

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 937 Perinatal Mental Health
SPONSOR(S): Health Innovation Subcommittee; Nuñez
TIED BILLS: **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|--|---------------------|---------|--|
| 1) Health Innovation Subcommittee | 13 Y, 0 N, As CS | Beattie | Crosier |
| 2) Health Care Appropriations Subcommittee | 12 Y, 0 N, As CS | Mielke | Pridgeon |
| 3) Health & Human Services Committee | | | |

SUMMARY ANALYSIS

Women are more likely to develop depression and anxiety during the first year after childbirth than at any other time of their lives. "Perinatal mental health" refers to the mental health of mothers and fathers during the period immediately before and after pregnancy. Perinatal mood or anxiety disorders ("PMDs") include antenatal depression and anxiety, postpartum depression and anxiety, postpartum anxiety/panic disorder, postpartum obsessive compulsive disorder, postpartum post-traumatic stress disorder, and postpartum psychosis.

Nationally, about 1 in 9 women experience postpartum depression, but state estimates can be as high as 1 in 5 women. A 2010 CDC study shows that approximately 4% of fathers experience paternal postpartum depression in the first year after their child's birth. In 2016, over 225,000 babies were born in Florida. The Florida Department of Health (DOH) tracks infant and maternal health issues, including postpartum depression. An estimated 45,000 children in Florida were born to mothers suffering from perinatal mood or anxiety disorders in 2016 alone. PMDs and poor perinatal mental health care during pregnancy can lead to a higher instance of preterm births, babies born at low birth weights, and adverse neurodevelopmental outcomes in infants. PMDs may also contribute to a parent's compromised caregiving activities for an infant.

A birth center is any facility, institution, or place, which is not an ambulatory surgical center, a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy. Birth centers are licensed and regulated by the Agency for Health Care Administration (AHCA). A birth center must ensure that its patients have adequate prenatal care, maintain records of prenatal care for each client, and make the records available during labor and delivery.

The bill requires the Department of Health, by January 1, 2019, to provide perinatal mental health information through its Family Health Line toll-free hotline. The bill requires the hotline to provide basic information on postpartum depression, may recommend that a caller be further evaluated by a qualified health care provider, and may refer a caller to an appropriate health care provider in the caller's local area.

The bill revises components that are included in postpartum evaluation and follow-up care provided by birth centers to include a mental health screening, provision of information on postpartum depression, and the telephone number of the Family Health Line.

The bill appropriates \$104,320 recurring General Revenue funds and \$21,600 nonrecurring General Revenue funds to the DOH to implement the provisions in the bill. The bill does not have a fiscal impact on local governments.

The bill provides an effective date of July 1, 2018.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

STORAGE NAME: h0937c.HCA

DATE: 2/13/2018

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Health Line

The Department of Health currently contracts to operate the Family Health Line, a toll-free hotline that provides callers with information about pregnancy, prenatal care, childbirth, breastfeeding, family planning, infant care, parenting, smoking cessation, substance abuse, and the Medicaid Family Planning Waiver Program. In 2016, this hotline received a total of 10,911 calls.¹

Perinatal Mental Health

Women are more likely to develop depression and anxiety during the first year after childbirth than at any other time of their lives.² “Perinatal³ mental health” refers to the mental health of mothers and fathers during the period immediately before and after pregnancy.⁴ Perinatal mood or anxiety disorders (“PMDs”) span a broader spectrum of disorders, including:

- Antenatal depression and anxiety
- Postpartum depression and anxiety
- Postpartum anxiety/panic disorder
- Postpartum obsessive compulsive disorder
- Postpartum post-traumatic stress disorder
- Postpartum psychosis

Pregnancy and childbirth may also exacerbate pre-existing mental health disorders.⁵ The causes of PMDs are multifaceted, but the most likely hypothesis is that mental health changes are triggered by the significant changes in a woman’s hormones during the perinatal period.⁶ PMDs are often generalized as postpartum depression, as this is the most common complication after childbirth.⁷ While 50-80%⁸ of women experience worry, sadness, and tiredness after having a baby, these “baby blues” typically resolve themselves after a few days.⁹ However, postpartum depression is more intense and lasts longer than “baby blues.”¹⁰ Symptoms of postpartum depression are similar to symptoms of depression, but may also include:

- Crying more often than usual.

