Child Care Health Consultants:
Strategies to Support Safe Sleep Environments in Early Childhood Education (ECE) Programs

April Powell: Welcome. Thank you all for standing by. My name is April Powell, and I am the resource program manager for the National Center on Early Childhood Health and Wellness. And I'm pleased to welcome you to today's webinar, "Strategies to Support Safe Sleep Environments in Early Childhood Education Programs." This is a webinar for childcare health consultants.

Before we begin, I have a couple of announcements. All participants will be muted throughout the presentation portion of the webinar. There's a slide presentation being shown through the webinar system. And if you have a technical question, please type in the chat box on the bottom of your screen. There's a lot that we'll be covering within the next hour, but you may submit questions at any time by typing in the chat box.

Only you and the webinar staff will see your questions. Some questions, we'll answer right away. And other questions that we don't have a chance to answer, we'll give you an email afterwards with the answer. And also, some questions will be answered at the very end of the webinar.

Immediately following the webinar, you'll be prompted to take an evaluation. Only those who take the evaluation will get a certificate, and that certificate will be e-mailed to the email address you provide within 10 business days. This webinar is being recorded in an archive version along with some of the slides. And many of the resources that we talk about during the webinar will be sent to you in a follow-up email after the webinar has aired. So with that, I'm going to hand it over to our first presenter, Mrs. Kimberly Clear-Sandor.

Kimberly Clear-Sandor: Thank you, April, and welcome, everybody, to today's webinar. We're so happy you're joining us. This is the third in a series of webinars we are doing for child care health consultants. So if you've joined us before, thank you so much for joining us again. And if this is your first time, we look forward to you joining us for future webinars.

So we're looking forward to the next hour to sharing information about safe sleep in early childhood education programs. As April shared, my name is Kimberly Clear-Sandor, and I'm a Senior Training and Technical Assistance Associate with the National Center on Early Childhood Health and Wellness. As a nurse and family nurse practitioner, I've worked for over 20 years caring for children and families in under-served settings. I'm passionate about leveraging my understanding of health, families, and early childhood to advance children's health, safety, growth, and development within educational settings and the home.

In addition to my work at the National Center on Early Childhood Health and Wellness, I'm also the executive director of the Connecticut Nurses Association and provide private health consultation and training to early childhood programs. Today, we are lucky to be joined by a very special guest, Dr. Rachel Moon. Dr. Rachel Moon is the division head of General Pediatrics and SIDS researcher at the University of Virginia. She received her medical degree from Emory University and completed her pediatric residency at the Children's Hospital of Philadelphia.

She is Division Head of General Pediatrics and Professor in Pediatrics at the University of Virginia School of Medicine. Her research centers on SIDS and SIDS risk factors, particularly in high-risk populations such

as African-Americans and infants attending childcare. She's also chair of the American Academy of Pediatrics taskforce on SIDS and associate editor for the Journal of Pediatrics.

You can see how lucky we are to have her spending her time with us today. So just as a reminder, the National Center on Early Childhood Health and Wellness is part of the Administration for Children and Families early childhood training and technical assistance system. The National Center on Early Childhood Health and Wellness is jointly funded by the Office of Head Start and the Office of Child Care in partnership with Maternal and Child Health Bureau.

It is on your screen and it is marked by the orange outline. Our center is charged with providing research exploring best practices on health and wellness to the early childhood community, including early childhood professionals and health consultants who support them. So today's webinar will be examining the new safe sleep recommendations from the American Academy of Pediatrics and considering how this applies to your work in early childhood education programs.

Safe sleep is addressed in the Head Start Program Performance Standards and the Child Care Development Block Grant Final Rule. As childcare consultants, you may be in an excellent position to support programs to implement safe sleep policies and create safe sleep environment for infants. The objectives for today's webinar as shown on your screen include, the participants will understand the current recommendations, science, and research about sudden infant death syndrome or SIDS and sudden unexpected infant death, SUID.

They will identify how to communicate safe sleep practices in early childhood education program policies and identify resources to support early childhood education programs to understand best practices and safe sleep environments, including the 2016 updates to safe infant sleeping environments. So we're going to have an opportunity to do a poll, and we'd like to hear from you what types of early childhood education programs you are working with.

So if you can, on your screen, go ahead and select which types of programs you're working with – and you can select more than one – we will see how that shows up. And those results are coming in really fast. And it's no wonder that we're talking about safe sleep for infants, that we have – over 90 percent of our participants today work with infant and toddler programs.

And then, they also have overlap with our preschool at 60 percent, our school age at 20.7 percent, and we even have some nighttime care programs which, I know, is something that Dr. Moon was interested in finding out. So that is exciting that there is such a variety joining us today. So thank you all very much for participating in that. So at this time, we're going to go ahead and get started, and I will turn it over to Dr. Moon.

