Promoting Safe Sleep Environments for Infants

Melissa Linn: On today's webinar, we are pleased to have Ms. Kimberly Clear-Sandor, Dr. Christina Pease, and Dr. Rachel Moon presenting. Mr. Steve Shuman will join us later to moderate the Q&A. Now I'll turn it over to Kim to kick us off.

Kimberly Clear-Sandor: Thank you, Melissa. We are all thrilled to be here with you today to talk about safe sleep environments for infants. This information is so important for all families, staff, volunteers, and really anyone working with infants. As early childhood professionals, you recognize the importance of maintaining up to date research, inform policies, procedures, and practices, and education materials for your staff and for your families.

We hope that today's webinar provides you with lots of good information and opportunity to have some of your questions answered and show you some great resources that you can use in your work. My name is Kimberly Clear-Sandor. I'm a nurse and a family nurse practitioner, and I have lots of experience working with children and families and communities.

For the past 10 years, I've been working with the national center and have also worked as a child care health consultant, working in many different types of early childhood programs. Dr. Christina Pease and I are so excited that we are able to be on this webinar today with the premier expert in the field, Dr. Rachel moon. I'm going to pass this over to Dr. Christina Pease.

Christina Pease: Hello, everybody. I'm Christina. I am a general pediatrician practicing in Seattle, Washington, at a federally qualified community health center and serving mostly Spanish speaking families in my clinic. Most recently, I was super excited to come on as the medical advisor for our center back in March, replacing Dr. Jill Sells.

Super excited to be here and share just some of my experiences with this topic in clinic. We are super thrilled to have Dr. Moon on this panel and appreciate her time. I will pass it on to her and let her introduce herself.

Rachel Y. Moon: Hi, everybody. I'm Rachel Moon. I am also a general pediatrician and I work in Charlottesville, Virginia at the University of Virginia. I also have been doing research in SIDS and sudden unexpected infant death for, oh, boy, now it's been more than 20 years, almost 30 years maybe. But we're not getting any older, are we?

I've been doing this a lot and this is something I'm very passionate about. I'm also the chair of what used to be called the American Academy of Pediatrics Task Force on SIDS, we now have a new name and we are now called the subcommittee on sudden unexpected infant death. I am very happy to be here. I'm excited that there are so many of you who are interested in this topic and have taken some time out of your day during this very challenging week to do this. Thank you.

Christina: We'll stay on this slide, which I really wanted to take a short pause just to remind us all to take the time to step away and prioritize your own well - being during this session. Discussing infant death is very hard topic and we really hope that by sharing a lot of the research that Dr. Moon has been involved in and the recommendations that have had such incredible impact that by sharing these recommendations, we can all together move to prevent more infant deaths.

Take the time you need, but as listed here in this slide, our main goals are for all of us to understand what we do know about a tragic but very sudden unexpected infant death occurrence. This SUID does include what many of us are more familiar hearing about SIDS or sudden infant death syndrome.

The good news is that through all the work that Dr. Moon and her colleagues have done, we found a lot of ways of how to prevent SIDS. That's where we will focus our energy today in the sleep environment and not only review how the recommendations came about, thanks to having Rachel here with us, but also to bring you the latest updates that were presented and published in 2022. We hope that by sharing these you can more confidently share this information with your staff and families.

But our most important message is really for you who are spending much time with these babies, these children, and their families to lean on and into the relationships you have with them. I see patients very quickly, unfortunately. I can't overstress the power you have; they trust you with their babies and their children. They let their children nap at your centers.

They let you into your home if you're a home visitor. Thank you for all you do and all that you model, the standards that you have with safe sleep in your infant rooms. You will often, we understand, be witness or hear about home sleep environments that may be less than ideal knowing these recommendations.

This being a more difficult position to be in, we hope today's format of a conversation between the three of us can address some of these common concerns and hopefully set you up to have these conversations in a nonjudgmental way and partner with your families. I know we spent a lot of time, but we really want this to be a conversation and that we can set our families up for the most optimal way for a safe sleep environment based on their unique circumstances.

As Melissa introduced, you have the Q&A. We'll do our best to get to those either written or in our Q&A session at the end. But please use that Q&A or email the info line that will be in the chat. Next slide Olivia, please.

