomplished history. The tenth Legislative Assembly of the State of Montana meeting in 1907 established the State Bureau of Vital Statistics and charged this Bureau with registration of all births and deaths and other matters of sanitary affairs. Beginning in June of 1907 this Bureau began working with counties to implement the state vital statistic system. At that time, two primary goals existed for collecting vital statistic information related to births. The first goal was to provide administrative and legal documentation of the event. The second goal was to collect accurate and thorough demographic, medical, and health-related information regarding the health status of Montana mothers and infants to identify preventable risks and adverse conditions. These goals are the same in 2015, not only in Montana but all across the United States.

The State of Montana, like to all states in the United States, follows the National Center for Health Statistics recommendations regarding data elements collected in birth records. In so doing, we assure uniformity of vital record information collected across the United States. These essential data are used by the Department to monitor and identify preventable risks and adverse conditions among mothers and infants statewide, and to identify, implement and evaluate prevention actions to address these risks and adverse conditions. Aggregate de-identified information from the birth records is also used by local and Tribal Health Departments, clinical providers, and hospitals to identify and implement public health and clinical actions to improve the health of mothers and infants served in local areas.

Systematic collection of birth record data informs our actions, and the public health and clinical measures taken to address preventable risks and adverse conditions. Montana mothers and infants have experienced substantial improvements in both health status and life expectancy because of the use of thorough vital records data. As examples, major preventable conditions leading to twentieth century maternal illnesses and deaths were identified through use of accurate and thorough birth record data. Montana's public health system, clinical providers, and hospitals took action to address these preventable conditions, which led to significant reductions in the number of maternal deaths. Similarly, based on high quality birth record data we know many key preventable maternal and infant risk factors and conditions in Montana for the twenty-first century. Examples include risk characteristics associated with low birth weight babies, smoking during pregnancy, and inadequate prenatal care. In 2015, the Montana public health system, clinical providers, and hospitals are taking action to address these preventable conditions and these actions can be effectively targeted and evaluated because thorough birth record information is available.

Allowing medical and health-related data elements of the Montana birth record to be optional might substantially impact the accuracy and thoroughness of this information. Montana would become the first and only state in the United States to allow essential vital record information to be optional. We would also not have accurate and thorough vital records information to identify the current and future preventable risks and adverse conditions among Montana mothers and infants. Basically would begin walking in the dark.

The Department asks that you oppose this legislation to ensure Montana continues to have a high quality vital statistics system. Mr. Chairman, committee members — thank you.

## PREVENTION OPPORTUNITIES UNDER THE BIG SKY

### High Prevalence of Smoking in Pregnancy in Women Enrolled in Medicaid

Smoking during pregnancy has a multitude of negative health impacts on the mother, the fetus, and the newborn.<sup>1</sup> When pregnant women do not smoke the risk of premature birth as well as premature death for the baby is reduced. This issue of *Montana Public Health* describes the prevalence of smoking during pregnancy in Montana women overall, and in women enrolled in Medicaid.

**The Magnitude of the Problem in Montana** Birth record data from the Office of Vital Statistics were used to calculate the prevalence of smoking during pregnancy in Montanans with a live birth from 2004 through 2006. Birth records were also linked to Medicaid claims data to identify women enrolled in Medicaid during their pregnancy.

From 2004 through 2006 there were over 35,000 live births to Montana residents. Eighteen percent of these women smoked during their pregnancy compared to 11% among women in the U.S. in 2005.<sup>2</sup> The prevalence of smoking during pregnancy in Montana varied by county from  $\geq 30\%$  in Roosevelt, Mineral, Deer Lodge, and Silver Bow Counties to less than 10% in Gallatin and Teton Counties (County specific rates can be viewed at [http://www.dphhs.mt.gov/PHSD/prevention\\_opps/MT-PH-prevent-opps-newsletters.shtml](http://www.dphhs.mt.gov/PHSD/prevention_opps/MT-PH-prevent-opps-newsletters.shtml)).

### Extraordinary High Rate in Pregnant Medicaid Women

Approximately one-third of women who gave birth from 2004 to 2006 were enrolled in Medicaid (11,186 of 35,586). Women enrolled in Medicaid during their pregnancy (average age 24) were younger than women not enrolled (average age 28), and were more likely to be American Indian (Medicaid, 23%; not enrolled, 8%), live in a frontier county (42% and 33%), and have less than 12 years of education (25% and 10%).