¹ Department of Health, *2018 Agency Legislative Bill Analysis*, (Dec. 12, 2017), on file with the Health Care Appropriations Subcommittee.

² Mental Health America, *Position Statement 49: Perinatal Mental Health*, available at <http://www.mentalhealthamerica.net/issues/position-statement-49-perinatal-mental-health> (last visited January 21, 2018).

³ Merriam Webster, *Definition of “perinatal,”* “occurring in, concerned with, or being in the period around the time of birth,” available at <https://www.merriam-webster.com/dictionary/perinatal%20mental%20health> (last visited January 21, 2018).

⁴ This includes parents who lose an infant during the perinatal period: Lauren DePaolo, *Florida’s largest reproductive health issue: Perinatal Mental Illness*, Florida Children & Youth Cabinet presentation, May 4th, 2016, available at <https://www.flgov.com/cyc-2016-meeting-materials/> (last visited January 21, 2018).

⁵ *Id.*

⁶ *Id.*

⁷ *Id.* See also Alachua County Perinatal Mental Health Coalition, *Alachua County Maternal Mental Health Needs Assessment*, May 2017, at 1, available at https://docs.wixstatic.com/ugd/8de022_cdf337ae9de947d5bdf60033899bc506.pdf (last visited January 21, 2018).

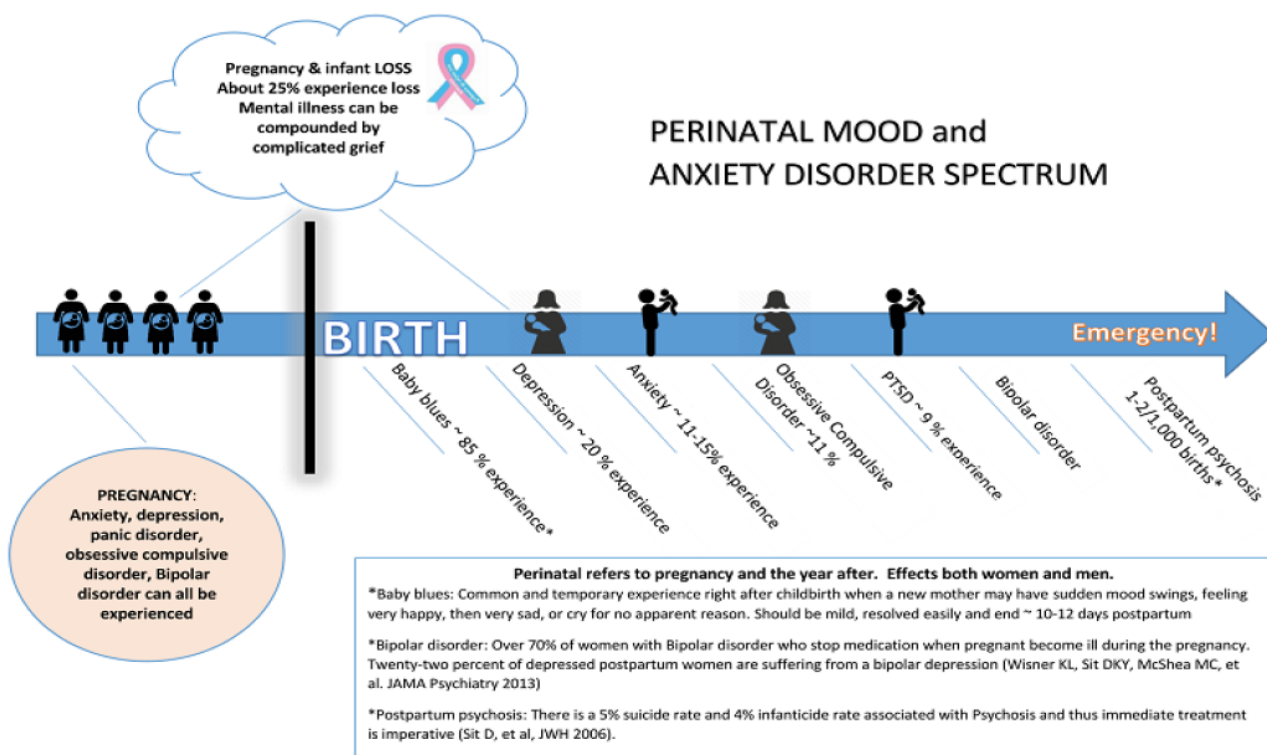
⁸ Marian Earls, *Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice*, from the American Academy of Pediatrics, at 1033, available at <http://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf> (last visited January 21, 2018).