Quick just celebration of sleep being a bonding ritual, a special time when you see a baby sleeping, when you as a parent and exhausted caregiver can finally get some time and some rest. Let's not forget how important that bonding time is, how important routines are, culture, family, togetherness. Those are unique to each family. Next slide, Olivia.

As I said, I have maybe five minutes to really address these. I think it's over years that we build relationships, but you truly are in a special relationship with these families. I often get families who are moving shelter to shelter. Coming out with blanket statements and advice that your baby needs their own space to sleep, their own let's say crib, really sometimes does not apply to many of my families.

These are a few of the open - ended questions. If things are going well that I try to focus on, the more positive aspects of their bedtime routine. Often if a parent looks exhausted as many of them are in that difficult newborn period is really seeing if they have questions or concerns and about their baby's sleep habits and also about where their baby is sleeping and asking for permission to share this research - based guidance.

Keeping the conversation going, if I sense defensiveness or we all feel that is just to take a pause and back off, our families are the experts. They already judge themselves more than anybody else. We've all been parents and I know I do this to myself. I think it's just really realizing and starting that conversation and allowing a safe space for sharing guidance.

We'll transition today, giving you the specifics of what you can consider incorporating into your policies, updating your policies, discussing and training, having open conversations with your staff as to difficult situations that may have arisen. Next slide, please.

We'll get into a little bit more of the terms. Dr. Moon, could you help us understand how these acronyms came about or what they mean and how that can be placed into context for our conversation today?

Dr. Moon: Sure, I'm happy to. The first initials that I want to talk about are SUID. SUID, this stands for sudden unexpected infant death. This is exactly what it sounds like. It is when an infant, a baby who is younger than one year of age dies suddenly and unexpectedly.

This is a catch all category. Some of these deaths turn out to be explained deaths later and others are unexplained. An example of an unexplained death would be what's called an ASSB, which is when a baby accidentally suffocates or becomes strangled in a bed or a crib or sleep area.

SIDS or sudden infant death syndrome is also part of this. This is when a baby dies suddenly and unexpectedly without explanation. This is slightly different from what's the red part of the circle, the pie chart on the left, unknown causes. This is when the pathologist or the coroner isn't quite sure what happened, and some of these fall into the unknown category.

Kim: Thank you for explaining that. When I look at that pie chart, I think of that as the big term, the sudden unexpected infant death, and that once they explore and try and figure out the cause, it's either going to fall into the SIDS bucket or the accidental suffocation and strangulation or there still may not be able to understand.

I think it's just so important that we have these terms and we don't want the terms to get in the way of the important work that needs to happen to keep children safe when they do go to sleep. Thank you for sharing that. Next slide.

It was great when we found this graph because it really shows the progress that's been made since sudden unexpected infant deaths have begun being explored and recommendations being put out there. We have that since 94, the American Academy of Pediatrics had put out a policy statement. If you look to the left, you can see how high those rates of that unexplained death were and how they've come down.

As you can see at the bottom, they have plateaued a little bit. We still want to continue to try and identify practices and risks that can keep our babies safe, that we achieve the ultimate goal of every baby has a safe space to sleep and is safe when they sleep.

Your policy that you put together with your colleagues really does such a wonderful job of taking much information, digesting it, and putting out recommendations for us to work with. I was wondering if you could tell us a little bit about what that process is with your team and how you go about creating those recommendations.

Dr. Moon: This is a process that each of these policy statements takes about two to three years to write. We start with a list of topics that we think are important to address in this. Then we go back into the literature and look at every single paper that has been published on this topic since the last time we reviewed the policy statement.

We decide what needs to be changed, what needs to be reinforced, what needs to be modified. Then we develop a draft and then it has to be approved by every single relevant committee and council in the American Academy of Pediatrics and then by the executive board. It is a long hard process that takes place every few years.

Kim: Forgive me if you don't want to answer this question. I know you were hesitating on how many years you've been doing the work, but how many times have you been involved in leading this work, Dr. Moon?

Dr. Moon: I think that I've been involved in the last four statements. I think that I have led the team in the last two or three statements.

