

MCHB/DHSPS November 1, 2006 Webcast
A Toolkit for Reducing Infant Mortality:
Standards, Regulatory and Legislative Strategies

November 1, 2006

JOHANNIE ESCARNE: You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you're participating from. If we don't have the opportunity to respond to your question during the broadcast we'll email you afterwards. We encourage you to submit questions at any time during the broadcast. On the left of the interface is the video within development you can adjust the volume of the audio using the volume control slider which you can access by clicking the loudspeaker icon. For those of you who selected the accessibility features when you registered you'll see text captioning underneath the video window. At the end of the broadcast the interface will close automatically have an opportunity to fill out an online evaluation. Your responses will help us plan future broadcasts in this series and improve our technical support. Now I will pass the microphone to Lori Cooper who will introduce our speakers. Lori.

LORI COOPER: I'm going to make a quick pass to Paul Rusinko and I'll follow him.

PAUL RUSINKO: I'm the director of the bureau's SIDS and other infant death program. I welcome you all here today and for the webcast, "A Toolkit for Reducing Infant Mortality: Standards, Regulatory and Legislative Strategies". I think it's a very exciting presentation and I hope that you all benefit from it and also share with your colleagues who don't have a chance today to participate, that it will be archived for people to review at another time. With that I would like to pass the phone over to Lori Cooper who will be the moderator for today's session. Thank you.

LORI COOPER: Thank you, Paul. I wanted to say thank you on behalf of Project IMPACT for the opportunity to talk with all the state and MCH programs that are focusing on reducing risk for SIDS and providing bereavement support for SIDS and other infant death. We know the SIDS landscape is changing. SIDS cases are decreasing due to better scene investigations, the advent of genetic screening and the expanding of it. The reduction of risk reduction behaviors most lately pacifiers. This webcast was designed to assist you, those leaders in MCH and SIDS and other infant death in making certain that your community, whether it's at the state or local level, can assure in this changing landscape a comprehensive response to sudden unexpected infant death. That is why we have put together a range of strategies that are standards, regulatory and legislative strategies to help you think about how to institutionalize best practices or evidence-based practices, stay with me. We have a number of successful strategies which can be adapted for your community. And I'm very pleased to have the participation of the speakers you will now hear from and we'll start with Program Support Center who will talk about professional standards and training.

>> Thank you, Lori for that lovely introduction. My first slide, which is the sudden infant death syndrome, continuing education curriculum for nurses is one of the first projects that I would like to talk about that the Program Support Center has partnered with the National Institute of child health and human development, which runs the original back to sleep campaign with a number of partners. This project was an effort to do some serious outreach to nurses through the development of a curriculum. We worked with several national nursing organizations. It's been underway for three years now. Currently the status of it is the curriculum has been drafted and presented at national conferences.

We'll be at the National Association of neonatal nurses in November in Nashville from the 9th to the 10th we'll be presenting the curriculum then and one of the ideas behind this effort -- next slide, please -- is that the learning objectives are defined SIDS, list the critical SIDS risk reduction barriers. Describing the key role as educators to parents, caregivers and SIDS about SIDS. Describing ways to effectively community the SIDS reduction messages to parents and caregivers all focusing on what the tasks of nurses are and their importance in patient education even more so today than ever. And once this curriculum is currently under draft and not for distribution because it's going through the Maryland accreditation process for continuing education hours, and once that is in place, nurses can receive this module and they can receive contact hours for completing it.

Next slide, please. One of the ideas behind this project was that parents do tend to copy the practices that they observe in hospital settings. At the Program Support Center we

also have posters and other tools that nurses can use in their nurseries to assist them in not only parent education, but as well as staff development so nurse supervisors and such can put these posters up in the nursery and the well baby unit to remind nurses that the behavior that they're modeling for the parents is very important. Parents will do what they see nurses doing. Now, why nurses as models?

Next slide, please. Nurses can model the SIDS risk reduction techniques to insure families now how to reduce the SIDS risk. The most critical period during which nurses can influence a past behavior is during the 24 to 48 hours following delivery. Nurses are in a unique position because more than any other healthcare provider, you can model the SIDS risk reduction techniques to ensure that families know how to reduce the risk. There was a study conducted in New Haven, Connecticut that found that nurses who placed infants to sleep on their backs during the postpartum hospital stay changed the parents' behavior significantly. More so than the patient education piece what they heard the nurse telling them. It's what they saw the nurse doing that was most effective in teaching them how to care for their babies.

Next slide. Knowledge versus practice. There are several studies that indicated to us that nurses were aware of the back sleeping recommendations but when studies were followed up with observations in the nurseries, there was a discrepancy between what they were telling us and what they were doing. And so henceforth we made this effort to reach out to make sure that why this discrepancy was occurring. Were they saying it because they knew that's what the policy was but not doing it because of a number of

variety of reasons we found. We found due to their experience they depended on their experience, they are perceptions much more so than a policy that was in place. More nurses did think that the side sleeping position was still acceptable.

Next slide. Writing the message. So the studies indicated that nursery staff do not uniformly recommend the back sleeping position to parents and that training nursery staff to emphasize the back sleeping education with parents does change the parent behavior. So one of the most important things that we do in this curriculum is that we address the barriers or the challenges that nurses are experiencing as well as parent caregivers so that we can have a dialogue with patients and teach them enhance their skills and patient education regarding having a dialogue with the caregiver about how they're going to sleep the baby, what the whole infant sleep environment is.

Next slide, please. Infant care often has its roots in tradition and experience. This is true and that's what nurses bring to their profession is their tradition and experience as well as that's what parents bring to caregiving. More than 15% of African-American infants are still being placed to sleep on their stomachs. We've done a really good job and there has been an increase of people sleeping on their backs but we're still finding there are quite a few still sleeping on their stomachs, which makes it even more important that we continue getting the message out. And certain studies have been known to show that infants in American Indian, Alaskan native families are more likely be to be overdressed for sleep and one of the risk factors for SIDS is overheating.