⁹ Centers for Disease Control and Prevention, *Depression Among Women*, available at <https://www.cdc.gov/reproductivehealth/depression/index.htm> (last visited January 21, 2018).

¹⁰ *Id.*

- Feelings of anger.
- Withdrawing from loved ones.
- Feeling numb or disconnected from the baby.
- Worrying about hurting the baby.
- Feeling guilty about not being a good mom or doubting one's ability to care for the baby.¹¹

The exact prevalence of PMDs is unknown because many cases go unreported, and PMDs often have overlapping symptoms, which complicates diagnosis.¹² Reports from the Centers for Disease Control and Prevention ("CDC") show that nationally, about 1 in 9 women experience postpartum depression, but state estimates can be as high as 1 in 5 women.¹³ The rates of depression for low-income mothers and pregnant and parenting teenagers are even higher, at 40-60%.¹⁴ It is estimated that every year, over 400,000 infants are born to mothers who are depressed, which makes perinatal depression the most underdiagnosed obstetric complication in America.¹⁵



Source: Alachua County Perinatal Mental Health Coalition, *Alachua County Maternal Mental Health Needs Assessment*, May 2017, at 10.

Additionally, a 2010 CDC study shows that approximately 4% of fathers experience paternal postpartum depression in the first year after their child's birth.¹⁶ Other studies suggest that the rates for fathers are similar to those for mothers.¹⁷ Research suggests that depression in one partner is significantly correlated with depression in the other partner.¹⁸ Maternal postpartum depression is the primary risk factor for paternal postpartum depression.¹⁹ One study found that 24-50% of men with

¹¹ *Id.*
¹² *Id.*
¹³ *Id.*
¹⁴ *Supra* n. 8, at 1032.
¹⁵ *Id.*
¹⁶ *Supra* n. 8.

¹⁷ Kathleen Biebel & Shums Alikhan, *Paternal Postpartum Depression*, Vol. 1, Iss. 1 U. Mass. Journal of Parent & Family Mental Health August, 2016, at 1, available at <https://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1000&context=parentandfamily> (last visited January 21, 2018).

¹⁸ *Id.*
¹⁹ *Id.*

paternal postpartum depression also had partners with it.²⁰ This means that infants may be in family situations where multiple caregivers are depressed.²¹ Compounded effects from parental PMDs can lead to more severe disruptions in infant development.²²

Effects of PMDs on Infants

PMDs and poor perinatal mental health care during pregnancy can lead to a host of issues for infants.²³ Maternal stress and anxiety have been linked to a higher instance of preterm births, babies born at low birth weights, and adverse neurodevelopmental outcomes in infants.²⁴

PMDs that continue after birth may also contribute to a parent's compromised caregiving activities for an infant.²⁵ Reports show that infants of mothers with postpartum depression are more likely to be abused, neglected, and be diagnosed as failure to thrive.²⁶ Studies also report links between maternal depression and reduced likelihood of continued breastfeeding, problematic sleep practices, and fewer preventative services (and more emergency services) for infants.²⁷ Depressed mothers are also more likely to have thoughts of harming infants.²⁸ One study found that 41% of depressed mothers compared to 7% of the control group mothers admitted to thoughts of harming their infant.²⁹ A majority of these depressed mothers had a problem with thoughts of harming their infant, fear of being alone with the infants, and an inability to care for the infant.³⁰