Kim: That's amazing. Well, I bring that up because I think when I picked up the policy statement and started looking through it, the amount of literature and research and things that has been combed over and thought about is so impressive. I really appreciate your leadership and all the work being done with that team.

In your recommendations, you do talk about something, the triple risk model, and I was wondering if you could explain a little bit about why that's so important. Olivia, if you could move to the next slide. Excellent. There we go. Oh, can you hear me?

Dr. Moon: The next slide with the triple risk model, please.

Kim: Thank you.

Dr. Moon: The triple risk model talks about two really important concepts when it comes to these deaths. One is arousal, how the baby wakes up. This triple risk model talks about how a baby is vulnerable. You have a vulnerable baby and this baby is vulnerable because they do not wake up as well as they should.

This may be because that there's probably some dysfunction in their brain stem and that could be because of genetics and that could also be because of exposures. We know that babies who are exposed to tobacco and/or drugs during pregnancy don't wake up as easily as babies who are not exposed.

Then you have this baby that goes through this critical developmental period and we know that the highest risk is between two and four months or even one in four months. Then there's a stressor and the stressor could be sleep position, it could be bedding, it could be a whole host of things. Olivia, you could click on one more time.

What that creates is an environment where the baby is not getting enough oxygen. Asphyxiation is when you don't get enough oxygen. The baby is not getting enough oxygen and they don't wake up enough to realize it then they will likely die.

It is this interplay between being able to wake up, which is why back sleeping is protective because babies wake up more frequently on the back than they do on the stomach and then the asphyxiating environment, environment where the airway is blocked or the face and nose and mouth are blocked. These are places where the baby's not getting enough oxygen.

Christina: Thank you, Rachel. We've heard some of the technical terms and the science, I think, for all of you really in the moment and wanting a summary. This slide highlights in different areas relating to healthy behaviors, the sleep area, position, as well as various routines. Just a summary of the current recommendations many of you will be familiar with because as we've seen, the work has been going on for many years.

The back to sleep, but we'll highlight in the next few questions with Dr. Moon, just some of the updates as well as the reasoning behind all of these. Again, it's not just saying do this and your baby will be fine, remember that relationship we all have with these families. We know how chaotic it can be in a home with many children.

Many of our families don't have a separate rooms or they're moving place to place. Next slide, please. We'll start with healthy behaviors. The 2022 policy identified factors prior to birth that can contribute to sudden unexpected infant death. Being an early childhood programs as home visitors or an infant rooms, you often will come across pregnant people and being able to provide this guidance prior to baby's arrival is really tremendous.

Rachel, can you just review these recommendations as they're outlined on the slide and then discuss why they are important and what pregnant people can do to protect their child after birth?

Dr. Moon: Yes, of course. We want all pregnant people to get regular prenatal care because we know that that is where if there are problems, those can be identified. We know that counseling can happen there that can also be helpful.

We want babies to all be vaccinated. If pregnant people can be vaccinated as well, that is very important because we know that a minor illness like a viral illness or something like that is a risk factor for babies dying suddenly and unexpectedly. Avoiding smoke and nicotine exposure during pregnancy and after birth is critically important. As I mentioned, it impacts on baby's arousal.

Even if you smoke one cigarette a day during pregnancy, that doubles your baby's risk of dying suddenly and unexpectedly. That is very important. Same reason, alcohol, marijuana, opioids, illicit drug use. We want to avoid all of those during pregnancy and then after birth as well because those can impact on the baby's brain and the baby's ability to arouse.

Then after the baby is born, that can also impact on your ability to arouse if something's going on with the baby. Then we recommend human milk, breastfeeding for babies as much and as long as possible because we know that that is protective against these sudden infant deaths. It also provides extra nutrients and extra antibodies for the baby.

Also babies who receive human milk, they wake up differently. We think that it makes them more arousable and that is protective.

Christina: Great. Thank you. Next slide, Olivia. We'll go into the sleep area and the biggest thing that I noticed is, we've heard about firm, flat, and back to sleep, I also noticed this non-inclined sleep surface. We'll get into that a little bit further.

Would you be able to review these recommendations and just go over that? It's excellent to hear you say it in your real terms.