Next slide. The common arguments against the back sleeping that we address is the fear of aspiration or choking, the comfort of the infant. There is a perception that babies sleep better and are more comfortable in the tummy position rather than the back sleep position. There is an increased concern about flattened skull as well as advice from others. Nurses may encounter resistance from parents and families when discussing SIDS risk reductions for some of these reasons as they themselves might have some issues regarding back sleep because of these reasons. So we fully address these issues. There has been an increase in flattened skull, the research has indicated that and we address it by talking about tummy time and other things that they can do with the baby to decrease that. The fear of aspiration. There is a whole description of anatomy and physiology within the curriculum that allows an exploration of the physiological differences between tummy sleeping and back sleeping as well as the physiology of side sleeping to assist nurses when discussing with patients and caregivers why we prefer the back sleeping position. We want to partner with professionals to train them and train the colleagues and parents. As I said we've been going to numerous in this stage of the project we've been submitting abstracts and going to numerous national nursing conferences as well as regional ones. We've done the national black nursing association as well as the Mississippi and Wisconsin. We're planning one in South Carolina for the coming year and North Carolina, as well as Texas and we are looking for more opportunities to sponsor conferences. We're looking to do one in West Virginia as well in the coming months.

Next slide, please. And one of the things that we like to leave these messages with is what can nurses do? And we let them know they can do a lot. They can encourage parents to

take action. They can provide conditions for learning through observation. And we enhance their skills about what is learning through observation and the key ones of attention, retention, reproduction and motivation. Those are some of the things we go through during the curriculum.

Next slide. We always make sure that we let the nurses know that they shouldn't just discuss the back sleeping position, but let it be more of a conversation about how and where will the baby be sleeping? They can provide the SIDS risk reduction educational materials as well as guiding parents and modifying the crib in the home environment so the baby can be sleeping in the most safe possible manner.

The next slide, in the manual there are numerous citations, over 100 sign indications being as evidence-based practice as possible. Over 100 citations in the manual regarding where they can look for further education regarding any particular topic that maybe they didn't believe us on. The current research findings and theories about SIDS as well as factors thought to increase the risk of SIDS and those thought to protect against it. The challenges to SIDS risk reduction and effective SIDS risk reduction communication.

Next slide. As I said earlier, we do also, through the Program Support Center have model behavior sample guidelines, these are sample policy guidelines for hospitals that have well baby nurseries and we've done a mass mailing and had a good response to these materials. They're all free and provided through our center.

Next slide. Some of our user feedback regarding the model behavior was today I received in your model behavior materials to share with my staff. The materials you sent were both timely and very much appreciated. I would love to hang one or two posters in each of my departments. I think the model behavior poster is fantastic tool and will be displayed prominently in the nursery. One for care providers would be wonderful to be placed in each new mother's hospital room. As I said earlier, we are looking for partnership opportunities. Childbirth educators, lactation consultants. Trainers for babysitting courses. WIC clinics across the nation, as well as state health departments throughout the country. We are doing some trainings in New York City in the coming year as well.

Next slide. Some other resources is Project IMPACT has developed a tool card for use in grand rounds for training and education courses. We take those with us on trainings and hand them out as well. They are a wonderful key ring tool card that has all the risk reduction messages as well as healthy prenatal care behaviors. And we want to help clinicians respond to the occasional loss of an infant by providing information on appropriate responses to parents' varied expressions of grief. There is information on death scene investigation and the responsibilities of medical personnel. Resources for bereavement counseling for their patients who suffer a loss and support for their own personal and professional response to the loss. Those tool cards are a great resource and tool.

Next slide. We have also other amplifying the message with evidence-based partnership. We have a number of different resources and samples of different things that have worked

in hospitals across the nation as well as state health departments. They're popular. And my last slide I believe is just our contact information. For the NICHD and First Candle SIDS Alliance and the Program Support Center. And there are two more slides. One is regarding the professional standard. This is the bereavement counseling for sudden infant death syndrome core competencies for the healthcare professionals developed by the association of SIDS and infant mortality programs which is a wonderful tool for healthcare providers and state health department program coordinators in assisting them in core competencies for the healthcare professionals with regards to bereavement. Then the last slide is the professional guidelines, these were developed through the Program Support Center and they are guidelines for Christian clergy, medical professionals and funeral directors and all of them are relevant with regards to providing care to the family that experiences a perinatal loss, SIDS or other infant death. That is the end of my slides. Thank you, Lori.

LORI COOPER: Thank you. There you have it. That is our first strategy and we're hoping that states can do one, two or three of the following three things. First, that you'll use the program support materials to reach your own maternity care hospitals. She mentioned these materials were sent in a partnership with the American hospital association to the 4,000 maternity care hospitals in the country. Now, as we all know we all get a lot of materials and whether those materials get used and displayed may depend on community or other partners requests or demand that they get used. So that's one thing to give some thought to. Project IMPACT is also exploring whether and how it might be useful to work with the joint commission on accreditation of healthcare organizations to see if there are

ways to institutionalize some of these professional practices through required protocols, through testing and guidance and accreditation standards and finally many states require special training and professional standards for the wide range of professionals who respond to SIDS and sudden unexpected instant death including firefighters, emergency medical text, law enforcement officials and so forth. You can find a very nice up to date summary of those kinds of laws that was put together by the national conference of state legislatures by going to their website which is not referenced here. [Wwwncsl.org](http://www.ncsl.org) and look at their summary of laws. I'll move on to introduce Jane Perkins, who will speak to us from the National Health Law Program in North Carolina on language needs in healthcare.