In contrast to a large body of literature on maternal care, there are fewer studies of the relationship between child development and paternal care.³¹ Even so, research shows that infants establish secure attachments with primary caregivers that allow them to develop basic biological and behavioral regulatory patterns that are important for growth.³² Infants who live in a setting where one or both parents is depressed are likely to show impaired social interaction and delays in development.³³ Unaffectionate parenting from either or both parents may lead to insecure attachment with infants, which can cause long-term effects.³⁴ Insecure attachment has been linked to later conduct disorders and behavior problems.³⁵

Status of Perinatal Mental Health in Florida

Number of Infants in Florida Affected By PMDs

In 2016, over 225,000 babies were born in Florida.³⁶ The Florida Department of Health (DOH) uses its Pregnancy Risk Assessment Monitoring System (PRAMS) to track infant and maternal health issues,

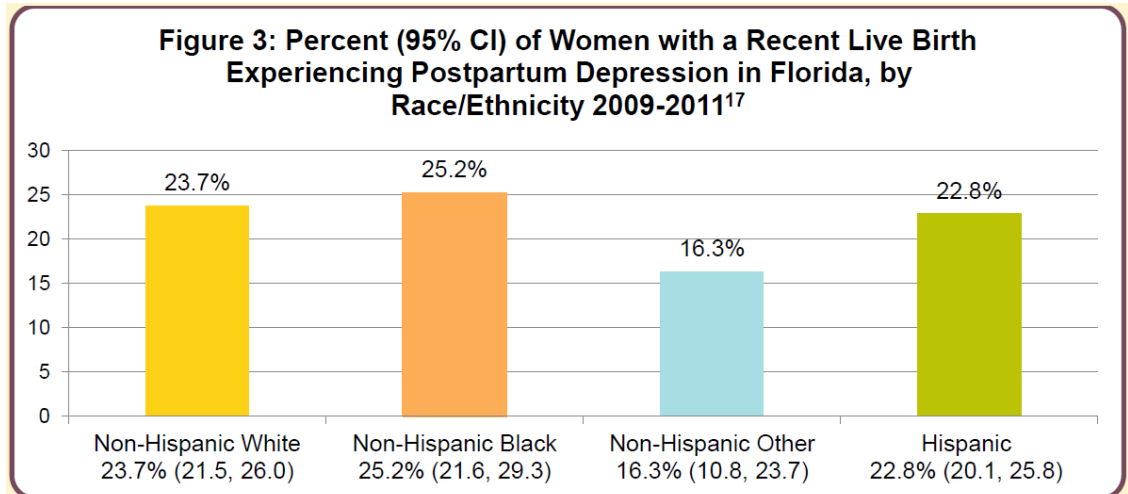
²⁰ *Id.*
²¹ *Id.*
²² *Id.*
²³ Christine Schetter & Lynlee Tanner, *Anxiety, depression and stress in pregnancy: implications for mothers, children, research, and practice*, *Curr Opin Psychiatry*, March, 2012, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4447112/> (last visited January 21, 2018).
²⁴ *Id.*
²⁵ Tiffany Field, *Postpartum Depression Effects on Early Interactions, Parenting, and Safety Practices: A Review*, *Infant Behav Dev.*, February, 2010, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2819576/> (last visited January 21, 2018).
²⁶ Holicky, A., Phillips-Bell, G. *Florida Life Course Indicator Report (Mental Health)*, Florida Department of Health (Dec. 2016), at 4, available at <http://www.floridahealth.gov/programs-and-services/womens-health/florida-life-course-indicator-report/mental-health-2017.pdf> (last visited January 21, 2018).
²⁷ *Supra* n. 25
²⁸ *Id.*
²⁹ *Id.*
³⁰ *Id.*
³¹ *Supra* n. 17.
³² *Supra* n. 23
³³ *Supra* n. 8.
³⁴ *Supra* n. 23.
³⁵ *Supra* n. 8, at 1034.
³⁶ Florida Department of Health, *Florida Birth Query System*, available at <http://www.flhealthcharts.com/FLQUERY/Birth/BirthRpt.aspx> (last visited January 21, 2018).
STORAGE NAME: h0937c.HCA
DATE: 2/13/2018

including postpartum depression.³⁷ The results from the 2009-2011 study are reflected below, and show that 23.4% of women with a recent live birth were experiencing postpartum depression.