Dr. Moon: Yes, we want every baby to sleep on a firm, flat, non-inclined sleep surface. By firm, I mean hard, hard as rock. If you push down on it, it should not go down. We want it to be flat, we want the babies to be flat on their back.

We'll talk about that more, but think about the baby's airway as a straw, that straw needs to be totally straight. If the baby is on an incline, if their head is above the rest of their body, their airway can become kinked and that can become dangerous. We want the cribs to comply with the safety standards that the Consumer Product Safety Commission has for cribs, that's going to be the safest.

Then it's going to be the safest for the baby to be in the same room as a parent, but on a separate sleep surface for the baby for at least the first six months. There should be nothing in the baby's crib and the baby's sleep area except for the baby themselves.

Christina: Wonderful, I often think I get families not uncommonly who come in and say they've spent one night in one place, then they have to go to another shelter, or they're staying with some family, or they just don't have a lot of space and their housing changes quite a bit. Can an infant sleep in a bassinet portable crib box or cradle board or how would you help support these families as to keeping their babies safe?

Dr. Moon: Ideally, we want them to be in a product that meets safety standards because the safety standards are there to make sure that these are as safe as can be. Bassinets have to meet safety standards. Playpens or play yards have to meet safety standards.

Cradleboards, we consider those culturally appropriate places for babies to be, even if they're not any standards. There are no standards for boxes, and I would be cautious about that.

Christina: Great. Thank you. Next slide, please.

Kim: I'm just going to highlight that it seems I know there's a couple of questions in the chat too about the different types of the bassinet with the sleeper on there or different things that people do have their children sleep in. The key is that June 2021 CPSC safety standard, that's what I'm hearing.

That's not right. Let me know because I keep hearing, the CPSC, June 21, updated standards where a baby under five months old can sleep. Being able to look at your cribs and look at those types of bassinet or portable crib and make sure that it met that.

Families have a hand - me - down crib or a portable crib or something, it may not be in compliance with that 2021 update. I think that's a really important thing to be aware of as you're working with families and looking at your own equipment in your program.

Christina: Speaking to a little bit further dive into the sleep area, you started explaining this concept of the airway like a straw. Rachel, if you could continue just to give us more of a visual, which you kindly have in this picture to help us understand why non-inclined is so important.

Dr. Moon: We recommend that the sleep surface be no more than 10 degrees at an angle. Like I said, the airway is like a straw, the head is big for the size of their body compared to you and me, and the neck muscles are not very strong yet. If they are at an incline, then their head can tilt forward or to the side and that kinks the airway.

We know that can block breathing. I mean we definitely recommend car seats when you're traveling, that is going to be the safest place for your baby. But if you are not traveling, once you get to where you're going, the safest thing to do is to move the baby onto a flat surface. That is going to be the safest thing.

Then we'll talk about reflux in a little bit and wedges for reflux later. But we don't recommend wedges for multiple reasons and we'll talk about that later.

Christina: Now, since working with you, Rachel, on this presentation, I mean, that really helps just in the exam room, that concept of the straw and how kinked the babies can be because I often get families saying, the baby's nose is so stuffy, I need to keep them upright. If we go to the next slide, this is also another common question I get when babies who do spit up a lot, their stomach muscles don't hold that food down.

If we go to the next slide, Olivia. We all share this, but this also goes along with the non-incline. This video that we'll play in just a little bit really does help me visualize and better explain to my families actually that flat [Inaudible] mouth up which seems counterintuitive, that maybe, oh, my baby is going to spit up and then they're just going to breathe it all in. This doesn't feel like a safe way to sleep and I get that comment quite a bit.

If we can go ahead and push play on this video. If we're not hearing the sound, which I'm not, that's OK, we'll try again, but I want you to visualize just hear that food pipe being when a baby is facing up where you eat, the tube for food is below and where you breathe is above.

That can really help understand that let's say a baby spits up, the milk is going to come from that lower pipe, that food pipe and up. It has a turn it has to make to get into the air pipe. As much as we see it all coming out of their mouth and that they're going to just breathe it back in if you see it just with this diagram and you can share this with families as well.