JANE PERKINS: Hi, this is Jane Perkins. Thank you so much for having me today. I've been asked to speak for ten minutes or so to give you an overview of using and addressing language needs as a tool for reducing infant mortality. And as you can judge by the name of our program, the National Health Law Program we're approaching these issues at the beginning from what the law requires. But back behind the law there are practical reasons why language issues should be -- ways to address them should be in your toolkit. As you see from the first substantive slide there which addresses the need for language services in healthcare settings, as we all know, there is an increasing population of limited English proficient residence in the United States. It's about 48 million now who don't speak English as their primary language. I think we all think of border states such as Arizona, Texas, Florida, and California when we think of language questions. However, the largest growth in limited English proficient populations is occurring not in percentage growth not in these states but in other states such as North Carolina, Georgia and

Nevada. So whether you're in one of these states or neighboring them, it's clear that language access and ways to address language access are increasingly becoming business necessities for doing business today. The lack of language services also has been associated with a number of adverse health consequences. Using untrained interpreters. Not just individuals who may be working or on staff at a healthcare setting or site but also the use of family and friends, including and in particular minors, using untrained interpreters has been associated in studies with omissions, substitutions, addition of information, volunteered opinions and semantic errors. One study that was conducted recently found that language barriers create access barriers that are similar to those experienced by individuals who lack insurance. In other words, the language barrier is associated with a reduction in the use of primary and preventive care and with increased use of the emergency room. On the other hand, the availability of qualified interpreter and services and translated written materials can ensure informed consent, patient compliance with treatment regimens and prescriptions and just in general that the appropriate standard of care is followed.

When we think about language access as you see in the next slide we look first at the federal law and there is in the federal law a number of requirements that have been held by courts and by the implementing federal agency, the Department of Health and Human Services, to require language access. Typically referred to as meaningful language access. The first is 42US C-section 2000 D of the Civil Rights Act of 1964. It says no person shall be discriminated against on the basis of race, color or national origin. But court and federal agency have interpreted Title VI to address or include it --

regulations implementing title VI prohibit not just intentional discrimination but also activities that have the effect of discriminating. In other words, a policy that would provide services in English only. That some states have and some states are actually considering as aspects of English-only laws could run into these Title VI regulations because they could have the effect of discriminating on the basis of national origin because they serve to exclude national origin minorities. When President Clinton was in office he issued executive order 13166 in 2001. You see there the citation in the federal register where the executive order was placed. This actually has been reaffirmed by President Bush and it requires all federal agencies to issue guidance to federal fund recipients to provide them instruction on how to comply with Title VI.

The Department of Health and Human Services was actually the first agency other than the Department of justice which is the lead agency for implementation of executive order 13166. The Department of Health and Human Services was the first federal agency to issue these guidelines and you see the federal register citation where those guidelines appeared. They include or present instructions for assessing the need for language services and for preparing a plan to address them. They apply to all federal fund recipients. Federal funds are things like Medicaid, Medicare and federal Block Grant monies. The first step in this process for determining language needs is to engage in a four factor analysis, the first step being assessing the number of -- how likely they are to use your services, third to determine the importance of the services to individuals so that, for example, needing a healthcare service would be more important than needing to go to a hockey game. And have translated services. And then the fourth aspect of this four-

factor analysis is to assess the availability of resources to address interpreter and translation needs.

The ultimate product of stepping through these four factors is to develop a plan for addressing language needs. The plan may be to have on site interpreters. It may be to use telephone interpreters or refer the small number of LEP individuals to another provider who agrees to accept those individuals because they have language capabilities. The important thing is to develop -- is to take steps to assess the needs in the community and to develop a plan for addressing them. The Department of Health and Human Services has recommended that that plan be a written one and has said in these guidelines, which are quite extensive with suggestions for data to use and ways to step through this four factor test with -- it helps the federal fund recipients to be able to respond if there were ever a complaint filed by an individual or an investigation initiated by the Department of Health and Human Services. On that score, it's important to know that if a complaint is filed against a federal fund recipient it must be investigated by the office for civil rights of the Department of Health and Human Services. They don't have the discretion to ignore it. In addition -- so that's the federal law. I think the important thing of what is going on there and the important thing to look at is that's federal guidance document from the Department of Health and Human Services and to look at the process of going through that four factor analysis. An initial suggestion that is included in that kind of document is to have someone on-site at the federal fund recipient. At the healthcare facility who has the possibility for engaging in the process, engaging in the four step process and understanding community resources and how -- and the needs of the facility and how community resources can be

used to provide those oral interpretation services and written translations when they're needed. In addition to the federal laws there are also state laws. And I've given a few examples here of the state laws that are in place. The majority of states have now passed laws that address language access and healthcare settings. Not all of them are specific to Maternal and Child Health issues but some of them are and I've given a couple of examples here. The first from California where a statute requires substance abuse prevention and counseling programs within the Division of child and adolescent health to be linguistically appropriate. You see a statute that reflects a broad policy commitment to providing language accessible services in these maternal, child and adolescent health programs.

By contrast in the next slide are the Massachusetts laws which are more specific. When you look at the first of those regulations there is a regulation in Massachusetts that says that maternal and newborn services must be made available or maternal and newborn services must make available health education materials and activities in languages spoken by any non-English speaking group that comprises 10% or more of the population being served. That 10% cutoff is one that we commonly see in state laws whether they be in regulations such as the Massachusetts regulation here or in, for example, Medicaid managed care contracts that might include language requirements as a condition of contracting with the Medicaid program. And a number of states do that. Another example of a state law is again from Massachusetts which requires Maternal and Child Health and newborn services to make available nutritional information and consultation to mothers in a way that is bilingual and bicultural personnel. There are a number of state laws that

address language access. We have conducted a state by state survey of all 50 states' laws and posted that on our website. The last slide that I have shows resources for -- that are available to you for looking into and improving and adding language access to the toolkit. The first is a website called www.lep.gov and it contains a number of very helpful tools particularly with respect to written translation. I think one of the things that can be daunting for a program, particularly a small program that is beginning to get into this issue is the idea of how much it is going to cost and how difficult it is going to be. When you go onto the lep.gov website you'll see a lot has already been done in the area of written translation and you can download much information. We recently surveyed small provider sites around the country making site visits and coming up with model activities in a report that was published by the Commonwealth fund. One of the things we found there was a number of organizations such as the American College of obstetrics and gynecology and American Academy of pediatrics are making translated brochures and informational packets available for healthcare providers online. Particularly with respect to Spanish language translation. But at any rate that website is a helpful one particularly with respect to written translation. And finally I've given the address to our website, www.healthlaw.org. We have a folder on our site that is addressing language, linguistic access and cultural access issues. The state by state assessment of language laws is posted there and it can be downloaded. We also have posted a copy of the report on small provider sites that we prepared for the Commonwealth fund. What we were aiming at with that report was to make note of and disseminate information about reproducible activities that small provider sites can do to get language services out. So there are other websites. We have linked to other websites as has the lep.gov website. If there are questions, please

feel free to contact me. By email I've given my email address on the very first title page slide.