| Table 3: Percent (95% CI) of Women with a Recent Live Birth Experiencing Postpartum Depression, 2009-2011 | |
|---|-----------------------|
| Nation ^{12*} | Florida ¹⁷ |
| 23.0% (22.9, 23.0) | 23.4% (21.8, 25.0) |

*The national average is derived from states participating in the CDC's CPONDER data system between 2009 and 2011. To be included in the system, states must have greater than 65% response rate on their PRAMS survey. Florida was not included in the national estimate. The numbers reported here may not be directly comparable.

Source: Holicky, A., Phillips-Bell, G. *Florida Life Course Indicator Report (Mental Health)*, Florida Department of Health (Dec. 2016)



Source: Holicky, A., Phillips-Bell, G. *Florida Life Course Indicator Report (Mental Health)*, Florida Department of Health (Dec. 2016)

The most recent PRAMS (from 2014) asked study participants two different questions from the 2009-2011 data:

1. "Since your new baby was born, how often have you felt down, depressed, or hopeless?" (8.6% answered "always or often").
2. "Since your new baby was born, how often have you had little interest or little pleasure in doing things?" (10.6% answered "always or often").³⁸

Although these data sets cannot be directly compared, the 2014 results may reflect that there is improvement in the incidence of postpartum depression in Florida.³⁹ Using this highly-cited estimate,⁴⁰ if approximately 20% of mothers experience some form of PMD, an estimated 45,000 children in Florida were born to mothers suffering from perinatal mood or anxiety disorders in 2016 alone.

³⁷ *Supra* n. 25 at 4-5. Questions asked were:

1. Since your new baby was born, how often have you felt down, depressed or sad?
2. Since your new baby was born, how often have you felt hopeless?
3. Since your new baby was born, how often have you felt slowed down?

Women responding "always" or "often" to any of the above questions were considered to be experiencing postpartum depression.

³⁸ Bo Yu et. al., *Florida Pregnancy Risk Assessment Monitoring System (PRAMS) 2014 Surveillance Data Book*, Florida Department of Health (Nov. 2017), at 69-70, available at http://www.floridahealth.gov/statistics-and-data/survey-data/pregnancy-risk-assessment-monitoring-system/_documents/reports/prams2014.pdf (last visited January 21, 2018).

³⁹ *See id.*

⁴⁰ *See* Lauren DePaolo, *Florida's largest reproductive health issue: Perinatal Mental Illness*, Florida Children & Youth Cabinet presentation, May 4th, 2016; Centers for Disease Control and Prevention, *Depression Among Women*, available at <https://www.flgov.com/cyc-2016-meeting-materials/> (last visited January 21, 2018).

Cost of Perinatal Mood and Anxiety Disorders in Florida.

Perinatal mood and anxiety disorders create a substantial cost to parents, infants, and the state. The cost of adverse health outcomes such as preterm birth, low birth weight, and compromised attachment and development for infants of mothers suffering from PMDs are difficult to measure, but significant.⁴¹ If a mother's depression continues during an infant's childhood, the child will be more likely to experience developmental delays and thus require services through the early intervention system.⁴² Research further indicates that a parent-child relationship affected by maternal depression may lead to increased risk for social and emotional problems and delays or impairments in cognitive and linguistic development.⁴³ Besides the cost to the child, these impairments or delays may result in an increased need for early intervention services.⁴⁴