That food pipe, it's better for that baby to be on their back in the air pipe where air goes in, oxygen is going to be protected. Babies will naturally turn their head. Obviously, if you're awake and alert you're going to respond. I often get that, OK, babies need to go back on their backs for sleep. What if when my baby starts to roll, some of my patients are super athletic and they start rolling really fast.

If you put them to sleep on their back and they tend to adjust their position, that's as far as we understand, correct me if I'm wrong, Dr. Moon, but they can remain in that position. Do you have any other comments on this?

Dr. Moon: A couple of things. One is with regards to the slide here. When the baby's on the back, the food has to go up against gravity to get into the airway and that's really hard for food to do. The back is going to be the safest for that.

With regards to rolling over, if the baby can roll both ways, they can roll from front to back and then back to front again, then that's OK, you can leave them. But if they cannot roll back to their back, then it's going to be safe as if you can put them back on their back. The other thing to remember is if they're rolling, you want to double check.

There should not be anything in the baby's sleep area at all. But you want to double check that because we've had babies that have rolled into a bumper pad or a blanket or a pillow, and then they haven't been able to get themselves out and they've died that way.

Christina: Great reminders. I think just keeping that in mind and optimally adjusting every time. A baby is not a little robot that's just going to stay put. I think it's just being mindful of all the different scenarios. Next slide.

Kim: I think the video is ready to be played, Christina.

Christina: I think we'll keep going. I think we addressed it. Then I think the next video will be more important for it to play. Going into just how baby is dressed for sleep, we've addressed a lot of these different areas and I often get families thinking my baby's too cold, I need to add more blankets to them. as Dr. Moon just said, extra fluff is just all the more potential for what we can definitely see as impairing good breathing.

I try and remind families also that babies are tough and they are growing, their metabolism rate is super high. I often get that, “Oh, my baby sweats at night.” They're growing, so they are little furnaces. In general, one more layer than what you are comfortable as an adult in whatever environment you're sleeping in is important.

Different families may not have access to all the different wearable blankets, but adding on another layer of clothing like this baby has rather than a loose item is super helpful and noticing signs of overheating. Anything you can tell us more about the importance of how babies dress for sleep Dr. Moon?

Dr. Moon: I think you've pretty much covered it, but I would reinforce it. You can put on multiple layers on that baby. We see pictures of babies from Mongolia where they don't have central heating, and these children must have five or six layers. I get a lot of questions from people who live in the northern part of the world or close to one of the poles and just put more layers on them if you're worried about that and they will be nice and warm.

Christina: That's great. Again, a reminder here of weighted blankets, this has been more recent. I haven't had it come up too much, but I have seen on Amazon that they are easy to buy. But think of this little baby, yes, they're tough and they survived birth. But their little chest, I mean, all their effort and energy is going into breathing, if we add more weight onto their little chests weighted blankets for anxiety and comfort, as a child gets older, that's more for discussion.

These little ones should not be having weighted blankets and the obvious thing of necklaces, clips for pacifiers, things like that should all be removed. Dr. Moon mentioned before the concept of loose blankets and swaddling. It sounds to many of my families and when we say it the hardest surface hard, as a rock for a baby.

When you think of this little one as a delicate little person, but we know just giving them that firm surface and not adding a lot of extra. Swaddling is super useful in that newborn period and

can calm and soothe and we'll speak about it. In our homes when a baby starts to roll and just like we discussed, a baby rolling to one side or rolling face down, but not being able to roll up, having extra loose blankets really can impede their airway.

Really swaddling up until that baby shows signs of potentially having enough strength to turn their torso and move. Where children stay in group care in our infant rooms, that is different when we're caring and responsible like you all are for many little infants. Well, the CFOC standards which you can review and are in the resource handout, I just wanted to remind that it is a different standard for group infant care and the best practice is that there is no swaddling.

Obviously, that is a best practice recommendation. I mean, there are certain programs where swaddling is intricately involved in the culture. Being mindful that once those babies start to roll, they are at high risk if there is loose blankets there.

Kim: I also think Christine, sorry, Dr. Moon.

Dr. Moon: I was just going to say also going back for the swaddling, once they start to roll, take them out of the swaddle. Then for the weighted blankets, remember that babies, their rib cage is not bone yet. It's still cartilage, and if there's any weight on it, it's just going to compress and it's going to make it harder to breathe for that baby. That's why that's so dangerous. We don't recommend those.