Dr. Rachel Moon: Thanks, Kimberly. If you could go to the next slide – so the title of this talk is "AAP Task Force on SIDS: What's New in 2017." So what we're going to talk about is, we're going to talk about the most recent guidelines. And I'm going to focus on the ones that are most relevant for you all. And we'll go quickly through the things that haven't changed and really try to focus on some of the changes and the nuances for this year.

Next slide, please. So when you talk about SUID, I just want to go through this so that you understand what we're talking about. So SUID is sudden and unexpected infant death. And when a baby dies

suddenly and unexpectedly, it can be explained or unexplained. So explained – the explanation can come during the death scene investigation, the autopsy, the review of the clinical history.

And some of the things that explained SUID ends up being are diagnoses such as trauma, drowning, if there's a known diagnosis already, and then accidental suffocation. The unexplained SUIDS are SIDS and undetermined. And the undetermined deaths are the ones where the coroner or the medical examiner isn't quite sure which category to put the death in.

So it may seem like it's a SIDS death, but perhaps it occurred in a place where there have been several SIDS deaths before. And so that just raises some eyebrows and people aren't quite so sure. So that's the difference between there. Some of the medical examiners and the coroners are also using undetermined as almost a substitute for SID.

Some people are reluctant to use it now for various and sundry reasons. And so sometimes, undetermined will be in that category as well. Next slide. The vast majority of SUID deaths occur during sleep or in the sleep environment, and these are what we call, sleep-related deaths. And the three big categories for this are SIDS; suffocation, strangulation, and entrapment; and then, undetermined, ill-defined, or unknown. And that's the undetermined category that I just was talking about.

Next slide. So when we talk about SIDS, SIDS is when it's any SUID that remains unexplained after a complete review of the history, an autopsy, and a death scene investigation. And typically, it's a baby who has seemingly been healthy, who's found dead after sleep period. It is a diagnosis of exclusion, meaning that you have to rule out every other possibility, and it is not predictable.

Next slide. Suffocation – there are a few terms here that I want people to understand for suffocation. So asphyxia is any situation in which there is a decrease in oxygen and an increase of carbon dioxide in the body. And the reason I bring up asphyxia is because that sometimes is what comes up on the death certificate. Asphyxia can happen if you stop breathing, if your mouth, nose, or any part of your airway becomes obstructed, or if you re-breathe carbon dioxide.

So if you have a baby who's face-down in soft bedding, they may trap carbon dioxide around their face and re-breathe that in. And that can cause asphyxia, too. Suffocation is a form of asphyxia.

Entrapment is when a baby is trapped in a situation that produces asphyxia. So for instance, if the baby falls off a bed and gets trapped in between the headboard and the mattress or between the mattress and the bedside table. Strangulation is when something is wrapped around the neck, which blocks the airway, causing asphyxia.

Next slide. It doesn't take a lot of pressure to completely obstruct an infant's airway, If you just put your finger very lightly on the baby's chin, that can obstruct the airway. If you rest your arm on the baby's back or chest when they're lying down, that can be enough to obstruct the baby's airway.

Next slide. So when it comes to SIDS and asphyxia, we know that asphyxia has always been a part of SIDS. SIDS is a respiratory death. It's not a cardiac death. It's not because your heart stops beating. It's because you stop breathing. It's a respiratory thing.

And there are many risk factors that are associated with potentially asphyxiating environments. So the things that you hear about that you're not supposed to do because it can cause SIDS or can be associated with SIDS are prone sleeping, sleeping on your stomach, soft bedding, pillows, bumper pads, bed-sharing. All of these risk factors for SIDS are associated with potentially asphyxiating environments.

There are some asphyxial situations that would cause death in any baby. So for instance, if a baby gets trapped in between the bed and the night table, that could cause death in any baby. But there are some situations where not all babies die. And so why do these babies die?

Next slide. So the triple risk model tells us that these babies are vulnerable. And the babies that die have some kind of a brain stem defect or something that's going on with their genes. And what we think is happening is that there's a defect in arousal, that these babies don't wake up. They fail to arouse.

And so you have this vulnerable baby who is going through this critical developmental period. And we know that the highest risk for SIDS is between two and four months of age. And so as the vulnerable baby is going through this critical developmental period, if they are stressed – if there's an outside stressor such as prone sleeping, smoke exposure, soft bedding, anything like that, then the confluence of these three factors will lead to SIDS.

Next slide.

Kimberly: So Dr. Moon, I would just like to make a comment about the triple risk model, because it's really interesting information. And when I look at the model, I think about our children that are presenting, our infants that are coming to our early childhood education program. And from what you've shared, it really seems impossible to identify, just by looking at an infant, who is a vulnerable infant.

So it sounds like our approach would be to manage all infants the same way to prevent SIDS. And as consultants, we can then work with programs to ensure safe sleep policies for all the infants in our program that include and address some of those key components related to the outside stressors that you mentioned, such as the prone sleep position and soft bedding.

Dr. Moon: Right. You're absolutely right. So because we can't tell which baby is vulnerable, you have to assume that every baby is vulnerable. I think you're absolutely right with that.

Kimberly: Thank you.