LORI COOPER: Thank you very much, Jane. That was great and that was a packed ten minutes. I would like to just comment that I think Jane has given us some ways to really reach toward health equity that would be 100% access and 0 disparities in healthcare. I urge everyone to look again at what progress you're making at the state or local level with respect to this. We're going to move on now to Terry Davis, who is going to talk to us about death scene investigation and about the current progress of the sudden unexpected infant death reporting initiative. Terry.

TERRY DAVIS: Good afternoon. Thank you so much. Such a pleasure to speak with you today. I'm going to try to do this in ten minutes so bear with me. I would like to talk with you today about the strategies to improve infant death scene investigations particularly the consistent investigation and reporting of sudden unexplained infant death. We have established a training academy. We still have three to go. We completed two. I'll give you information about what we're teaching these team members to take back to their states and to their local counties and then let you know what has happened since we have done these two academies. Those of you who aren't familiar with this, we've developed the state into five regions training ten states at a time with a five member team, a medical examiner, coroner, law enforcement officers, first responder, university professor and child protection specialist. We use the SIDS definition so that they understand that a sudden death of an infant under one year of age which remains unexplained after a thorough case

investigation, including the performance of a complete autopsy and examination of the death scene and the review of the clinical history is what constitutes a death scene investigation.

Statistics show that Sudden Infant Death Syndrome cases are possibly over reported and under investigated. It is not an interrogation of caregivers. It is an interview process. They are to be professional but compassionate. Investigation protocols are inconsistent from county to county across the United States. Out of 21 states that we've already presented this training. The reporting protocols are inconsistent. There is insufficient information provided to pathologists. There is insufficient knowledge of infant growth and development. There is duplications of efforts by team members if there is indeed a team that exists. And there is lack of uniformity in death certification. An ideal situation would currently tell us that we have uniformity of investigation, of reporting and of classification. We do this by lectures. We have 13 faculty and staff members but we also do labs. The labs have proven to be very beneficial. We have an interview lab we take them through that actually takes them through an interview process of someone who has just had -- lost an infant. So you start out by introducing yourself and you get the demographic information, you ask open ended questions. You determine who placed the infant and the person who found the infant. Determine the infant's position when they were placed and last seen alive and when they were found and you use a checklist to be thorough, which is the reporting form.

The scene investigation we teach them about that so that they know a death certification cannot be accurately done without an accurate scene investigation. So in a lab that we do they go through and how to work with a grieving family. Working through how the infant was placed, how the infant was found and who knew or who was the last person that actually saw the infant alive and we teach them to photograph the scene. The different types of photographs that they need for that scene. And then they in turn send this information to the forensic pathologist or medical examiner before the autopsy so we've stopped a lot of this hopefully where we have an infant that arrives at the medical examiners office with a name and approximate time of death and that's it.

So the back of the form there is -- we call them the top 25 train the trainers. It's divided into five groups. We look at the sleeping environment, at the infant's history. The family information, at the external examination and the investigator's insight. While we're doing this we're also teaching them about asphyxia. We teach them the evidence of overlying, wedging, choking, nose or mouth obstruction. Breathing issues, neck compressions, immersion in water. We also teach them about sharing sleep surfaces. A change in the sleep condition, hyper or hypothermia. Environmental hazards. Maybe unsafe sleeping conditions. We also teach them about the infant history. Get what the infant's diet consisted of. Any recent hospitalizations. Look at previous medical diagnosis and acute life threatening events in the history of that infant. Do a complete medical history of the infant. Were there any recent falls or other injuries and look at the history of religious, cultural and ethnic remedies and also make them knowledgeable in the causes that could be natural other than SIDS.

Family information. We want to know about prior sibling deaths, previous encounters with police and social service agencies. The objection to autopsies and the exam we want to know and we teach them about EMS showing up and what their role actually is at the scene. What they did, what they saw, what they know. And then we also go through a complete history of death due to trauma, poisoning and intoxication. We ask for suspicious circumstances. Maybe the witness information does not or is not consistent or a delay in reporting or other alerts to the pathologist. Certainly he would like to know or she would like to know if there have been other infant deaths in that family or previous records. So for a thorough investigation there needs to be an in-depth interview with notes.

Photographs at the scene and an autopsy. Needs to be an accurate death certification, there needs to be a complete research of medical history. One of the ways that we do this, there is communication between the people in the field gathering this information and the information getting to the pathologist is through a log. That is a website that has been put up and that is free for investigators and medical examiners to share information.

For our state legislation efforts, currently I think there are 13 states with no SIDS laws. However, there is legislation mandating coroners to investigate sudden unexpected infant deaths. The state medical examiner of Tennessee was instrumental in passing a SIDS appropriation bill for the state to pay for autopsies provided a thorough death scene investigation protocol was followed and conducted. In most cases counties usually pay for the autopsies. If you're a county and had 200 deaths, that's \$300,000 to pay for autopsies. Now, what Dr. Levy's appropriation bill did was asked the state legislators for the \$300,000