From 2004 to 2006 women enrolled in Medicaid were over two and a half times more likely to smoke during their pregnancy than women not enrolled in Medicaid (Table). The prevalence of smoking among women enrolled as well as those not enrolled in Medicaid during their pregnancy was highest among unmarried women, and women with <12 years education.

#### KEY FINDINGS

- Women enrolled in Medicaid were 2 ½ times more likely to smoke during their pregnancy than women not enrolled in Medicaid.
- The prevalence of low birth weight infants was higher among women who smoked during their pregnancy compared to women who did not.

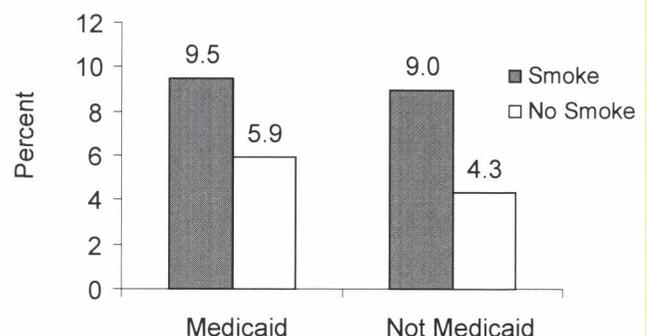
**Table. Prevalence of smoking during pregnancy, by Medicaid status, Montana, 2004-2006.**

Characteristic	Medicaid (%)	Not Medicaid (%)
Total	33	12
Age (yrs)		
<20	31	29
20-29	33	14
30+	33	6
Race		
Am. Indian	30	26
White	33	11
Marital status		
Married	24	6
Unmarried	37	32
Education (yrs)		
<12	46	35
12	32	20
12+	21	5

### Low Birth Weight Associated with Smoking in Pregnancy

Overall, the prevalence of low birth weight infants (<2,500 g) was higher in women with a singleton birth who smoked during their pregnancy (9.3%) than in women who did not (4.7%). The prevalence of low birth weight was higher in both women with a singleton birth either enrolled or not enrolled in Medicaid who smoked during their pregnancy than in women who were non-smokers (Figure).

**Figure. Low birth weight prevalence, by Medicaid status, Montana, 2004-2006**



**What Can Be Done to Help Pregnant Women Quit?** A key strategy to help women quit using tobacco during pregnancy is for health care professionals to identify women who smoke, provide counseling and support for their efforts to quit, and to refer these women to the Montana Tobacco Quit Line.<sup>3</sup> Support for women is also important after delivery because many who quit during pregnancy begin to smoke again. The Montana Tobacco Quit Line also provides a valuable service to pregnant women (and all Montanans) trying to quit using tobacco. A trained cessation coach will assist women in developing a plan to quit and provide free ongoing telephone counseling.

MONTANA TOBACCO



**Recommendation: What health care providers can do to help pregnant women decrease exposure to the leading cause of premature death in Montana**

Ask about tobacco use  
Advise to quit  
Assess willingness to make a quit attempt  
Assist in quit attempt  
Arrange follow-up

Refer patients to the Quit Line  
1-800-QUIT-NOW (784-8669)  
or  
use fax referral form

For more information about the quit line, free patient education materials, and fax referral forms contact Heather Beck (406-444-7373, [hbeck@mt.gov](mailto:hbeck@mt.gov)) or Stacy Campbell (406-444-3138, [stcampbell@mt.gov](mailto:stcampbell@mt.gov)). Visit Montana Tobacco Prevention at <http://tobaccofree.mt.gov>.

**References:**

1. US Surgeon General. Women and smoking: a report of the Surgeon General. Rockville, Maryland: US DHHS, PHS, Office of the Surgeon General; Washington DC, 2001.
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Table. Prevalence of smoking during pregnancy among women with a live birth, by county of residence, Montana, 2004-2006.