Dr. Moon: Okay. Next slide? So our current hypothesis is that SIDS results when a vulnerable baby cannot adequately defend against an asphyxiating environment. So what that means is that this happens when a baby has a lower level of oxygen or a higher level of carbon dioxide. And it's a level where most babies would wake themselves up and be Okay. And they would do something to change their environment.

For some reason, the vulnerable baby can't do that, and we think it's because they don't wake up. Okay, next slide. So switching gears a little bit, I just want to talk about the AAP Task Force on SIDS.

So the American Academy of Pediatrics convened the task force in 1992 because of initial data that was noting the association between sleep position and SIDS. And the mission of the task force was to review the evidence and to make recommendations about sleep position. And it was comprised of experts in the field that were selected and approved by the AAP executive board.

It was initially supposed to be a temporary task force. But here we are now in 2017, and SIDS is still happening, and there are still questions to be asked and to be answered. So the task force continues on. Next slide.

So just to talk about what happens when one of these policy statements comes out – so what we do is, we create a list of all the important topics, and then we do an extensive literature review on everything that has been published about those topics. And we look at the strength of the data, of the quantitative data, which are the data with the numbers. And then, we also look at the qualitative data, which is basically focus groups and interviews with people, because those help us to interpret the quantitative data, and they help to provide context and understanding of what we're seeing in the numbers.

Once we do the literature review, we develop a draft statement, and then it has to be approved by every single relevant AAP section and committee. And these include the Section on Breastfeeding, the Committee on Fetus and Newborn, and the Committee on Hospital Care. And then, it also has to be approved by the Executive Committee of the AAP.

So we go through multiple, multiple revisions, and we answer questions from each of these sections and committees to make sure that everyone is Okay with what we're saying and that they're in agreement with what we say. The entire process takes approximately two years. And then every three years, we have to review all of the the most recent policy statements. And then, we either reaffirm it, retire it, or revise it.

So approximately, 2 and 1/2 years ago, we decided that it was time to revise it. And then, it took about two years to write this new one. Next slide. So the other thing I want to mention is that the recommendations are not static. They don't always stay the same.

So for instance, in 1992, the AAP recommended side or back to reduce the risk of SIDS. Then in 2000, we said back was preferred, but side was better than prone. And then, in 2005, back only. So why do the recommendations change? Does it mean that we're confused and unclear about what's going on? Next slide.

So actually, what happens is that we get new data. So with regard to side position, multiple studies have shown that side positioning places babies at higher risk for SIDS than the back position. And these studies actually came – we were able to see this once we got rid of a lot of the prone sleepers, because the prone sleeping placed people at such high risk that in the statistics, in the analysis, we couldn't see the risk of the prone.

So the recent studies show that the risk with side and the risk with prone are really statistically the same. So they're both about two to 2 and 1/2 times the risk of sleeping on your back. And the reason why we think this is the case is because the side position is unstable.

And so a lot of those babies end up on their stomach when they're not accustomed to that, and that's really very, very dangerous. And actually, if you look on a population basis, babies who are on their side are more likely to die of SIDS than babies on their stomachs. Next.

So the other thing that happens is that we look at the SIDS rates and the SUID rates. So if you look at the lines here, the yellow line at the top is the combined SUID rate. So that includes SIDS, the unknown or undetermined causes, and the accidental suffocation or strangulation in bed. And as you can see, the combined suicide rate has declined as has the SIDS rate. But if you look at the unknown rates and the ASSB, or the accidental suffocation and strangulation in bed rates, those have actually increased over time.

Next slide. So if you look at this a little bit differently, you can see that the rates of ASSB over the past 15, 20 years have really skyrocketed. And so they have actually increased sevenfold between 1995 and the present. Next slide.

So the other thing we look at is racial and ethnic differences. So as you can see here, the bottom part of the bars, the purple, is SIDS. The blue is unknown or undetermined. And then, the green is accidental suffocation and strangulation in bed. And so you can see that the people that are at the least risk are the Hispanics and the Asian Pacific Islanders.

The non-Hispanic whites are, kind of, in the middle. The non-Hispanic blacks and the American Indian, Alaskan natives have much, much higher rates in all three categories than any of the other racial and ethnic groups. Next slide.

So the other thing that we can see is that the proportion of babies that sleep on their backs or are placed on their backs really depends on race and ethnicity as well. So if you look from left to right, left is the white babies, then the black babies, Hispanic babies, and the Asian babies. And so you can see that the African-American, the black babies are much less likely to be placed on their backs than the whites, the Hispanics, and the Asian babies. Next slide.

So the recommendations change as the evidence evolves. So statistics and risk factors may change. There are new risks that emerge, like the side positioning. There may be a different levels of risk that emerge. And then, policies and procedures may change.

So right now, we're doing much better death scene investigations than we used to. And so there's this diagnostic shift. So we're seeing more in the way of the accidental suffocations and strangulations, and maybe less of the SIDS deaths. And then, we have unintended consequences.