The emotional cost of depression may be compounded by the guilt felt by parents who are unable to form bonds with their infant or experience thoughts of harming their infant.⁴⁵ Additionally, untreated antepartum and postpartum depression can lead to ongoing depression, which has been associated with an increased likelihood of cardiovascular disease, stroke, and type-2 diabetes.⁴⁶ As women are more likely to develop depression and anxiety during the first year after childbirth than at any other time, receiving perinatal mental health treatment may be crucial to preventing continued mental health issues.⁴⁷

Untreated maternal depression has also been associated with negative outcomes in the areas of employment and income.⁴⁸ Depressed mothers when compared to non-depressed mothers may be more likely to be unemployed and less likely to be employed full time.⁴⁹ Depressed mothers may also have difficulty getting and keeping a job, leading to lower income and possibly a greater need for public assistance.⁵⁰ For the general population, depression has been shown to predict greater work disability and lower income over time, and treatment of depression has been shown to improve work productivity and decrease absenteeism.⁵¹ This suggests that untreated postpartum depression decreases the productivity and incomes of affected parents, imposing economic costs on parents, employers, and the public assistance system.

The estimated two-generational (mother and child) annual economic cost of not treating one mother with maternal depression is \$22,647.⁵² However, this estimate is from 2010, and it does not account for the costs to the state, which may expend more resources on parents and children of parents affected by PMDs.⁵³ It also fails to include the cost of fathers experiencing PMDs, the healthcare costs to mothers experiencing ongoing depression that began from insufficient perinatal mental healthcare, or the mental and emotional costs on parents and children of parents experiencing PMDs. Relying on this cost estimate, there is an economic loss of over \$1.02 billion for the 2016 birth cohort alone.⁵⁴ The true

⁴¹ See n. 23.

⁴² Lisa Sontag-Padilla, et. al., *Maternal Depression: Implications for Systems Serving Mother and Child*, Rand Corporation, (2013), pg. 3, available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR404/RAND_RR404.pdf (last visited January 21, 2018).

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ See n. 23 and 25.

⁴⁶ See n. 42.

⁴⁷ *Supra* n. 2.

⁴⁸ *Supra* n. 42 at 2.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Jose Diaz & Richard Chase, *The Cost of Untreated Maternal Depression*, Wilder Research (October, 2010), available at <https://www.wilder.org/Wilder-Research/Publications/Studies/Cost%20of%20Untreated%20Maternal%20Depression/The%20Cost%20of%20Untreated%20Maternal%20Depression,%20Brief.pdf> (last visited January 21, 2018).

⁵³ *Id.*

⁵⁴ \$22,647 x 45,000 = 1,019,115,000 (where 45,000 is the estimated be the number of babies born to mothers affected by perinatal health issues (number of births multiplied by 20% prevalence). Number of total births found at: Florida Department of Health, *Florida Birth Query System*, available at <http://www.flhealthcharts.com/FLQUERY/Birth/BirthRpt.aspx> (last visited January 21, 2018)).

price of insufficient perinatal mental healthcare is likely much higher than the estimate reflected in the table below.

Estimated Annual Costs

| | |
|--|-----------------|
| Total cost of not treating a depressed mother and her child | \$22,647 |
| Cost of not treating mothers with depression | \$7,211 |
| Lost income of mothers | \$945 |
| Cost due to lost productivity of mothers | \$6,223 |
| Costs associated with a child born to a depressed mother | \$15,323 |
| Cost of treating low birth weight (LBW) babies | \$6,283 |
| Cost of pre-term deliveries | \$1,130 |
| Loss of future income of babies due to LBW | \$3,522 |
| Loss of future income of babies due to delayed brain development | \$2,465 |
| Loss of future income of babies due to death of LBW child | \$1,577 |
| Cost to the justice system | \$120 |
| Loss in tax revenues (mother and child) | \$383 |

Source: Jose Diaz & Richard Chase, *The Cost of Untreated Maternal Depression*, Wilder Research (October, 2010).