Kim: Thank you, I just want to highlight the incredible role that early childhood programs can play in sharing these recommendations with families. There are times where families are working with their pediatricians, and the pediatricians have advised that they can swaddle until they roll over. When they come into the center, there is being shared that is not a best practice in group care to swaddle a baby.

Sometimes families are hearing things from one place or another and the best practice in a group care is just different. We just need to take the time to share that it's different and why it's different so families can best understand why in different settings swaddling is handled differently.

Dr. Moon: When you do swaddle, I see a question here, you want to make sure that the hips are loose, the swaddle around the hips is not tight so the baby can move their hips around for hip development.

Christina: Well, that's a great tip. Next slide, Olivia, please. We'll talk a little bit more about routines. We'll move through this a little bit more quickly, but one new recommendations is offering a pacifier. Can you comment on this, Rachel, on how that came about and what the pacifier does?

Dr. Moon: Almost every single study that has looked at pacifiers have shown that babies who have a pacifier in their mouth when they fall asleep are at lower risk of dying suddenly and unexpectedly. It may have to do with their arousal. It may be that having the pacifier in their

mouth when they fall asleep does something in terms of how they wake up or how they breathe.

If baby is totally exclusively breastfed, then we wait until breastfeeding is going well, the baby is gaining weight appropriately before you offer it. That's usually within a week or, and then if they are not being breastfed, then you can offer a pacifier immediately. Make sure that there are no strings or beads or anything like that are attached to it, but otherwise, that is fine.

Christina: That's a good tip. Again, you're not forcing a baby to take a pacifier, but I mean, definitely just one more tool. I'll just move to the other two bullet points and, oh, you can go back one more time. Just reiterating that CFOC also does have some standards on pacifier use for your group care settings.

I often get this from a lot of times a former preemie baby who was in, in the intensive care unit used to lots of monitors really want the reassurance to have a monitor at home. They've really looked into this. Each device is different, there can be false alarms, you can be over - relying on it.

I find that I'm focusing truly on that bonding aspect with their newborn, even if they were more fragile medically to really focus on that. If we're doing all the other measures we've discussed here today that parents can feel confident they're doing their best. I'll move to the next and last slide of the recommendations which there's back to sleep campaign.

I would agree parents do notice more flattening at the back of the head. This isn't forced exercise for your little baby but tummy time and just moderation in different positions as they grow and evolve is important. Again, you don't need to be a drill sergeant, it's really soon after discharge is short periods of time.

I demonstrate that on the exam table if the baby shows that they're quite fussy, I mean, leaning on the parents chest when they're looking up and gazing into their caregivers eyes. Those are all other ways of some tummy time and gradually increasing that, introducing books to visually stimulate them. I think, Kim, if you wanted to share the CFOC standards and we'll try and wrap it up in the next five to maybe take some questions.

Kim: The next slide, I really want to make sure you have these resources at your fingertips because as your program looks at your policies and developing a policy and procedure for safe sleep, making sure that all parents, families, staff, anybody coming into the infant room has that training and understands what the policy and practice is, is really critical.

Making sure families and staff understand that when a child arrives in a car seat, if the child's fallen asleep, the parents can move them and help move them to a safe sleeping space. But everybody should know the child needs to move to those safe sleeping spaces. Another thing I think is really important to highlight is about the smoking. Dr. Moon talked a lot about those prenatal behaviors.

If those programs, working with pregnant people can talk about safe behaviors during pregnancy, but it's also to remember that second hand smoke, third hand smoke is not great. If clothing reeks of smoke, that clothing should be changed if you're working in an infant room. Thinking about how all those recommendations play out in a program is really important.

These resources on this slide and I know we've been putting them in the chat all throughout, but we have many resources to help you look at your policies and procedures, think about how they relate to your specific contents of your environment to really help you make informed decisions on implementing these new safe sleep standards.

The Caring for Our Children online standards database was recently updated with all the new recommendations. We hope that they can be a resource to you to answer some of your questions as you move forward. Next slide.