So when we first said the baby should be placed on their backs, then we learned that if you place babies on your back all the time, that they're more likely to have flattened heads, plagiocephaly, and they may roll over at a little bit older age. And so then, we developed tummy time recommendations to try to combat that, and that seems to have worked.

But the recommendations will change as evidence the evolves. And so it's not a stationary thing. It's not a static thing. Next slide. And we know that change is difficult. And you know, not to make a political statement, but we're going through some change right now, and some people want to keep things precisely as they are, and some people don't. But it's difficult, and it's messy. Next slide.

Kimberly: I agree, Dr. Moon. Change is a bit messy sometimes when recommendations keep changing. But I truly appreciate the great overview that you've provided for us. It shows us all the reasons why many of these changes and how these changes have evolved.

Because as we are in the early ECE program, we often have families. They might have many children. And the recommendations have changed for them, you know. From the first child to their third child, it may have changed, and our families might not even be aware of the changes.

And on the other hand, our staff who may have children of their own, grandchildren, and may have been working in the child care setting for a long time – they may be part of different changes and different recommendations along the way. And so our opportunity as consultants to really be able to work with families and staff to truly understand why the changes have occurred and to clear up, you know, concerns or questions – it's really a great opportunity to look at the policies and procedures and educate people, folks that we're working with and working directly with the infants in the program. So thank you.

Dr. Moon: Okay. Next slide. So the messages have also evolved a little bit. The recommendations have become more nuanced. So in other words, they've become more complicated. So Back to Sleep, which used to be a very simple message, has evolved to Safe to Sleep, which is not just sleep positions but also include sleep location, bedding, no smoking – and it, kind of, goes on and on. So it has become a more complicated a more nuanced message.

Next slide. So in general, moving into the recommendations now, the point of them is to reduce the risk of SIDS and sleep-related suffocation, asphyxia, and entrapment. So in general, the recommendation should be used consistently into one year of age. And the reason for that is that most of the epidemiologic studies upon which these recommendations are based include babies up to one year of age.

So if you have a study that compares SIDS babies versus non-SIDS babies, since SIDS goes up to a year of age, the control babies or non-SIDS babies, since they all are age-matched, will go up to a year of age two. So it's very difficult to separate out the younger babies from the older babies for that. So in general, unless I say something differently, you should assume that these recommendations should be used until the baby is a year old. Next slide.

There are two documents. There's a policy statement, which is a summary of recommendations – and it's a shorter document – and then the technical report, which has the background literature review and the data analyses that are the basis for the policy statement and the recommendations. Next slide.

So I'm gonna state all of the recommendations, and then I'm going to go quickly through each of them and highlight the changes in each of them. So the recommendations are – back to sleep for every sleep. Use a firm sleep surface. Breastfeeding is recommended. Room-sharing with the infant on a separate sleep surface is recommended.

Keep soft objects and loose bedding away from the infant sleep area. Consider offering a pacifier at nap time and bed time. Avoid smoke exposure during pregnancy and after birth. Next slide.

Avoid alcohol and illicit drug use during pregnancy and after birth. Avoid overheating. Pregnant women should obtain regular prenatal care. Infant should be immunized in accordance with AAP and CDC recommendations. And do not use cardiorespiratory monitors as a strategy to reduce the risk of SIDS. Next slide.

Kimberly: So Dr. Moon, it sounds like if a consultant has the opportunity to provide parent education beyond just working with the programs and staff, there are actually some new recommendations that really apply to prenatal care and things that may be going on in the home as well.

Dr. Moon: Yes. So those are important things to note. Actually, those recommendations have been there for a while, but it's important to highlight those, that we do want – it isn't just all in daycare. It's what's going on outside of daycare as well, what's going on in the home, and even before the baby is born. We want good health care, because we know that regular prenatal care – those babies are healthier and they have better outcomes.

Kimberly: That's great.

Dr. Moon: Okay. So now, there are other recommendations that are aimed more towards the health care community, Health care providers, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk reduction recommendations from birth. Media and manufacturers should follow safe sleep guidelines in their messaging and advertising, and the Safe to Sleep campaign should be continued. Next slide.

Kimberly: So I love to hear that the recommendations include so much community engagement as working in the child care programs with families and staff. Knowing that they're working on that really supports our consistent messaging for families. So when a child care provider shares the information about safe sleep, we actually have the opportunity in the program to reinforce that information, to role model some of those practices, to put posters up and really share information to support families in creating safe sleep environments.

Dr. Moon: Right, and that is critical. I'm sorry – go ahead.

Kimberly: No, yeah. I think it's so neat that they're paying attention to the media and the manufacturer. Because those images in print ads or TV shows – you know, they really create that mess that you were talking about and the inconsistent messages, and work against us. So to know that they're working towards creating some consistency there really supports us in our work with families, to support your work with families.

Dr. Moon: Right. And we know that the more consistent the messages are that the parents get, the more likely they are to follow the recommendation. So it's really critical that everybody be on the same page. Next slide.

