SOUTH DAKOTA
DEPARTMENT OF
HEALTH

Maternal Child Health

Infant Domain - Jill Munger, Coordinator

State Action Plan	Implementation Timeframe: October 1st, 2022 through September 30th, 2023
NPM 5 A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
State Priority Need: Safe Sleep	
Objectives: 1) Reduce the number of SUID deaths related to unsafe sleep environment from 139.8/100,000 in 2019 to 103.9/100,000 by 2025 (NVSS). 2) Increase the percent of infants placed to sleep without soft objects or loose bedding from 55.8% in 2020 to 57.2% by 2025 (PRAMS).	
Facilitator: Jill Munger (DOH – MCH Infant Domain Coordinator/CDR Coordinator) **Workgroup Members:** Alyssa Christensen (Avera McKennan Nurse Manager; Postpartum & Newborn Nursery), Bette Schumacher (CNS Sanford NICU), Laura Nordbye (DSS Childcare Services-Licensing Program Manager), Audrey Rider (SDSU Extension-Early Childhood Field Specialist), Kaylyn Davis (Statewide CDR abstractor/West River NVDRS abstractor, BHSSC) Bri Edwards (Family Advocate, Lach's Legacy) Paul Forney (Research Assistant, Avera Research Institute, Pine Ridge) Christine Catts (DOH-MCH Women's Domain Coordinator/Maternal Mortality Review Abstractor) Teah Bell, RN (DOH-CHN, Pine Ridge)	

Strategy	Activities	Status	ESM	Responsible person(s)
Strategy 5.1: Disseminate culturally appropriate safe sleep educational materials, resources, and messages via social media and print.	Continue to post safe sleep messages on For Baby's Sake and DOH Facebook pages.			Chris Jill
	Continue to place ads in parenting magazines and professional journals.			Chris Jill
	Continue to disperse safe sleep infographic (with data from CDR) to providers and partners across the state.			Workgroup members

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	Activities	Status	ESM	Responsible person(s)
Strategy 5.2: Collaborate with diverse community partners to provide Child Death Review and disseminate findings to all South Dakotans.	Work with team from Johns Hopkins to translate CDR findings into actionable, evidence-informed recommendations			Bri Jill Kaylyn
	Work with Medical Examiners and law enforcement to provide infant death investigation and SUIDI form training to those that conduct the investigations.			Jill Kaylyn

	Activities	Status	ESM	Responsible person(s)
Strategy 5.3: Collaborate with diverse, multi-sector organizations/ agencies to promote safe sleep	Explore new opportunity *Today's Baby* with SD WIC program			
	Partner with Cribs for Kids and all SD birthing hospitals to promote bronze safe sleep certification within their system.		% of birthing hospitals that receive information on certification process that become safe sleep certified.	Alyssa Bette Jill

Updated: 8/22/22

OF HEALTH

POST IMAGE	TITLE	TYPE (Paid/Organic)	CUMULATIVE REACH	AVERAGE FREQUENCY
	SIDS prevention starts with safe sleep	PAID	12,588	4.2
	11 Key Ways Dads Can Help	PAID	22,525	3.85
	11 Safe Sleep Guidelines	PAID	40,006	2.6
	What Safe Sleep Looks Like (animation)	PAID	27,993	4.36
	Is my Crib Safe?	PAID	38,106	3.4