Christina: Next slide. I'll close this out and then I think we'll address a lot of the questions that are coming through. Our babies, they're our focus, families know their children the best and really empowering them to take that with them, and then offering important information. If we don't tell them all the work that Dr. Moon has been doing over all these years, then we're also not providing them with all the tools for them to do the best for their babies. Next slide, please.

Just remember take care of yourselves. If a lot of tragic unexpected deaths do occur, but doing your very best and each parent has to live with each and every decision they make. Really valuing that, recognizing how hard it is to have a newborn, how important it is to rest and recover and support each other and support each other as staff to help make it a safe environment.

It takes a lot of work and you are all doing tremendous things out there. Thank you for listening. Mr. Shuman is in our background. I think a lot of questions came in. I don't know if you do see a theme and we'll leave this takeaway slide up for a little bit and then we can maybe see Steve if you felt you wanted to speak up.

Steve: There are so many questions. Thank you all. I'm going to try to read some of the ones where people have been waiting quite some time, some that just clarify some of your important points. I think the first one is for Dr. Moon, have you found any correlation with the pain management used during delivery like epidural and IV narcotics to infants who are more susceptible to sudden unexpected infant death?

Dr. Moon: That's an interesting question. If you think about it physiologically, it shouldn't make a difference and we haven't seen any difference there. It's generally a one - time exposure for a short period of time, which would not be enough to cause these physiologic changes in the baby. No, there's no effect of that.

Steve: Great, thanks. I don't know who wants to take the questions about smoking, but if a pregnant person is smoking during pregnancy before they found out they were pregnant, will

that affect the baby's susceptibility for SIDS or SUID? What about vaping? Those questions together.

Dr. Moon: What about what?

Steve: Vaping.

Dr. Moon: Vaping. The more smoke exposure you have, the higher your baby's risk is. If you stop smoking, then your baby's risk is going to be much lower than if you don't stop smoking. However, it will be a little bit higher than if you did not smoke at all.

Then with regards to vaping, we don't know a whole lot about vaping yet, but it has the nicotine in it which is what is causing the problems with arousal. We believe that it has the same effect. It may have other effects as well or more effects because there's often other stuff like marijuana and other chemicals that are in there as well, which could cause problems for the baby.

Steve: Thanks, For the two doctors on the webinar today, what about pediatricians who are ordering wedgies for sleep when babies have reflux or parents that want to just elevate the mattress somewhat? This particular provider is pushing back but parents don't like to challenge their primary care providers.

Christina: Is the pediatrician recommending the wedge?

Steve: The pediatrician is recommending the wedge. What should providers do?

Dr. Moon: I think that's a difficult question if a pediatrician has written a prescription for a wedge and I think that puts you in a difficult position. Having said that, there's actually no evidence that the wedges do anything for reflux when the baby is asleep. Having their head above the rest of their body doesn't do anything for reflux.

I think it's fine for the baby to be upright when they're awake. I do have problems and concerns about the baby being asleep and being elevated again because of the potential for the airway to get kinked. I think that that's all I have to say. Christina, do you want to say anything?

Christina: I'm wondering as I learn more about the Head Start program and definitely the position that you're placed in, to what degree this is where engaging with your health mental, health service advisory committee or just supporting each other to discuss. Potentially what I would encourage is more partnering and discussion with that pediatrician.

I mean, definitely when I was in training, the hospital was full of wedges and that's what we did. A lot of people aren't able to stay completely up to date, You're ahead of the curve and knowing this. The same way we're engaging with our families and nonconfrontational ways, it's how can we partner?

I mean, with your child care environment, you know these babies and you know that the information that you're getting. In an ideal world, we could all come together and have a conversation like this and learn.

Kim: I think it's such a great opportunity for that discussion from program side. If something's being asked of you that's not something that's part of your policy, it's a recommendation of health care provider, that child may have a special health care need. Getting that documentation and individual health care plan, getting the written instructions from the child's health care provider is really, I think I would say Caring for Our Children has that in there as a best practice.

If someone is asking for a sleeping arrangement that is different than what your policy and procedure is. Getting that documentation, ensuring that you understand if the child has something that's different and using that opportunity, as both of you has said, to share the most recent updates and why your policy is the way it is for that collaborative agreement on how to move forward with sleeping.