Services Currently Available

There is currently no state-wide entity coordinating support for perinatal mental health. The Florida Department of Health website provides information for new mothers, and suggests that women experiencing symptoms of postpartum depression consult their doctor, or call 911 or the National Suicide Prevention Lifeline if necessary.⁵⁵

The goals of the Florida Association of Healthy Start Coalitions (FAHSC) are to reduce infant mortality, reduce the number of low birth weight babies, and improve health and developmental outcomes by providing prenatal and postnatal education and coordination of resources through home visiting.⁵⁶ The DOH, in collaboration with the FAHSC, is working to standardize the use of the Edinburgh Postnatal Depression Scale (EPDS) as the Depression Screening used for all Healthy Start participants statewide.⁵⁷ Standardization of when the EPDS is utilized, training, and other evidence-based interventions for women found to be at risk for postpartum depression based on the EPDS are also being finalized.⁵⁸ However, not all mothers utilize Healthy Start, so even once this additional screening is implemented, it will not cover all new mothers who may have PMDs.

Most new mothers in Florida appear to be receiving checkups. The 2014 PRAMS data shows that overall, 88.5% of new moms received a postpartum checkup for themselves.⁵⁹ It is not known if screening for perinatal mental health issues took place at these checkups.

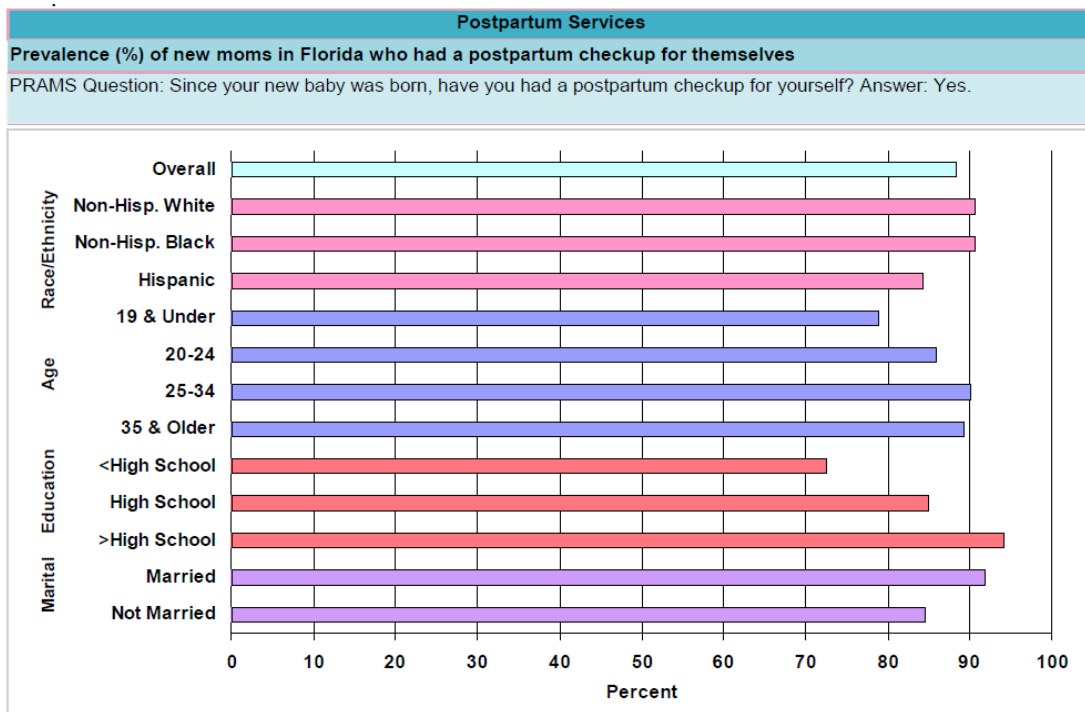
⁵⁵ Florida Department of Health, *After Pregnancy: The "Baby Blues" and Postpartum Depression*, <http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/after-pregnancy.html> (last visited January 22, 2018).

⁵⁶ *Supra* n. 25, at 6.

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Supra* n. 37, at 72.