Avoid use of commercial devices that are inconsistent with safe sleep recommendations. And then, supervised, awake time is recommended to facilitate development and to minimize the development of positional plagiocephaly or flat head. Next slide. So today, we're going to focus on the recommendations for the caregivers. Next slide.

So back to sleep for every sleep. So to reduce the risk of SIDS, back sleeping for every sleep. Side sleeping is not safe. It's not advised. Babies with gastroesophageal reflux should be placed on their back, and pre-term baby should be placed supine or on their back as soon as possible. And none of that has changed from last time.

Next slide. Use a firm sleep surface, covered by a fitted sheet with no other bedding or soft objects. And by firm, we mean it maintains its shape and it doesn't indent or conform or mold to the shape of the baby's head. The baby should be in a crib, bassinet, portable crib, or play yard that conforms to CPSC, Consumer Product Safety Commission standards.

And the mattress should be designed for that specific product. So don't put a playpen mattress in a crib or vice versa, or a bassinet mattress in a playpen and then try to pad it all around. Because that just is a disaster in the making. Next slide.

Sitting devices – some of this may not be quite so familiar for you. Car seats, strollers, swings, infant carriers, and infant slings are not recommended for routine sleep. Babies younger than four months are particularly at risk when they're in these environments. because they, kind of, get scrunched up and it can block their airway.

If the baby is in an infant sling or a cloth carrier, then you want to make sure that the baby's head is up and above the fabric, that you can see the face and that the nose and the mouth are clear of any obstructions. And if you have a nursing mom, then you want to recommend that after she nurses, that she repositions the baby into the upright position. And then, if the baby falls asleep in one of these devices, you want to move the baby to a crib or another appropriate flat surface as soon as is practical.

Kimberly: Dr. Moon, this raises some interesting questions that may occur in early childhood programs, as sometimes, when children arrive at the program, they've fallen asleep along the way. So what's the best way to manage an infant that is perhaps sleeping in a car carrier or a stroller when they arrive at the program?

Dr. Moon: Yeah. You know, if it's a baby who's younger than four months, those are the ones, again, that are particularly at risk. And so I really get nervous if they stay asleep in the car carrier, and they're not traveling anymore. Because they don't need to be in the car carrier in terms of safety, and I just really worry about that.

There aren't a lot of data about, like – there are no studies on drop-off at daycare or anything like that. But the younger babies, I really do get nervous if they spend a lot of time sleeping in the carriers.

Kimberly: So it sounds like if they're asleep, we should move them to that firm mattress in their crib or safe sleeping area at the program.

Dr. Moon: Yes. That would be my preference, because I think it's just a safer way for the baby to be sleeping. The other thing that's a problem is that lots of times, they come in, and they're totally bundled in so much clothing. And you don't want to move them, again, because they're sleeping. But they're in the carrier, and then there's also potential for overheating. So I worry about that as well, because overheating is a risk factor for SIDS as well.

Kimberly: And that happens frequently for us in the northern area. I also see sometimes that our teachers may have an infant – they might have a rocker, bouncy seat, or a swing, or something in the program that is used for a little bit of time with the children. But sometimes, the infants fall asleep in those bouncy seats or swings. So do you recommend, once they fall asleep, moving them right away to the crib?

Dr. Moon: You know, we say as soon as it is practical. So you know, it gives people a little bit of leeway but, again, particularly these young babies – you know, being in that upright position, it can really kink their airway. And that can put them into a situation that's not a good one.

Kimberly: Yeah. I think these are great points that programs may consider adding or really thinking through in their safety policies, even perhaps thinking about with some of the staff training. Or if consultants have the opportunity to do sight visits, they can even do some one-on-one sharing of this kind of information with our infant teachers. So thank you.

Dr. Moon: Okay. Next slide. So breastfeeding is recommended. We recommend breastfeeding for many reasons. Included in that is that breastfeeding reduces the risk of SIDS. And the protective effect of breastfeeding increases the more you do it. So unless it's contraindicated, we do recommend that mothers exclusively breastfeed for six months at least. But we also recognize that any breastfeeding is more protective than no breastfeeding.

Kimberly: It sounds like another great reason to ensure programs are supporting breastfeeding. [Laughter]

Dr. Moon: Yes. Yes. We want do all that we can to support breastfeeding. Okay. Next slide. Okay. So here, we have a poll. So tell us what you think about what should be in the crib – crib bumpers, stuffed animals, crib blanket, a baby with a tight sheet. So you can just submit those responses, and they're coming in pretty quickly.

Oh, you guys are great. Okay. So almost everybody said, just a baby with a tight sheet. Yes, and actually, that's all we want in the crib. We don't want crib bumpers, we don't want stuffed animals, and we don't want any blankets. So the safest thing is just the baby.

And if you're concerned about the baby getting cold, you can actually lay your clothing on the baby – sleep clothing on the baby – and that will be safer than using blankets. And we'll talk about crib bumpers in a bit. Okay, next slide. So Okay, here we go. Soft objects and loose bedding – we don't want any of that in the crib.

