A Statewide Safe Sleep Survey of Massachusetts Birthing Hospitals

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June 24th, 2015
What we know....

SUID is the leading cause of death among infants 1-11 months of age.

• In 2012, 30% (N=28) of all MA deaths in this age group were due to SUID

Source: Registry of Vital Records and Statistics, MDPH
Sudden Unexpected Infant Deaths, MA Infants 2008-2012

Year | Number of Deaths
--- | ---
2008 | 38
2009 | 49
2010 | 41
2011 | 31
2012 | 33

Source: Registry of Vital Records and Statistics, MDPH
Average Annual Rate of Sudden Unexpected Infant Death* by Selected Race/Ethnicity, MA Residents <1 Year, 2008-2012

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rate per 100,000 infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black non-Hispanic</td>
<td>110.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>68.5</td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>42.9</td>
</tr>
</tbody>
</table>

Source: Registry of Vital Statistics, MDPH.

*SUID includes: SIDS, unintentional suffocation in bed, and undetermined causes

Rates not displayed for racial and ethnic groups where count <5
MA Birthing Hospital Survey & Results
Survey of MA Maternity Facilities

★ MDPH and MA Perinatal Team collaboration

★ Maternity facilities are natural resource for newborn parent education about safe sleep

★ Purpose of survey was to document:
  - Current practices and policies
  - Input on how MDPH can assist facilities
Methods

- MDPH contracted with Harvard School of Public Health’s Injury Control Research Center (HICRC) to survey facilities
- Ad hoc committee and many advisors provided input on items
- MA Perinatal Team provided contact info
- Online survey via Qualtrics software administered April – September 2013
Participation

- 47 maternity hospitals and 2 birthing centers invited to participate
- Paul Muzhuthett of MA Perinatal Team sent invitation and multiple reminders
- HICRC contacted remaining non-responders personally
- 100% RESPONSE RATE
Limitations

- Survey was self-report, not based on objective observation
- Actual content of hospital written policies was not reviewed
- Policies do not always reflect practice
Results: Safe Sleep Policy

Half of the birthing hospitals had a written infant “safe sleep” policy.

Within their safe sleep policies:
- “Back Only” sleep was the most common component (95%)
- Exclusion of soft crib items (82%)
- Avoidance of general co-bedding (82%)
- Co-bedding multiples (68%)
- Encouraging co-rooming (68%)
- Avoidance of overheating (77%)

Twenty-six percent had a written policy with all six components
Results: Patient Education

100% of the nursing staff review a discharge document with each newborn mother.

98% of the discharge documentation have listed safe sleep recommendations.
Birthing Hospital Safe Sleep Report

★ MDPH’s Safe Sleep website:
www.mass.gov/safesleep

- Located under “Publications and Reports”
Where we are today?

★ Birthing Hospitals
  - Developed safe sleep programs
  - NICUs

★ Hospital Forum – June, 2014
  - 2nd Forum - 2015

★ Developing a model policy for birthing hospitals

★ Training/Presentations
Ad Hoc Advisory

★ MDPH
- Deborah Clapp
- Justine Egan
- Holly Hackman
- Jeanne Hathaway
- Ruth Karacek
- Lisa McCarthy-Licorish
- Paul Muzhuthett
- Carlene Pavlos
- Lauren Smith

• HSPH
  - Ruth Aga
  - Catherine Barber
  - David Hemenway
  - Christelle Salomon

• Hospitals
  - MA Perinatal Team
  - Lisa Alee
Thanks Also to

★ Respondents at MA maternity facilities
★ Dr. Munish Gupta
★ Dr. Susan Hwang
★ Charlene Torrisi
★ Becky Sarah
★ Mary McClain

• MA Perinatal Advisory Committee
• Funding by:
  • CDC National Center for Injury Prevention and Control
Thank You

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