County	Prevalence of smoking in pregnancy (% per 100)	Number smoking/ Total live births
Roosevelt	34	235/699
Mineral	33	48/144
Deer Lodge	30	69/231
Silver Bow	30	347/1,166
Powell	29	47/161
Blaine	25	89/359
Broadwater	25	26/106
Fallon	25	29/116
Hill	25	205/822
Lake	25	295/1,166
Sanders	25	70/276
Musselshell	24	29/123
Toole	24	30/125
Lincoln	23	120/511
Custer	22	95/432
Dawson	22	62/287
Richland	21	62/302
Sheridan	21	15/70
Cascade	20	657/3,355
Fergus	20	56/278
Valley	20	46/230
Glacier	19	133/714
Wheatland	19	11/57
Yellowstone	19	1,093/5,700
Flathead	18	579/3,285
Lewis and Clark	18	393/2,128
Pondera	17	37/214
Big Horn	16	123/785
Carbon	16	43/269
Jefferson	16	50/314
Stillwater	16	49/307
Missoula	15	546/3,544
Park	15	73/473
Rosebud	15	79/509
Beaverhead	14	35/259
Ravalli	14	182/1,272
Chouteau	13	16/123
Phillips	13	14/108
Sweet Grass	13	15/112
Other counties*	12	36/290
Garfield	11	6/54
Granite	11	8/72
Madison	11	17/150
Meagher	11	7/63
Gallatin	9	295/3,253
Teton	7	12/178
Montana	18	6,484/35,192
United States+	10.5	--

\*Includes counties with less than 50 total live births between 2004 and 2006 (Carter, Daniels, Golden Valley, Judith Basin, Liberty, McCone, Petroleum, Powder River, Prairie, Treasure, and Wibaux County). +Includes 36 states using the 1989 birth certificate variable for tobacco use.



# MONTANA

# PUBLIC HEALTH



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## PREVENTION OPPORTUNITIES UNDER THE BIG SKY

### Sudden Unexplained Infant Deaths in Montana, 2003-2010

Sudden Infant Death Syndrome (SIDS) is a diagnosis of exclusion: when an infant under one year of age dies suddenly and unexpectedly during sleep, and a complete autopsy, clinical history, and investigation cannot explain the death.<sup>1</sup> If these criteria are not met, the deaths are classified as unexplained sudden infant death (USID) or as sudden unexpected death in infancy (SUDI).

SIDS is the leading cause of infant mortality after one month of age in the US, accounting for 22% of deaths in this age group; most SIDS deaths occur between the ages of one and four months.<sup>2</sup> The cause or causes of SIDS deaths are not known, but transient neurologic, endocrine, respiratory, and cardiovascular dysfunctions have been implicated, as have genetic factors that predispose infants to vulnerability.<sup>3</sup> It is generally accepted that these physiologic conditions interact with environmental risk factors or triggers.<sup>1,4</sup> Prevention campaigns based on risk factors have been very effective in reducing the national SIDS mortality rate from 1.20 deaths per 1,000 live births in 1992 to 0.50/1,000 in 2008.<sup>2</sup> The most dramatic reduction was associated with the "Back to Sleep" campaign, followed by eliminating soft crib bedding, avoiding smoking during pregnancy, and protecting infants from second-hand smoke.<sup>5</sup>

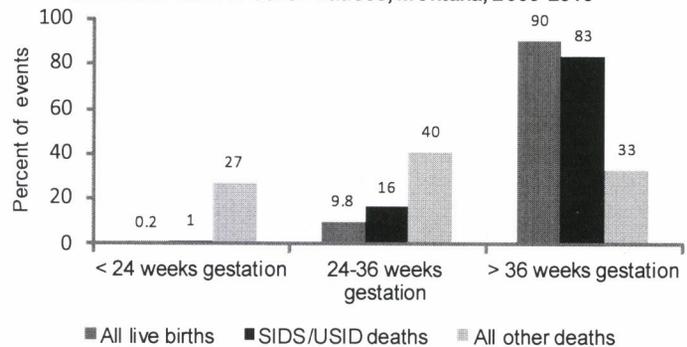
This issue of *Montana Public Health* focuses on SIDS and USID deaths in Montana between 2003 and 2010.

**Incidence of SIDS and USID deaths in Montana.** We identified 586 deaths of Montana infants; 91 were classified as SIDS (0.95/1,000 live births) and 54 as USID (0.56/1,000), jointly accounting for 25% of deaths in this age group, similar to the national experience. We were able to link 484 of the infant deaths to corresponding Montana birth certificates to examine the association of gestational age and maternal smoking during pregnancy with SIDS and USID deaths.

**Risk Factors for SIDS and USID deaths.** Prematurity is a risk factor for SIDS/USID. The overall rate of prematurity (<37 weeks completed gestation) among Montana live-born infants was 10%.<sup>6</sup> Only one SIDS/USID death occurred to an infant of less than 24 weeks, although 16% were of less than 37 weeks gestation (Figure 1). In contrast, 27% of infants who died from other causes were of less than 24 weeks gestation and an additional 40% were of 24 to 36 weeks gestation. Most of the other causes of death were sequelae of extreme prematurity and many were also associated with developmental or genetic birth defects, especially among the very premature infants. Nearly three quarters of the non-SIDS/USID deaths occurred before the age of one month, whereas most SIDS/USID deaths were distributed between birth and 4 months of age (Figure 2).