So this picture here is what you don't want to see. Because all of this stuff increases your risk of SIDS, suffocation, entrapment, and strangulation. So these include pillows, pillow-like toys, quilts, comforters, sheepskins, bumpers, loose bedding, including blankets and loose sheets. And like I said before, you can use infant sleep clothing instead. Next slide.

And none of this has changed. This is all consistent with what we recommended before. So now, what we do know that's new is that a lot of parents recognize that softening is a risk factor – and actually child care providers, too. But then, as the baby gets older and you've had many nights and many days

where nothing bad has happened, people become complacent, and so they start putting stuff back in to the crib.

But what we found in one of our studies looking at national data is that for babies between four and 12 months of age, soft bedding was the most important risk factor for babies that died. And what we think happens is that the babies start rolling. They roll into the bedding, and they can't extract themselves.

This is true for all soft bedding. We see a particular problem with bumper pads, which is why we don't want bumper pads in the cribs at all either. Okay. Next slide.

Kimberly: I think, Dr. Moon, oftentimes, parents may notice that an infant sleeping room is so different from the room or the space they may have created for their child at home. And knowing that the complacency may change as children get older, it's just another opportunity to be able to have conversations with families about the importance of the bare bed.

Dr. Moon: Right. Yeah, no, you're absolutely right. So the more you can talk about it, and the more you can provide consistent messages, the better it is. Okay. Next slide. Okay. So this is not new, either. So we want people to consider using a pacifier at nap time and bedtime. When placing the baby for sleep, don't hang it around the baby's neck.

And if the baby is being directly breastfed, some people would like for you to delay the pacifier until breastfeeding is firmly established, usually by three to four weeks of age. If the baby is not being directly breastfed – so they're being fed either breast milk in the bottle or they're being formula-fed – you can start the pacifier immediately. But for babies who are getting even some of their feedings directly from the breast, it's probably best to delay the pacifier introduction for a few weeks.

A lot of people ask about thumb-sucking or finger-sucking. And there really is insufficient evidence to show whether it is protective or not protected against SIDS, so we can't say anything about that. Okay, next slide. So we know that overheating and head-covering is associated with an increased risk of SIDS. The definition of overheating varies in the studies, and so we can't provide specific room temperature guidelines.

And actually, in some of the studies in New Zealand and Australia and in Europe – some of those places don't have central heating because it doesn't get that cold, according to them. And so sometimes, not having heating there in the wintertime there, the inside can get into the 50s and even a little bit lower, which, of course, in the US, nobody would tolerate.

But we don't provide specific room temperature guidelines. But what we do say is that babies should be dressed appropriately for the environment, with no more than one layer, more than what an adult would wear to be comfortable. So if you just have a t-shirt on, then the baby could have a t-shirt and maybe one other layer.

And then, some people have asked about fans. There was one study that looked at fans and found that there was a protective effect. but no other studies have been able to duplicate that. So right now, we think that the evidence is not out there yet to recommend use of a fan solely as a SIDS risk reduction strategy. Next slide.

There is no evidence, none whatsoever, that immunizations cause SIDS. On the contrary, immunization may have a protective effect against SIDS, because we know that a lot of babies who die of SIDS have had a recent illness before, and immunization obviously helps with that. So we want all of our babies to be immunized. And again, there's no change in that. Next slide.

Avoid commercial devices that are inconsistent with safe sleep recommendations. So if there's a device that claims to reduce the risk of SIDS, be wary of that. If there's a device that says that you don't have to follow the safe sleep recommendations, don't believe it. So there's no harm in – you know, there are some special mattresses out there.

As long as they meet safety standards, as long as they're firm, as long as they conform to the crib, they fit the crib and there aren't any extra spaces and things like that, they're fine. They're also expensive. I don't know that you need to use them, because I think a regular mattress would be fine. But there's probably no harm in using them.

But if they claim to reduce risk or they claim that you can put the baby on the stomach or bed-share with your baby or something like that, don't believe them, because there's no evidence saying that you can. Next slide. A lot of people ask about swaddling, and there's actually no evidence to recommend swaddling as a strategy to reduce the risk of SIDS.

We know that if a baby who is swaddled is placed or rolled to the prone position, there is a high risk of SIDS. So if you are to swaddle a baby, the baby should be on the back, totally on the back, and watched carefully. And once the baby starts to roll even to try to roll, you should stop swaddling the baby. Next slide.

We recommend supervised, awake tummy time. There really are no data about how often and how long to do it. But we do know that it helps prevent plagiocephaly. We also know that it helps the babies to develop upper body girdle strength. So those shoulders, the neck, upper-body body muscles – tummy time does help to develop those. Next slide.

And then, finally, health care providers and child care providers should have open, frank, non-judgmental conversations with families about their sleep practices. Because if you go into a conversation and the parents perceive that you may judge them, they're not going to be open about what they're doing. So I encourage you to have those conversations with families and to talk to them about sleep safety, because you guys are really experts in taking care of babies.

