

Oregon Child Welfare Safe Sleep Efforts

Child Fatality Prevention and Review Program

Goal: Eliminating preventable sleep related infant death by ensuring:

- 1) Oregon families with infants are supported through education, tools, and consistent messaging regarding safe sleep practices; and
- 2) Family serving professionals, including child welfare professionals, have the skills and tools to engage families in safe sleep conversations that elevate them as experts in their infant's health.

Inputs	Activities		Outcomes		
What Oregon Child Welfare invests	What Oregon Child Welfare does	Who Oregon Child Welfare reaches	Why this project: short-term results	Why this project: intermediate results	Why this project: long-term results
<ul style="list-style-type: none"> • Child Welfare Professionals • Technical Assistance • Maintenance • Data Tracking/ Measuring Outcomes • Commitment • Time • Continuous learning/research • Funding • Technology • Materials • Equipment • Leadership support • Relationship building/Community engagement • Evidence Based Practices 	<ul style="list-style-type: none"> • Collaborate with and learn from family serving professionals • Community led prevention • Purchase and distribute Safe Sleep kits as needed • Develop audience specific safe sleep trainings • Facilitate access to current information • Maintain ODHS CW rule, policy, procedure, forms, and OR-Kids • Maintain and promote use of Safe Sleep Checklist • Maintain website and other online resources • Create opportunities to develop, enhance, and maintain the skills of family serving professionals • Use a culturally responsive, strength focused, harm reduction model that recognizes impacts of trauma • Utilize data to focus efforts on disproportionately impacted families • Apply equity tool early and throughout 	<ul style="list-style-type: none"> • Families with infants • Family Serving Professionals, including Child Welfare Professionals • Resource families • Alternative caregivers of infants • Communities disproportionality impacted by sleep related infant death • Tribal partners • Family serving organizations and bodies that specifically serve African American/Black and Native American/Alaska Native Communities • Legislature • Oregon Medical Board • Oregon Nursing Board • Hospitals • Oregon Hospital and Health Systems Association • Public Health 	<ul style="list-style-type: none"> • Family serving professionals will: <ul style="list-style-type: none"> ○ enhance their knowledge about safe sleep practices ○ develop or improve skills to engage families in discussion about safe sleep ○ improve their ability to identify safe sleep risk factors and protective factors • Increase in community awareness about safe sleep practices • Communities begin to learn where and how to reach out for Safe Sleep resources and supports 	<ul style="list-style-type: none"> • Oregon family serving systems provide consistent safe sleep messaging to families with infants • Reduce disparities in sleep related infant death among African American/Black and Native American/Alaska Native Communities • Increase in number of child welfare cases with an infant where safe sleep checklist is completed • Safe sleep plans are developed prenatally with every pregnant parent engaged in Nurture Oregon pilot • Safe Sleep Kits are provided to Nurture Oregon participants without equipment necessary to implement safe sleep practices • Safe Sleep is a part of every plan of care when child welfare and/or Nurture Oregon is involved 	<ul style="list-style-type: none"> • Eliminate infant fatalities where circumstances involved high risk sleep practices • Eliminate disparities in sleep related infant death among African American/Black and Native American/Alaska Native Communities • Oregon families have access to materials and resources necessary to utilize safe sleep environments • Oregon families with infants consistently adopt safe sleep practices • Oregon families with infants self-report receiving consistent safe sleep messaging across family serving systems • Child welfare caseworkers have additional safe sleep conversations with families beyond the initial contact
<p style="text-align: center;">Assumptions</p> <ul style="list-style-type: none"> • AAP Safe Sleep practice recommendations are evidence based • Safe sleep practices reduce SUID/SIDS • Safe sleep practices are not discussed at the level they need to be effective • Family engagement skills regarding safe sleep education vary among professionals • Safe Sleep resources are not equally accessible to all Oregonians • Messaging about safe sleep is inconsistent • African American/Black and Native American/Alaska Native Communities are disproportionately impacted by sleep related infant death 			<p style="text-align: center;">External Factors</p> <ul style="list-style-type: none"> • (+/-) Cultural/generational beliefs/practices around infant sleep • (+/-) Professional's own beliefs/experiences with safe sleep • (+/-) Family of infant's support system • (+/-) Funding • (+) Cross system buy in • (-) Workload impacting engagement • (-) Turnover • (-) Caregiver substance/medication use 		