



State of Tennessee
PUBLIC CHAPTER NO. 331

SENATE BILL NO. 616

By Kelsey, Barnes, Beavers, Bell, Berke, Burks, Campfield, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Johnson, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Roberts, Southerland, Stewart, Summerville, Tate, Tracy, Watson, Woodson, Yager

Substituted for: House Bill No. 1601

By Maggart, John Deberry, Rich, Stewart, Pruitt, Parkinson, Eldridge, Don Miller

AN ACT to amend Tennessee Code Annotated, Title 68 and Title 71, relative to the care of premature infants.

WHEREAS, according to the Institute for Medicine, although there has been significant attention focused on neonatal intensive care for extremely preterm infants, little attention has been given to the majority of late-preterm infants born at thirty-four (34) through thirty-six (36) weeks gestational age. Even though these late-preterm infants may appear larger in size, they are still more vulnerable to complications and disabilities than full-term infants. All babies born premature, including late-preterm infants, are at risk for a host of health and developmental issues that can last into and sometimes beyond childhood; and

WHEREAS, there are no standardized procedures for hospital discharge and follow-up care of premature infants. As a result, babies born premature may leave the hospital after birth without adequate discharge and follow-up care plans in place to ensure they receive appropriate care to address their special health needs once they are home in their community; and

WHEREAS, although there is growing evidence that late-preterm infants are at increased risk for morbidity and mortality compared to full-term infants, late-preterm infants may not be identified or managed any differently than full-term infants; and

WHEREAS, without organized discharge care plans, premature babies are more likely to experience gaps in health care. These infants require diligent evaluation, monitoring, referral, and early return appointments for both post-neonatal evaluation and also continued long-term follow-up care; and

WHEREAS, it is important to focus on the care and management of premature infants because the number of babies born premature at less than thirty-seven (37) weeks gestational age continues to grow in the United States with an increase of twenty percent (20%) since 1990 and nine percent (9%) since only 2000; and

WHEREAS, in 2005, twelve and seven tenths percent (12.7%) of all births were premature at less than thirty-seven (37) weeks gestational age, or more than five hundred twenty-five thousand (525,000) infants; and

WHEREAS, the increase in premature birth rates in recent years is primarily associated with a rise in late-preterm births (34-36 weeks gestational age), which has increased twenty-five percent (25%) since 1990 and accounts for seventy percent (70%) of all preterm births. Although multiple births have contributed to this rise, substantial increases in preterm birth rates, and especially late-preterm rates, have occurred because of singleton birth rates since 1990; and

WHEREAS, several studies have found that late-preterm infants have greater morbidity and mortality than full-term infants; and

WHEREAS, late-preterm infants have a mortality rate that is three (3) times greater than full-term infants, with the highest risk occurring during the neonatal period; and

WHEREAS, late-preterm babies have significant differences in clinical outcomes than full-term infants during the birth hospitalization, including greater risk for temperature instability, hypoglycemia, respiratory distress, and jaundice; and

WHEREAS, late-preterm infants have higher rates of rehospitalization during their first full year of life compared to full-term infants; and

WHEREAS, the costs of premature births are significant. For the initial hospitalization after birth, the average length of stay for full-term infants was two and two tenths (2.2) days and the average cost was two thousand eighty-seven dollars (\$2,087); and

WHEREAS, late-preterm infants had a substantially longer average stay of eight and eight tenths (8.8) days and cost of twenty-six thousand fifty-four dollars (\$26,054). The average cost for late-preterm infants in their first year of life was thirty-eight thousand three hundred one dollars (\$38,301) versus six thousand one hundred fifty-six dollars (\$6,156) for full-term infants. Late-preterm infants had higher costs across every type of medical service category compared to full-term infants, including inpatient hospitalizations, well baby physician office visits, outpatient hospital services, home healthcare services, and prescription drug use; and

WHEREAS, the most frequent causes of rehospitalization for late-preterm infants are RSV bronchiolitis, bronchiolitis (cause unspecified), pneumonia (cause unspecified), esophageal reflux, and vascular implant complications; and

WHEREAS, because all premature infants, and especially late-preterm infants born at thirty-four (34) through thirty-six (36) weeks gestational age, have higher risks for medical complications and rehospitalizations compared to full-term infants, stakeholders should examine and improve the discharge process, follow-up care, and management of these infants to foster better health outcomes and lower risks for rehospitalizations and complications; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The Perinatal Advisory Committee within the Department of Health is directed to study issues and policy options relating to hospital discharge and follow-up care procedures for premature infants born less than thirty-seven (37) weeks gestational age to ensure standardized and coordinated processes are followed as premature infants leave the hospital from either a Level 1 (well baby nursery), Level 2 (step down or transitional nursery) or Level 3 (neonatal intensive care unit) unit and transition to follow-up care by a healthcare provider in the community. The committee is directed to report to the House Health and Human Resources Committee and the Senate General Welfare, Health and Human Resources Committee concerning its findings and recommendations for legislation, if any, on or before January 31, 2012.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

SENATE BILL NO. 616

PASSED: May 18, 2011



RON RAMSEY
SPEAKER OF THE SENATE



BETH HARWELL, SPEAKER
HOUSE OF REPRESENTATIVES

APPROVED this 30th day of May 2011



BILL HASLAM, GOVERNOR