And parents trust you. They trust you so much more than they often trust us. So you guys are critical in that. So please keep talking to families about this. Okay. Next slide.

I just want to acknowledge the other members of the task force on SIDS. It's a fabulous group of very committed, very smart, very wonderful people. And I just want to acknowledge all of them, because they've worked so hard in making sure that every single word is what we want to be saying. So I just want to put that out there. Next slide.

And we ran through it all, and you probably haven't heard a person talk that quickly in a long time. But we got through all of the recommendations.

Kimberly: Whew! I think the whew says it all, Dr. Moon. [Laughter] There was a lot of good information. You can take a deep breath now.

Dr. Moon: Okay. And I'll take a couple of sips of water.

Kimberly: There you go. [Laughter] We can't thank you enough for sharing your time and expertise with us today – really wonderful information and great data to help keep us informed about what's going on and some of the strategies that we can use moving forward. Next slide, please.

I tried to capture on this one slide some of the comments that you had made that may be something consultants can use with a parent education program or to think about sharing in parent education pamphlets with them about prenatal care, the bedside sleeper. I know there were some things about that that they can look at the recommendations to include in parent education – and information about the breastfeeding and pacifiers.

So I just wanted to try and capture some of those things on one slide for our participants in case they're thinking about creating some parent education program as well. Next slide. And I wanted to direct everyone to the Caring for Our Children National Health and Safety Standards. If you have been with us on previous webinars, you know that we've talked about this online searchable database that has a number of standards that are up to date in science-informed standards, that are related directly to the early childhood education settings.

And there is a specific standard that is on safe sleep. It's Standard 3.1.4.1. And it does address some of what Dr. Moon has shared with us today. It was recently updated to include all of the new recommendations. And it really looks at the recommendations through the lens of that infant early childhood classroom.

So it's a great place where you may find a great way of capturing some of that information that was shared today, because it is directly about that educational environment. So the website for that is right up on the screen. It's cfoc.nrckids.org. And you'll find on the top left-hand side that you can search that, and you can just enter the 3.1.4.1, and the standard will pop up.

Next slide, please. One of the really neat things about the standards is that includes rationale. So it helps – some of the consultants may find the rationale really helpful in having discussions with families and staff about what those recommendations are and why they're so important. The standard also includes lots of additional resources and references. So I threw up some on the screen here today.

These are some of the references that are at the end of the Caring for Our Children Standards, and there may be things that you're interested in taking a look at. So the TBC document about [INAUDIBLE] and kids is up there. The American Academy of Pediatrics Task Force on SIDS and other sleep-related infant deaths that we've just updated is linked through there. And there are other resources that may be of interest to you, that you can find right in that Caring for Our Children Standard. Next slide, please.

And I know we are going to have an opportunity to answer a couple of questions. But I just wanted to let all of you know about an opportunity to share and learn from each other within the child care health consultant community, where you can have that ongoing peer-to-peer learning continue. So there is an online community that the Office of Head Start has sponsored for child care health consultants.

And it's really a place to share strategies and best practices, to ask questions, and really learn from each other. And it's somewhat of a social site, but it's a private site, and you have to be invited to join it. Next slide, please. So this is what the site actually looks like.

When you are in the community, it is called a MyPeers MangoApps community. And the little child care health consultant, blue, with our two little friends up there – that's the community that we're part of. And you'll see it has different places for posting things and sharing and asking questions.

So online learning really is an opportunity to share and ask questions. Next slide, please. So if you would like to join, you can just pop us an email, and we're more than happy to add you to the child care health consultants community. Please know that if you're already part of MyPeers MangoApps community from the Office of Head Start and you would like to join the health consultant community, you can just do that already. You don't have to send us an email.

But if you would like to join and you're not a member, you can send an email to health@ecetta.info, just like up there in the fake email on the screen, with the subject, CCHC My Peers. And just write in there that you would like to be included in the community. Be sure to include your full name and your email. And we'd also love to know if you would like to share with us what state you're from and what's your position or title.

So again, if you're interested in joining that, you can send an email to health@ecetta.info. Next slide, please. And I just wanted everyone to know there should be a statement coming out, too, for our next child care health consultant series webinar, and that will be on playground safety.

And that will be happening in the beginning of June. So I just wanted to let you all know that was coming. So April, does it look like we have a couple of minutes to answer a couple of questions?

April: We do. We've had so many questions come in, so I'll go through and find a couple of good ones that we can ask. So the first one is for Dr. Moon. Can you just clarify – someone asked – is sleeping higher or equal risk factor in contributing to SIDS?

Dr. Moon: It's definitely equal to the risk of being on your stomach. Side and stomach have the same risk. So if you feel like it's a compromise and that it's not as bad as being on your stomach, that's actually not true.

So the risk is equal. And actually, if you look on a population basis, more deaths are because babies are put on their side than put on their stomachs, even. Not to say that you should do the stomach instead of the side, but both of them are bad.