CI = Confidence Interval Source: Bo Yu et. al., *Florida Pregnancy Risk Assessment Monitoring System (PRAMS) 2014 Surveillance Data Book*, Florida Department of Health (Nov. 2017), at 72.

Birth Centers

A birth center is any facility, institution, or place, which is not an ambulatory surgical center, a hospital or in a hospital, in which births are planned to occur away from the mother’s usual residence following a normal, uncomplicated, low-risk pregnancy.⁶⁰ Birth centers are licensed and regulated by the Agency for Health Care Administration (AHCA) under ch. 383, F.S., and part II of ch. 408, F.S.

A birth center must ensure that its patients have adequate prenatal care and must maintain records of prenatal care for each client and must make the records available during labor and delivery.⁶¹

Birth centers must provide postpartum care and evaluation that includes physical examination of the infant, metabolic screening tests, referral to pediatric care sources, maternal postpartum assessment, family planning, referral to secondary or tertiary care, and instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.⁶²

Effect of Proposed Changes

The bill creates s. 383.014, F.S., which requires the Department of Health, by January 1, 2019, to provide perinatal mental health information through its Family Health Line toll-free hotline. The bill requires the hotline to provide basic information on postpartum depression, may recommend that a caller be further evaluated by a qualified health care provider, and may refer a caller to an appropriate health care provider in the caller’s local area.

⁶⁰ Section 383.302(2), F.S.; Section 383.302(8), F.S. defines “low-risk pregnancy” as a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.

⁶¹ Section 383.312, F.S.

⁶² Section 383.313(3), F.S.

The bill amends s. 383.318, F.S., revising components that are included in postpartum evaluation and follow-up care provided by birth centers to include a mental health screening, provision of information on postpartum depression, and the telephone number of the Family Health Line.

The bill appropriates \$104,320 recurring General Revenue funds and \$21,600 nonrecurring General Revenue funds to the DOH to implement the provisions in the bill.

The bill provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Provides a title; "Florida Families First Act."

Section 2: Creates s. 383.014, F.S., relating to perinatal mental health care.

Section 3: Amends s. 383.318, F.S., relating to postpartum care for birth center clients and infants.

Section 4: Provides an appropriation.

Section 5: Provides an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill will require DOH to amend its current Family Health Line contract to add and to maintain a database of mental health providers and information, take calls, make referrals, and provide staff training and supervision. DOH estimates the increased cost for the first year to be \$125,920 and \$104,320 per year thereafter.⁶³ The bill appropriates these funds from General Revenue.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Birth centers currently provide maternal postpartum assessments in its postpartum evaluation and follow-up care. Birth centers may incur costs associated with providing a mental health screening, providing information about postpartum depression, and providing the Family Health Line telephone number as part of its postpartum evaluation and follow-up care.

D. FISCAL COMMENTS:

None.

⁶³ Email from Bob Peck, Government Operations Consultant, Florida Department of Health, *RE: HB 937 updated fiscal impact*, January 25, 2018 (on file with the Health Care Appropriations Subcommittee).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

According to DOH, no rule-making is required to implement this bill.⁶⁴ If necessary, DOH has sufficient rulemaking authority under s. 383.011(2)(a), F.S., which authorizes DOH to promulgate rules necessary to administer the maternal and child health care program.⁶⁵

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 23, 2018, the Health Innovation Subcommittee adopted a strike-all amendment that requires

- DOH to provide perinatal mental health information through its Family Health Line; and
- Directs birth centers to include a mental health screening and provide information about postpartum depression and the Family Health Line as part of its postpartum evaluation and follow-up care.

The bill was reported favorably as a committee substitute.

On February 13, 2018, the Health Care Appropriations Subcommittee adopted an amendment that appropriates \$104,320 recurring General Revenue funds and \$21,600 nonrecurring General Revenue funds to the DOH to implement the provisions in the bill.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.

⁶⁴ Email from Department of Health, *FW: Family Health Line*, January 22, 2018, (on file with House Health Innovation Subcommittee staff).

⁶⁵ *Id.*