to go to the state medical examiner to perform these autopsies. What we have is the process where it should be. The county investigates using the protocol or guidelines or the national standards and then the result is that the state performs the autopsies and covers the cost. This is a win/win situation. It's helping us determine exactly how our infants are dying. We'd like to use this as a model for all the states. Other legislation that has been worked on and passed since we began was one that Alabama has successfully done. They passed legislation mandating that all coroners are responsible for continuing education credits. Now, in the State of Alabama like in many other states the coroners are elected and they do not have to have any medical or law enforcement background. So this has been a huge undertaking. And now they have a state association that will bring all the coroners together and can actually provide this training. We have had full support from the national sheriff's association and the international medical examiners and coroner's association that have adopted this training curriculum and we're pending board approval through the National Association of medical examiners and the American board of medical/legal death scene investigators. The results of these academies. We've only had two. One was in June, the last one was in September. We've trained 21 states. So out of those 21 states we have trained 105 trainers. We ask these trainers that they go back and train a minimum of five people within the first year. So actually by September of 2007 we had hoped to see some results. And if they had done the minimum that we asked there would have been another 525 trainers out there with knowledge of actually how to do infant death scene investigation. To date this is six weeks after the second academy there have been over 3,000 law enforcement, social workers, medical investigators, coroners and EMTs that have been trained. 19 of the 21 states have already implemented the

training. Plus internationally Australia has adopted the reporting form outright saying this is the thing we're using all over Australia. England, New Zealand and Canada are very committed to an international team we're trying to put together in participate in the next academy in Boston in April of 2007. And then in Albuquerque in 2007 in August and the last academy will be in Seattle in March of 2008. We have had requests this form be translated into Spanish and French. Next month there will be another 200 law enforcements officers and district attorney's in Albany, New York that will be given a training on how to investigate infant deaths as well as 130 people in Wyoming on the Riverton Reservation including South Dakota, North Dakota and Montana as well. What we're doing is training these individuals to go out and to be consistent and to be complete, be confident and be compassionate when they are investigating infant death scenes. That's my presentation.

LORI COOPER: Thank you, Terry, very much. So for the states SIDS and MCH leadership if you do nothing else in relation to this, at least call up the -- those law enforcement, medical examiners and first responders who have participated to congratulate them on their participation. And to make sure that their work continues in your state. Now we'll move -- Terry, did you want to say something?

TERRY DAVIS: Let me give you two websites. One is my email address with is T Davis 5 at CDC.gov and the second website is any of you listening can go to and like on the United States and see who has been trained from your state. Those people are to assist you in these training efforts. The website is <http://suidi.orainc.com> and that will take you

right to the map of the United States. When you click on your state it will give you the five people who are already trained.

>> That's great. Thank you very much. We're now going to hear from Barbara Hamilton from the National Resource Center for health and safety in childcare and Sheri Aizer from the National Childcare Information Center.

BARBARA HAMILTON: Thanks, Lori. If you'll go to slide trends and resources I'm pleased to participate on today's webcast and represent the National Resource Center and our resources related to reducing the risk of SIDS in childcare. The National Resource Center's mission is to improve the quality of childcare by the development and dissemination of resources for the childcare community, policymakers, parents and families and health professionals.

Next slide that says trends. In 2003 we started to track how many states included at least one of the following three components regarding sleep position and risk reduction factors in their childcare licensing rules. One was placing infants on their backs to sleep, two was no soft bedding or materials in the crib and three was that required training on SIDS risk reduction methods for caregivers. We also tracked to see if they required physician authorization for a different position other than on the back and also for parent authorization for a different position. As you can see by the slide the number of states has grown over a three-year period including at least one of the components in their regulations. My co-presenter Sheri aizer will share how many states require different

components and the National Resource Center plans to continue to compare the states on this issue each year to follow hopefully an upward trend in this inclusion. T

The next slide for resources. So if you're looking to advocate for new language in your childcare rules about SIDS risk reduction or to improve and expand what might already be there, we have several resources on the National Resource Center's website to help. First is a compilation of ten standards from the publication and online resource caring for our children that deals specifically with helping to reduce the risk of SIDS. For those of you unfamiliar with caring for our children the document contains 707 best practices for standards for health and safety in childcare programs. They were developed by leading experts from the American Academy of pediatrics, the American public health association and other major organizations. Because of the size of the dock. We've created subset of hot issues. Reducing the risk of SIDS and the link to the subsection is listed on the slides. It is used as a resource to update and improve state regulations. Each standard includes the rationale why this practice helps to prevent harm or increase the health and safety of children. This rationale assists policymakers in justifying why it's important to include in regulations. These standards also can be used in training providers on this topic as well.

Next slide, state licensing site. Also on the National Resource Center's website is the full text of all the childcare licensing rules for the 50 states, District of Columbia, Puerto Rico and Virgin Islands. Rules are including for any type of childcare program regulated in that state. We contact states twice a year for updates so the regulations should be fairly current at any given time. The state rules are searchable and a good way to view the

actual language used. For SIDS language I would particularly recommend looking at Alabama's language as it's very comprehensive. Also one quick reminder state regulations change constantly. We've already made 71 update changes in the past 12-month period. So in any given study you may see different numbers when researching on a specific topic like SIDS risk reduction.

Next slide references. The first reference listed here is to the comparison that the National Resource Center did and you can see the results on the website with the link given. The second is Dr. Rachel moon and others from the American Academy of pediatrics stuff recently published findings of their research and give a lot of detail on different components more so than what we do in our comparison. Then the last, the American Academy of pediatrics healthy childcare is a good source to keep up to date information on the American Academy of pediatrics policy on SIDS risk reduction particularly in childcare. They have excellent resources designed specifically for the childcare provider and the parent who has children in childcare about SIDS risk reduction. Last slide, for more information if you have any questions, I'll -- please feel free to email or call me about how to use our website or how to get the resources. Our general website address is listed on this slide and thanks very much for your attention. And now to Sheri.

SHERI AIZER: Thank you, Barbara. This is Sheri Aizer, I'm a research at the national childcare resource center. It's technical assistance center with clearinghouse with information on a variety of topics related to childcare. We're a service of the federal childcare bureau.

What I'll talk to you about today you can move to the next slide is findings from a recent study that NCCIC has produced in collaboration with the national association for regulatory administration. NARA is a professional organization of childcare licensing staff as well as other human service care professionals are part of the association. We have conducted a study of childcare licensing regulations focusing this year's studies on childcare center regulations. This will be an annual study that will be produced and over the next year we'll be conducting a similar study of family childcare regulations.