April: Got it. Perfect. Thank you. And we had a lot of questions about swaddling. One question was and I think you might have answered this, but can you reiterate? When should swaddling stop?

Dr. Moon: So when I see a baby who is looking like they're starting to roll, trying to roll, I immediately recommend that you stop swaddling. Once a baby gets to be – if they haven't started rolling, once they get to be about 2 and 1/2 three months, if they haven't, I would go ahead and stop swaddling. Because they're going to roll over pretty quickly, and you don't want that first time to be when they're swaddled.

April: Thank you. Let's see some other ones. We had questions about sleep sacks. You mentioned commercial products. Did you mean sleep sacks when you were referring to the commercial products?

Dr. Moon: No, I didn't mean sleep sacks. Sleep sacks are fine. I consider those sleep clothing. And sleep sacks are great. I think that those are definitely things that we would prefer child care providers and parents use rather than loose blankets.

April: Perfect. Thank you. And there was a question about baby sleeping in Pack 'n Plays and things like that, that are not a car seat or a crib. What is the recommendation on that?

Dr. Moon: Pack 'n Plays, like a playpen or a play yard – those are fine, as long as they meet CPSC standards. So those are considered an acceptable sleep surface for babies.

April: Okay. So if a baby is under 12 months, and you put the baby to sleep on their back, and they roll over to their stomach, what should be done? Should they continue to put the baby onto their back, or let them sleep on their stomach?

Dr. Moon: So it depends on the baby. So if it is a baby that you know can roll pretty comfortably from back to front and front to back, then I think it's fine for them to stay on their stomach. But you do want to make sure that that crib is pristine, that there is nothing else in there, because you don't want that baby to roll into any softening. So there should be no bumper pads, no stuffed animals, nothing like that. If the baby is not at the age where they are comfortably rolling over yet, then I would I would actually put them back on their back.

April: Got it. And do you have recommendations on ways to talk to parents that say, my baby won't sleep on her back? So I put her on her stomach so that she'll leave. Do you have suggestions on what a child's health consultant or a teacher or anyone can say to that parent to help them to understand the risk that they're incurring for their child?

Dr. Moon: Well, number one, I think that making sure that you have a written policy in your centers – I think that that's critical. Because parents, people really respond to the fact – if you just say, I'm sorry, but that's our policy, to put the babies on their back all the time. And you know, parents have a hard time – people have a hard time arguing with a policy. So if you have a policy and you stick to it, then I think that that's number one.

Number two, I think it is important to talk to people about – yeah, they do sleep more soundly on their stomach, but that may be why it's so dangerous. Because remember, what we think is going on with SIDS is that these babies don't wake up. And this is why we think that babies on their stomach are more likely to die of SIDS, because they're sleeping so deeply that they don't wake up. So if you put a baby in a situation where they're sleeping more deeply, then you're putting a baby in a situation where they're more likely to die of SIDS.

April: Thank you, thank you. So I have another question, and I think we'll only have a couple more. You did say, no stuffed animals, no bumpers, no blanket. But we did have a question, what if you tuck the blanket into the end of the bed? Is that Okay?

Dr. Moon: We're not recommending that anymore. Because number one, what we had said a few years ago was that if it was one of those thin swaddling blankets, you could do that. But the thin blankets are not big enough to tuck on all sides.

And we actually have a lot of problems with those becoming untucked and becoming loose bedding. And sometimes, if you have a baby that is moving a lot, that loose blanket can get wrapped around the baby's body, neck, or head. And so it's just safer not to have anything.

April: Great. Thank you.

Kimberly: April? This is Kim. I just saw there were a couple of questions about the swaddling and the pacifier. And I just encourage – I know that we are going to be answering those questions. But as the time is running too close, I just wanted to encourage folks to look into that searchable database on the caring for our children website, as they do have a specific standard for early childhood programs about swaddling and about the pacifier use.

So they are right on that same website that we talked about with the safe sleep standards. They also do address some information there that may or may not answer your questions. But it's a place to get an immediate response.

April: And I know some of you were asking about the website that we had posted. All of the resources that we're talking about, we'll send you the link so you can click on the hyperlink directly. And it'll come in a post-webinar email within 24 to 48 hours. We'll make sure that you get that information.

And also, if you have some questions that didn't get answered and you would like an immediate response, you can ask our infoline. And the email address is right there on the screen. It's health@ecetta.info, and we have subject matter experts that will answer your question for you. And also, I've seen a lot of people asking about the slides. We'll send those in a post-webinar email as well.

So I think we'll go ahead and wrap things up. So thank you so much, Dr. Moon. And thank you so much, Kim, for speaking about this topic. I know there were so many questions and there's so much interest in this. It's such a hot topic.

So we will go ahead and conclude our webinar. And thank you, everyone, for joining. We will be sure to follow up with all of the questions that have been asked, and we'll get answers for you with input from Kim and Dr. Moon.

Thank you.

[End video]