Dr. Moon: If you feel comfortable talking to the pediatrician about this and asking, this often works for me, you can pretend to be the person that doesn't know anything and say, we were taught and this is our policy here, based on what we understand to be the latest research, could you share the research behind what your recommending because that way I can go back and teach my folks that if you have any additional research? My guess is the pediatrician is going to go looking for that research and is not going to find any.

Steve: Thank you, A whole bunch of questions about safe sleep environments. The three - in - one diaper bags that have bassinets that fit mats, sleeping bags, the popular Montessori style of sleeping on the floor with a firm mattress, pros, cons, yes, no, oh, and drop - down sides of cribs. That was the other part of this.

Dr. Moon: I'm googling three - in - one diaper bag with bassinet right now.

Christina: I think they're pack and plays that have an infant one where they can have the top and correct me if I'm wrong.

Dr. Moon: No, this is wrong. This is a diaper bag that folds out into a bassinet.

Christina: A diaper bag.

Dr. Moon: I would have to look at the firmness of it. Just looking at it, it looks like it's OK, and I would look to see if it meets safety standards for bassinets. Mats on the floor, if the mats are firm and they meet safety standards, I think that that is fine. What was the other question?

Kim: Drop down crib.

Dr. Moon: Drop down cribs, I noticed that in the video too and I wasn't sure if that was right or not but drop - down cribs are no longer approved by the CPSC.

Christina: Kim had that pointed out, good catch.

Steve: Good. There were lots of questions about swaddling and sleep sacks, can you just reiterate some of the points that you made during the webinar? That may be our last question.

Dr. Moon: From a safety point of view, it is fine to swaddle babies, young babies until they start to roll. If babies are swaddled, they should always be on their backs. You should make sure that the swaddle is not too tight around the chest and definitely you want it to be loose around the hips.

They should only be on their backs, never on their sides, never on their stomachs. If you notice that the baby is starting to try to roll even when they're not swaddled, that is the time to take them out of the swaddle. You don't want weights in the swaddles. But you can have the Velcro panel that helps you swaddle, that's fine.

Steve: Great. Ideal temperature, I know you talked about that children in what is often frigid Mongolia, but an ideal temperature in an infant classroom.

Dr. Moon: It's interesting because most of the studies that have come out about temperature being a risk and babies being overheated are in countries that have no central heating. Places like Australia and Europe, sometimes the temperatures get down into the 50s or lower.

I think that in general here in the US, what we say is if it's anywhere between 60 and 80 to 85 is fine. Then you would dress the baby just one layer more than an adult would to be comfortable.

Steve: Thank you. I think it's time to turn this over to Melissa to close us out. There were 75 questions, I think we answered just about half of them. Melissa and I have been putting links into the chat.

If you still have unanswered questions, please write to us. We have access to these incredible experts and the National Center on Health, Behavioral Health, and Safety want all your questions to be answered. Thank you all. Melissa, take it away.

Melissa: Thank you, Steve, and thank you to our presenters today, Kim, Christina, and special guest Dr. Rachel Moon for sharing all of this information with us. If you have more questions, please go to MyPeers, continue the conversation, or write to health@ecetta.info.

You'll see on the screen the evaluation link or QR code. It was also in the chat if I could ask my colleagues to drop it in one more time, please complete the evaluation. We value your feedback, and it helps us to continually improve our training and technical assistance offerings. After you complete that evaluation, you will see a link to download your certificate.

I think I'll just ask us to go to the next slide. We'll put up the evaluation link in a moment again but thank you much for choosing to spend a part of your day with us. Please subscribe to our

monthly list of resources using this URL and stay connected with us on social media, as well as MyPeers to continue these conversations. Next slide, please.

If you have more questions after today's webinar, as always, please write to us at health@ecetta.info. You can find today's resources and more in the health section of the Head Start website. Next slide.

We can leave the evaluation link for just a moment longer. Thank you, much once again. You will get this link after we close the webinar.

Steve: The link is now in the chat. It will be in the follow up email and it will pop up when the webinar platform closes. Thank you, Melissa.

Melissa: Thanks, Steve. Thanks, everyone. Have a wonderful rest of your day.