Next slide, please. Our methodology for this study included compiling central licensing regulation from the national website Barbara just told you about. We had another aspect of the study which was a survey of all state licensing agencies that looked at their enforcement policies. Information about investigations and inspections and monitoring of childcare programs are included in that piece. But I'm focusing today on data that we found in the compilation of licensing regulations. All of our data include 50 states which includes the District of Columbia. Idaho was the only state that doesn't have licensing at the state level so there is no information to get from Idaho.

Next slide, please. This slide includes what we have found from the childcare center regulations that looks at the requirements related to reducing the risk of SIDS in centers. As you can see there are 24 states that currently require centers to place infants on their backs to sleep. 20 states allow for an authorization from physicians for a different sleep position. And five states allow parents to authorize a different sleep position. There are

currently 17 states that specify that soft bedding is not allowed in cribs and seven states require center staff to have some type of training related to the prevention of SIDS.

Next slide, please. I also understood that there will be some discussion about smoking on this call so I included some of the data that we found out related -- we found related to smoking requirements. As you can see there are 47 states that have requirements in their childcare licensing regulations related to smoking in centers. Of those states, 31 specify that smoking is not allowed in a center. 19 specify that smoking is not allowed on the grounds of a center. And 18 specify that smoking is not allowed in the presence of children. And also 11 states say that smoking is not allowed in areas used for the care of children. There are 10 states that do say that smoking is allowed in a designated area of a center.

Next slide, please. Finally, this is just some further information about the licensing study report. Our full report will be released by the end of this year. It is actually more like closer to December of 2006 than November. It will include national analysis of all the data that we compiled, state data profiles that will include the requirements that we pulled out from the regulations for each state. The data that I'm presenting today is a small piece of what we have collected. We have over 1500 variables we collected from childcare center regulations. And also will be included are some 50 state data tables. There is also provided with you a website to NARA's website that has currently on it an executive summary of our licensing study as well as some 50 state tables related to licensing monitoring and inspections. Finally my last slide is just a thank you and includes contact

information for the National Childcare Information Center if you have any further questions. Thank you.

LORI COOPER: Thank you, Sheri and Barbara very much. That's a perfect segue, I think, to Dr. Anne Malarcher who is talking to us about second hand smoke from the CDC office on smoking and health.

ANNE MALARCHER: Thank you, Lori. I guess we're starting with the second hand smoke slide and then can I have the next slide, the title slide. Before I review the findings from the 2006 Surgeon General's report on the health effects associated with second hand smoke exposure I want to give some background information about the prevalence of smoking among women in the United States and also cessation measures and interventions.

Next slide. This graph shows trends over time and the prevalence of cigarette smoking among men and women in the United States. As you can see the prevalence of smoking has been reduced by about half since peak prevalence in 1965 among women. And approximately 18% of adult women now smoke in the United States.

Next slide. However, this smoking is more common among women of reproductive age and you can see one out of five women age 18 to 44 years smoke and decreases with increasing age as women in their mid 40s begin quitting and then also mortality during -- due to smoking-related disease.

Next slide. This just shows smoking among girls and this is really our future. You can see there was an increase in this prevalence of smoking in the 1990s and then a decrease after that. Right now we're seeing some slowing or stalling in the decrease of smoking among high school girls.

Next slide. There are also very important disparities that still exist in cigarette smoking. This shows cigarette smoking by women by race, ethnicity and you can see that American Indian, Alaska native women have much higher rates of smoking than the other racial ethnic groups and that's followed by white women, African-American women, Hispanic women and Asian women.

Next slide. The -- there is also significant disparities by educational levels. You can see that smoking is relatively low in women who have graduated from college and much higher in women who have not completed high school. These disparities you can see have not changed over time from the 1960s until today.

Next slide. This graph is from birth certificate data and reporting of smoking on birth certificates and you can see similar to the overall percentage of women smoking, among pregnant women we've also HALVED the number of smoking and 10% of women smoke during pregnancy in the latest year available.

Next slide. This slide speaks to that mirroring what is happened with smoking among all adult women. Among pregnant women we're also seeing large disparities by racial and

ethnic group where younger women are more likely to smoke than older women. Past Surgeon General's reports found pre-natal non-smoking is a preventable risk factor toward SIDS.

I want to turn to the next slide to look at cessation by women in the United States. This is a graph among those women who have ever smoked, now the majority have reported that they have quit smoking. So over 50% of women who have ever smoked report that they are now former smokers. So that's somewhat good news. And there was an elimination of the gender difference over time.

And next slide you can see that there is a lot of interest in quitting among women age 18 to 49 years old and we've looked at this by whether the women reported whether they had a live birth within the last five years and to give a sense if they had small children in their household. You can see that among these women regardless of whether they've had a live birth in the past five years between 45 and 50% report that they -- of current smokers report they tried to quit in the past year. Among those who tried to quit in the past year most were advised by their physician to quit smoking. However, very few used a recommended cessation method. These are methods based on the Public Health Service guidelines. You can see that there also is a disparity where women who do have small children in their household are less likely -- smokers are less likely to use a recommended method when they try to quit. That's something of a concern and we need to increase the levels of use of recommended methods by these women and it actually mirrors, you know,

use of recommended methods is low among all smokers. I think you'll -- you've heard that most people try to quit on their own or cold turkey and that is still true.

Next slide. What we do have is we have very -- we know what works in smoking and we have several effective interventions. These are just some of the guidelines on this slide.

Next slide, however, as the Surgeon General has pointed out, our lack of greater progress in tobacco control is really more a result of a failure to implement proven strategies than the lack of knowledge about what to do.

Next slide. This is from the community guide for preventive services and this can be found on the web under the [community guide.org](http://communityguide.org). For increasing cessation these are the strategies that have been shown to be effective. And they include increasing the price of tobacco products. Telephone cessation quit lines. Reducing out-of-pocket costs for treatment and the healthcare system changes reminder systems for providers.

Next slide. We need to do more in terms of Medicaid coverage. This is for 2005 and you can see not all states either cover the medications that have been found to be effective for cessation and fewer still cover counseling and some only provide this coverage for pregnant women. We need to actively engage Medicaid within states to get these numbers up and more people covered.

