From Data to Action: Using Medical Examiner’s Reports to Inform Creation of a Community-Based Safe Sleep Coalition

Learning Objectives

In this session, participants will:
1. Understand how local data were used to identify risk factors for ASSB
2. Differentiate between ASSB and SIDS and understand the importance of using consistent terminology for prevention
3. Identify steps to assembling a community-based coalition to address ASSB

Statement of Purpose

Austin Public Health (APH) provides safe-sleep education to health care providers and community organizations as part of its injury prevention programming. To reduce the number of sleep-related infant deaths in Austin/Travis County, APH compiled comprehensive data from Travis County Medical Examiner’s Office (TCMEO) reports on infant suffocation deaths to determine demographic characteristics, health risk factors, and sleeping environment related to these deaths. Following analysis, APH convened local stakeholders to identify gaps and formulate strategies.

Methods

Five years of data from TCMEO reports (N = 41) were extracted through case review of each report and then categorized based on known risk factors from the literature or on data trends. A report was produced and distributed among stakeholders in Austin/Travis County. APH then convened these stakeholders to discuss the data, develop common terminology, set goals and develop strategies, and form committees for a community-based safe sleep coalition.

Results

Known risk factors were identified in these deaths, including 1) being <= 6 months of age (90%); 2) not sleeping on back (54%); 3) sleeping in an adult bed (73%); and 4) bed sharing (66%). Additionally, during case review and community education outreach, the need for a common understanding of death coding and terminology was identified. APH convened a workshop to discuss findings, identify goals and strategies for community-wide prevention efforts, and form committees for further work. During the workshop, four priority areas were identified: Branding and Messaging; Resources; Community Education; Clinical Policy, Practice and Education. Twenty-nine participants representing 13 agencies attended the workshop, and 23 participants joined the priority area committees.

Conclusions

Using locally available death data to guide education and action was an effective method for garnering stakeholder input and reinvigorating support for addressing a county-wide public health problem. Multi-sector collaboration involving public health, healthcare, public safety and community partners is essential for a successful program to reduce unsafe sleep deaths in infants.

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Denise Geleitsmann is the Injury Prevention Program Coordinator for Austin Public Health covering safe sleep, drowning prevention, motor vehicle safety and falls prevention. She has worked with both the Austin Police and Fire Departments and prior to that spent seven years teaching English as a second language in Berlin, Germany. She is the founding member of the Travis County Safe Sleep Coalition, is a member of Safe Kids Austin and the Child Fatality Review Team and is a Child Passenger Safety Technician. She is married with one son, two dogs and multiple fish and enjoys traveling and camping in her spare time.
Connecting to the Community to Reduce Disparities in Infant Sleep Related Deaths

Learning Objectives
Demonstrate how our infant mortality reduction program has reached out to unique partners to increase education on infant safe sleep within the community. Show how providing save sleep education through various avenues can influence behavior change and help caregivers improve on infant safe sleep practices.

Statement of Purpose
The purpose of this activity is to highlight efforts in Tennessee to reduce racial disparities in infant sleep-related deaths. This presentation will include information on reaching low income housing, evidence based home visiting, faith based communities, birthing and non-birthing hospitals, and engaging local fraternities in safe sleep education.

Methods
Black infants are 2.1 times more likely to experience a sleep related fatality than white infants. Through outreach with traditional and non-traditional partners we provide standardized materials to educate infant caregivers on safe sleep practices, model behaviors, and collect feedback, as well as monitor behavior change. There are multiple touch points within the community that reach populations at higher risk for infant sleep related death. All families are provided with safe sleep education during the hospital stay after a birth. The evidence based home visiting programs monitor safe sleep practices before and after providing education to families. The programs also survey families on their current safe sleep practices, at the follow up 2 months later to observe families on any changes that occurred with those behaviors. Families are also asked if there is any particular educational component that helped improve on their infant safe sleep practices.

Results
Safe Sleep education was provided on over 80,000 births in Tennessee annually for the last 5 years. Additionally, over 250,000 safe sleep materials are distributed through various avenues such as hospitals, home visiting agencies, medical providers, faith communities, pharmacies, low income housing authorities, first responders, child care providers, and local health departments each year.

Conclusions
Through developing unique community connections, we have been able to educate and provide guidance populations at highest risk for infant sleep-related death through trusted members that can help influence change. We have been able to reach families where they are in the community to share the message.

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Infant Safe Sleep Environment: A Community Perspective

Learning Objectives
Describe unsafe sleep-related mortality in an urban area
Identify barriers to safe sleep practices from community professionals' perspective

Statement of Purpose
Unsafe sleep-related deaths is the leading cause of injury death among children less than 1 year of age in Dallas County. From 2015 to 2017, the number of unsafe sleep-related deaths among infants increased by 50%. A Safe Sleep Workgroup consisting of community professionals was created to address the issue by becoming more informed about hospital safe sleep messages, as well as those of community services organizations. The information gained from the workgroup will be used to effectively address unsafe sleep practices and reduce injuries.

Methods
Medical Examiner Data was used to describe child deaths where an unsafe sleep environment was a factor in their death. Data was collected from six hospital systems in Dallas County. The workgroup gathered information on training provided to hospital employees on safe sleep practices, hospital policies, and how patients are educated. Hospital representatives on the workgroup completed a survey for their site. Additionally, a community focus group of professionals was conducted to determine barriers to safe sleep practices that their clients/patients face. Themes were identified to determine presumed barriers to safe sleep practices.

Results
All of the hospitals train their staff on safe sleep practices and have a safe sleep policy with at least three of the American Academy of Pediatrics recommendations. Various hospital personnel educate on safe sleep practices at pregnancy, discharge, and or post-partum. Community-level professionals agreed that most families are aware of safe sleep practices, yet do not follow them due to various economic, cultural, and physical reasons. Alternative ways to safely bed share, such as the “Safe Sleep Seven”, were cited as barriers to safe sleep, but increase breastfeeding, which is a protective factor against SIDS/SUID.

Conclusions
Although hospitals educate staff and patients on safe sleep practices, parents of infants do not always follow the recommendations. Focus groups consisting of community professionals and families can provide insight into barriers to safe sleep practices. Common themes learned from the community can be used to create an effective and consistent safe sleep message.

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