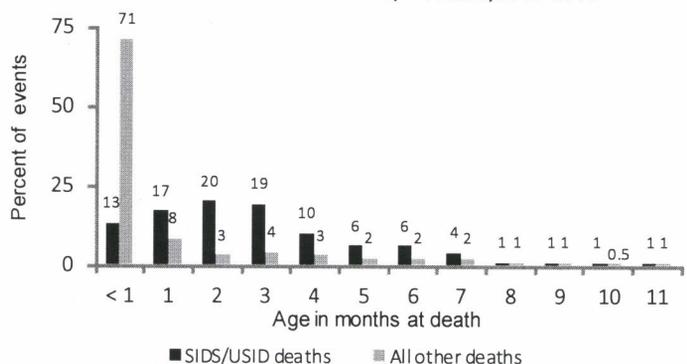
The sex ratio of live births in Montana was 51% male and the sex ratio of all infant deaths was 54%.<sup>6</sup> There was a slight but not statistically significant excess of male deaths among SIDS/USID deaths compared to all other causes (Figure 3, page 2). American Indian infants accounted for 12% of all live births; there were slight but

**Figure 1. Gestational Age of Deaths Under 1 Year SIDS/USID and All Other Causes, Montana, 2003-2010**



Based on 484 matched birth and death records. Difference in gestational age distribution among all live births, SIDS/USID deaths, and all other causes of death is significant at  $p < .001$ .

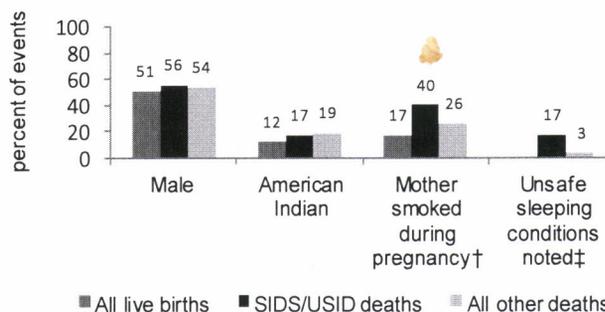
**Figure 2. Distribution of Age at Death Under 1 Year SIDS/USID and All Other Causes, Montana, 2003-2010**



Based on 586 death records. Difference in age at death between SIDS/USID and all other causes of death is significant at  $p < .001$ .

not statistically significant excesses of American Indian infants among both SIDS/USID and all other deaths. Among SIDS/USID deaths, 40% of mothers smoked during pregnancy, compared to 26% of mothers of infants who died from all other causes, and 17% of mothers of all live-born infants. Unsafe sleeping conditions (not on back, not in infant-appropriate bed, with soft bedding, sharing a bed) were noted in 17% of SIDS/USID deaths but in only 3% of all other deaths; in the latter, sleeping conditions were noted in positional asphyxia and strangulation deaths involving bedding.

**Figure 3. Selected Risk Factors for Deaths Under 1 Year SIDS/USID and All Other Causes, Montana, 2003-2010**



† Based on 484 matched birth and death records. Difference among live births, SIDS/USID deaths, and all other causes of death is significant at  $p < .01$ .  
 ‡ Based on 586 death records. Difference between SIDS/USID deaths and all other causes of death is significant at  $p < .001$ . There are no data on sleeping conditions for infants who did not die.

**Prevention strategies.** SIDS prevention should begin with preconception counseling and preparation for a healthy pregnancy, and early entry into prenatal care.<sup>7</sup> After the birth, Back to Sleep, firm bedding in a suitable infant bed, and avoidance of exposure to second hand smoke are evidence-based preventive measures.

**Recommendations for Clinicians**

- Counsel all women who are pregnant or planning a pregnancy not to smoke, or if they are smokers, to quit.
- Encourage parents to maintain a smoke-free home for their infant’s safety.
- Educate parents about safe infant sleep practices: on the back, in an age-appropriate bed of their own, in one layer of clothing, and on a firm surface without soft bedding or crib bumpers.

For information on smoking cessation services for pregnant patients, contact Simon Habegger, Montana Tobacco Use Prevention Program, [tobaccofree.mt.gov](http://tobaccofree.mt.gov), 406-444-5687 or the Montana Tobacco QuitLine at 1-800-QUIT NOW.

**References**

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