safe sleep ABCs

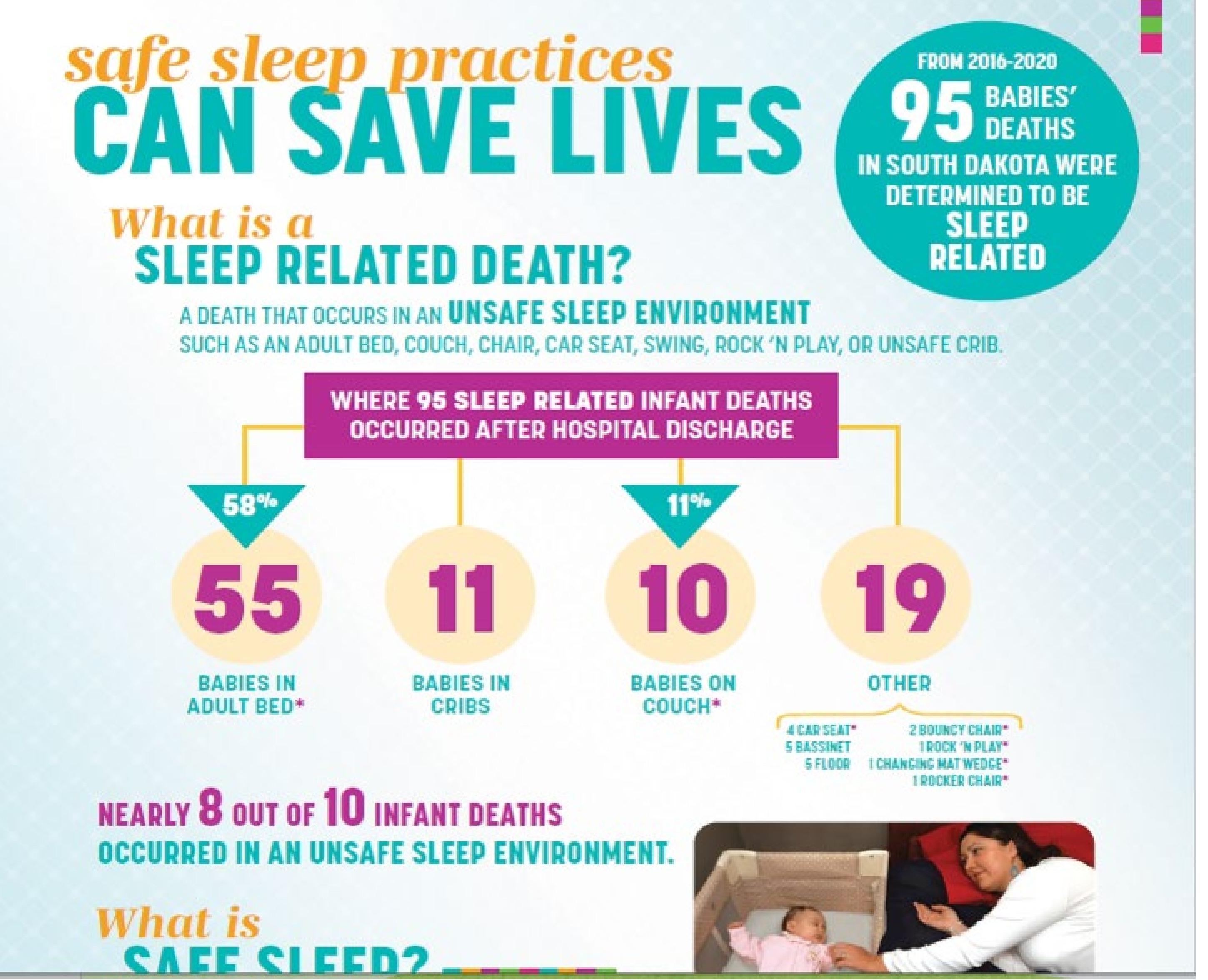
Alone Back Crib

BABIES SHOULD SLEEP **ALONE**, ON THEIR **BACKS**, AND IN A SAFE **CRIB**.

Quite simply, these safe sleep practices save lives. And remember, ***room sharing is recommended but bed sharing is not.*** Babies should never share any sleep surface with an adult, a child, or a pet.

To find out more about safe sleep guidelines and how safe sleep practices can reduce the risk of SIDS, go to **ForBabySakeSD.com/safe-sleep**.

Follow these simple ABCs at every sleep time.


safe sleep practices
CAN SAVE LIVES
FROM 2016-2020
95 BABIES' DEATHS
IN SOUTH DAKOTA WERE DETERMINED TO BE
SLEEP RELATED
What is a
SLEEP RELATED DEATH?
A DEATH THAT OCCURS IN AN UNSAFE SLEEP ENVIRONMENT
SUCH AS AN ADULT BED, COUCH, CHAIR, CAR SEAT, SWING, ROCK 'N PLAY, OR UNSAFE CRIB.
WHERE 95 SLEEP RELATED INFANT DEATHS OCCURRED AFTER HOSPITAL DISCHARGE
58%
55
BABIES IN ADULT BED*
11
BABIES IN CRIBS
11%
10
BABIES ON COUCH*
19
OTHER
4 CAR SEAT*
5 BASSINET
5 FLOOR
2 BOUNCY CHAIR*
1 ROCK 'N PLAY*
1 CHANGING MAT WEDGE*
1 ROCKER CHAIR*
NEARLY 8 OUT OF 10 INFANT DEATHS
OCCURRED IN AN UNSAFE SLEEP ENVIRONMENT.
What is

What is Fatality Review?

Fatality Review is an engaged, multidisciplinary community telling the story of each person's death in order to understand how and why the death occurred in order to take action to improve systems and prevent future deaths.

Two multidisciplinary teams, East River and West River comprised of:

- Forensic Pathologists
- DSS Child Protection
- Pediatricians
- Hospital staff (nurses, PA-Cs, NPs, Social Workers)
- Law enforcement (PD, Sheriff's Office, DCI, FBI, Tribal police)
- EMS
- Public Health
- States Attorney

CDR Process

Best Practices in Reviews

Case Review

- Guests from various law enforcement agencies present the case (ideal)
- Team members tell the story of the infant’s death from their agency's perspective.
- The team identifies systems issues
- The team identifies risk and protective factors in each case

What do we do with all this data anyway?

Effective fatality review teams work with partners in their states and communities to **share their findings**, **recommend solutions** that are known to be effective, and use their leadership to make sure their solutions are implemented.

Statewide Preventable Death Committee

- Newly formed; first official meeting was in March of 2021
- Plan is to meet at least annually
- Review data from CDR, MMR, and NVDR
- Discuss recommendations brought forth from death reviews and **implement strategies**

BRONZE REQUIREMENTS

- **Develop a safe sleep policy statement** incorporating the AAP's Infant Safe Sleep guidelines.
- **Train staff** on safe sleep guidelines, your hospital's safe sleep policy, and the importance of modeling safe sleep for parents.
- **Educate parents** on the importance of safe sleep practices, and implement these practices in the hospital setting.

SILVER REQUIREMENTS

- **Develop a safe sleep policy statement**
- **Train staff**
- **Educate parents**
- **Use or distribute wearable blankets** to model or educate no loose bedding in the crib.
- **Program Evaluation** via unit based Safe Sleep compliance audits.

GOLD REQUIREMENTS

- **Develop a safe sleep policy statement**
- **Train staff**
- **Educate parents**
- **Use or distribute wearable blankets**
- **Program Evaluation**
- **Provide community and media outreach** on safe sleep in your community.
- **Affiliation with or become a Cribs for Kids® partner** to provide a safety-approved sleep alternative to at risk parents in your hospital.

SAFE SLEEP. EVERY SLEEP.

From 2016 - 2020

73% of sleep-related **infant deaths** in SD were potentially **preventable**

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