Next slide. Now turning to the recently released Surgeon General's report on the effects of second hand smoke exposure you can see it's not the major report was a compilation of scientific evidence but we have a lot of good consumer pieces about second hand smoke exposure and how to address it within your home and workplace and these are all available at CDC.gov/tobacco.

Next slide. This just talks about the process we used. It is a systematic review of published scientific evidence.

Next slide. The senior editor was Jonathan -- the major conclusions of the report were that second hand smoke causes premature death and disease in children and adults who do not smoke and among adults this was for coronary heart disease and lung cancer.

Next slide, one of the chapters was on reproductive and developmental effects from exposure to second hand smoke and we considered exposure is complex and considered all these three periods of exposure and many different outcomes.

Next slide. And this is the conclusion of the report. There were two causal associations found. One was a causal relationship between maternal exposure to second hand smoke during pregnancy and a small reduction in birth weight and the second was a causal relationship between exposure to second hand smoke and sudden infant death syndrome. In terms of exposure to second hand smoke this was concluded that there was a causal relationship with maternal exposure of the infant, paternal exposure of the infant and

exposure to other living in the household. Ratios varied from 1.5 times the risk of an exposed infant to non-exposed up to 20 times the risk for infants exposed to a pack a day.

Next slide. There was another chapter that also talked about respiratory effects in children and I'll just -- I won't read these over but these are the ones that showed a significant relationship with second hand smoke exposure.

Next slide. So in conclusion, the Surgeon General found that the debate is over. The scientific evidence indicated that there is no risk-free levels exposure to second hand smoke.

Next slide. We know that many people are still exposed in homes and at work. Over half of all children are exposed. Prevalence varies significantly by income, gender and ethnicity.

Next slide. In this slide you can see that African-Americans have the highest levels of exposure and children have higher levels of exposure than adults.

Next slide. This just reinforces that message that children who live in homes where smoking is allowed do have higher levels of exposure.

Next slide, here we found that some good news is that women smokers who had small children in their household were more likely to have a smoke-free policy in place in their

household. Next slide. And we know from the community guide and other sources that smoking bans and restrictions are effective. Next slide. And this just reinforces the conclusions from the Surgeon General's report that smoke free policies protect non-smokers. There is no such thing as a no smoking section and cleaning the air and ventilating buildings don't fully protect against exposure to second hand smoke.

Next slide. In conclusion, I think we, from this whirlwind data that I presented and I hope you can look at it more at your leisure we need to encourage smokers to use effective cessation methods. One of the ones that is now available in every state through a national network is the smoking cessation quit lines at 1-800-quit now. We also need to expand coverage of cessation services in Medicaid and beyond Medicaid. And we do need to put in place restrictions and bans that protect adults and children from second hand smoke exposure. And last slide, this is my contact information. If you have any questions, please feel free to contact me. Thanks.

>> Thank you very much, Anne. I would like to encourage the state SIDS and MCH leadership to reconsider your partnerships with anti-tobacco organizations and with health departments if you aren't already in one or working down the hall from a group that does this. I think it's an area that we can really strengthen our partnerships with and especially with all of this evidence-based strategies. Next I'm going to talk very briefly about public awareness and then we'll have some time for questions. I put in public awareness because it's a strategy that can be used to amplify those legislative and regulatory strategies that may have already been put in place or it sometimes can be used to lead

into a law. So let's start with the slide that says strategies to increase public awareness and support. I'm going to cover -- there are a few different ways you can go at this. A gubernatorial proclamation. In some cases a presidential proclamation. I found president Reagan was the last one I found. I welcome anybody who is a scholar on this to correct me on that. We'll talk about concurrent resolutions and also laws. We have actually spent the last hour and 15 minutes talking about some specific laws, as well as related legal legislative strategies, so I'm not going to be -- I'm mainly focusing on these proclamations and concurrent resolutions for public awareness.

If you move to the next slide, a gubernatorial proclamation, this one features Arnold Schwarzenegger and California. The gubernatorial proclamations continue to be a way that states draw attention to the statement of the problem and frequently you can include data to help your state, providers, parents and policymakers understand more about the issue. Sometimes these are driven by the parents or providers. The use of proclamations seems to be diminishing, at least around SIDS and sudden unexplained infant death. I don't know exactly why that is. I don't know whether there are so many competing issues. I would simply say it is one way to bring attention to the issue. And we just are trying to track these but have seen them decline over the past few years.

The next slide addresses a concurrent resolution which is a way that Congress uses to bring attention to an issue without the impact of a law behind it. These are frequently used to recognize individuals, teams, "Increasing Your Program's Capacity Initiatives and so forth. They simply express the idea of Congress on a particular subject. Don't require the

signature of the president. The one you're looking at here I think a lot of people may not be familiar with. That is that there is a day every year during National SIDS awareness month that is called supporting the goals and ideals of pregnancy and infant loss remembrance day and you can go to this website to get that resolution in detail. I simply wanted to point out to people that if you are planning a -- any kind of a press event or educational activity in your state or with the media, it is often very useful to put the force of the recognition by Congress behind this. This is also true at the state or local level and while I mention that there are not as many gubernatorial proclamations I think we're seeing an increase in ordinances or declarations by city councils and at the lower -- at the local levels of government. So it's useful to think through where you'll get the most impact for attention to this topic.

And then finally, I just wanted to mention our website, which is the next slide, where we're tracking all of these things that we've just presented to you and trying to bring you the most updated information in each of these areas. So I encourage you to visit our website and to participate on our listserv which is a discussion of research and translating research into practice to move forward the agenda for risk reduction and bereavement support. If you're interested in joining that listserv go right to this website and in the upper right corner click on listserv and you'll see how to join the 600 people around the country who are currently in discussion about all of these best practices. So that concludes our presentation and I'm going to turn the session back over to Johannie for moderation of questions and answers. Thank you all for participating.

>> I would like to say thank you to all of our speakers for wonderful presentations and we do have quite a number of questions. I do want to remind our participants that if I do not get to your question, that I will go ahead and email your questions to the presenters and they'll be able to answer your questions later after the webcast. The first question is for I believe our first presenter. The question was, please address the issue of sleeping with your infant. What is your recommendation on this issue?

>> The NIC, we're going with the NICHD recommendation and also backed by the American Academy of pediatrics regarding bed sharing. And the current standard is that we do not support bed sharing and there is -- it would be inconsistent to try to tell people how to safely bed share since that seems to be incongruent to the message itself so what we do support is approximate sleeping area separate from the parents and caregivers but allows the baby it's own separate sleep environment. We support room sharing as opposed to bed sharing. We do think a proximate sleeping environment to the parents and caregivers would be a better idea and has shown to be as beneficial as bed sharing to babies if parents are doing it for issues of a bonding. We also do support breastfeeding and encourage it but ask that the mother place the baby back to sleep in its own sleeping environment that is proximate to the parents but not in the same bed as the parents.

>> Thank you. Are the professional standards that you spoke about available for download or can the participants get a copy of them?

>> I'm not sure if she's referring to the professional standards that are put out for the bereavement ones, which is Lori can address that question. That's the association of SIDS and infant basic product -- programs and I'm not sure if it's on web but it is available through Project IMPACT in ASIC1.org.

>> It's available in PDF and is on the home page of the Project IMPACT website.

>> Thank you. The next question is for the presenter on the SIDS risk reduction. Who should we contact for potential conference sponsorship and access to printed materials?

>> This is HANAN. I'm thinking that's a question for us. I don't know if anyone else spoke about it but you can contact our offices directly 1-800-221-7437. I had a brain pause there for a minute. And just ask for one of us and we can discuss sponsoring a conference.

>> Thank you. The next question I'm not sure which speaker this is for. It says how are participants chosen for the SIDS training through the CDC.

>> It's for Terry Davis.

>> Hi, there are two ways you can do that. Usually we choose the state medical examiner if there is a state medical examiner to take the lead and they put the team together or through a nomination process. Or you can contact me at T Davis 5 @ CDC.gov to let me know if you're interested in serving on the team.

>> Thank you, Terry. Is the training available for staff of agencies that provide services to families to reduce infant mortality? Also, is the checklist available for home visiting case managers to view? This can be used for possible risk factor in the homes of where the baby dies.

>> Part of the training that we do a part of the bereavement and one of the things we're teaching the investigators is to find out who in their community provides those services and we also give them a page of links so that they have other opportunities to research and find out where they can send the caregivers for that type of counseling. So -- as far as -- yes, anyone, when we say a first responder that could include an EMS person, a firefighter, someone from social services who provides counseling or a counselor that is on the scene of a death investigation. Put the team together so the person is part of the team so they go out when there is an infant death as well as working with the individual entity within the communities where the trainers go back to include them in their training.

>> Thank you. The next question I believe is also for Terry. Can you place a -- to set up a child with GIRD?

>> We get back to the crib thing. What we like to see in the crib and that's a firm mattress and the infant. And nothing else. I think the BLOPPIES are out. I have a 4-month-old new granddaughter and she received one of them and I actually have a picture of her on it but her mother is on the floor with her resting on her tummy with her head there and hands

and took a picture. It was just to change her position and she didn't leave her unattended. We really don't like to see those things in the crib when we talk about the back to sleep that's what we mean. Put the infant on their backs with nothing else in that crib but that infant.

>> This is Lori. I want to add because the question was raised about infants with gastroesophageal reflux disease. We're suggesting that people consult with their provider around the response for this -- for those particular infants because sometimes elevation may help them. But it really -- we're recommending that people talk specifically with their provider about their individual case as well.

>> Thank you, Lori. Also a question for Terry. Thank you for including some information about the states Tennessee and Alabama using creative legislative approaches to improve death scene investigations. Are there other new or best practices you know of? Please repeat the website to click on the status of the different states.

>> Okay. You know, yes, we hope that there will be a lot of legislation. One of the things that is happening with these teams coming together from ten different states and when we have the labs and they interchange with one another and they're sharing information we did this in our state and passed this legislation in our state and we're looking at doing this in your state and that's how it is going to have to get done. Not only state, it's county to county that things are so different. But hopefully what we hope to gain out of this and the end result of these academies is that yes, there will be some best practices for

recommendations on legislations and what currently -- even educating them on what currently is in your state and what their needs to be and then how you go about doing that. So that's been a huge effort and I hope we'll end up with the best practices from that. And the second part of the question was—

>> Repeating the website.

>> Okay. This may be a better way to find it. [Www.orainc.com](http://www.orainc.com). And you click on database and scroll down to SUIDI national academies and click on that and that will bring up the state. It eventually will be on our CDC website. Now you can get the form, the reporting form, but currently on the ORAINC website you can get the reporting form, the national guidelines adopted by the national association and your national examiners and coroners as well as the Power Point. Two wonderful power points, the teams have to compete and take back to their state a 20 minute Power Point that they do as a presentation and the Minnesota team was the one that won in the Midwestern states and South Carolina was the team that won in the southern states. Those two power points are there that give them more in depth detail of what is happening about the training at the academies.

>> Thank you, Terry. The next question is for Ann. Are there federal regulations regarding smoking in and around centers on reservations?

>> To my knowledge, no, there are not federal regulations. We do have ongoing programs with some of the tribes and we work through the tribal support centers to -- we just had a

program to collect some data about what is happening in terms of smoking prevalence and use of other tobacco products in 11 tribes and we hope to make that survey available to other tribes to use. And I think that sort of -- the 11 tribes, many of them are now using the data that they've collected to move forward and on their own establish some smoke-free policies, particularly in their healthcare settings but also some have actually begun working on smoke-free policies in casinos as well. If you need additional information about that, please feel free to contact me.

>> Thank you, Ann. That's all the time we have for questions today. On behalf of the Division of Healthy Start I would like to thank our presenters and the audience for participating. And thank the contractor at the University of Illinois School of Public Health for making this technology work. It will be archived available in the a few days at mchcom.com. We encourage you to let your colleagues know about the website. Thank you and we look forward to your participation in future webcasts.