<table>
<thead>
<tr>
<th><strong>Order</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client</strong></td>
</tr>
<tr>
<td><strong>Title</strong></td>
</tr>
<tr>
<td><strong>Presenter</strong></td>
</tr>
</tbody>
</table>
Marsha Presley: Okay, everybody. Welcome to the CGHS research webinars. Today we're going to be hearing from Debbie Raines. She's an adjunct faculty with our Health Education programs, and she joined CGHS just this last July. She's a nurse with a doctorate in administration and information systems from Virginia Commonwealth University, Medical College of Virginia and a master's degree from the University of Pennsylvania and a bachelor's degree from Syracuse University. Also, she earned her EDS in educational technology from Walden University.

Debbie was elected as a distinguished practitioner in the National Academy of Practice and is a fellow in the Academy of Nursing Education and the American Academy of Nursing. Debbie is a nurse specialist with a focus on perinatal care and family education. She is a contributing editor for Neonatal Network, The Journal of Neonatal Nursing with a focus on evidence-based practice and mother-baby care. In addition to teaching, she is a researcher at the Sisters of Charity Hospital. With that, Debbie, I'm going to mute myself and turn it over to you.

Debbie Raines: Okay. Great. Thank you. Thank you everyone for coming today, and I'm pleased to have this opportunity to share some of my work with you. This presentation's called Format Matters. It's really looking at something that as health educators and healthcare practitioners we do all the time, which is educate patients, but we don't have a whole lot of real good data about what happens to all that wonderful education that we give to people. Every research study begins with a story. I'm teaching the qualitative course right now and this week's discussion was how do you come with your project.

I actually just this morning read somebody's that used Halloween as the metaphor about why do people decorate for Halloween when Halloween's really targeted at the kids that go trick or treating. I thought I'd give you a little bit of the background of the story that led to this research study because it really does have sort of a history all of its own. In 2010, the American Academy of Pediatrics came out with their Back to Sleep guidelines with the goal of preventing SIDS or Sudden Infant Death Syndrome.

These guidelines said that babies should sleep on their back, which for those of us who had been practicing in maternal newborn settings and even for many parents were shocking because we had always said babies needed to sleep on their tummy or on their side. The rationale was if they spit up, it would come out of their mouth and they wouldn't choke on it.

Well, we found out or the American Academy of Pediatrics found out actually that there were lots of other dangers to sleeping on your back, including that you were more likely or the baby was more likely to aspirate anything in its mouth when it's laying on its tummy because of the way the anatomy in the
airway changes. Those were the new guidelines. The hospital where I work, Sisters of Charity, is a hospital that used to have a Diploma Nursing Program well into the early 1980s.

Debbie Raines: They have many nurses on their staff, which shocked me when I first came to Buffalo a couple years ago, that have worked in that same hospital for 30 and 40 years. They were taught to put babies on their back. They've mostly raised their own children, putting their babies on their back or on their stomach, sorry, but all of a sudden we were supposed to change. Then we noticed this plethora of headlines in the news about parents rolling over on their babies while sleeping in bed with them, a dad whose baby suffocated while the baby was sleeping on the father's chest.

The one that really caught our attention was from January of 2013. Six infants died during January deep freeze and that was in the Buffalo News, which is where I'm located. That particular January was bitterly cold. I don't think there were five days that got above 10 degrees that entire month, so everybody was trying to figure out how to keep yourself warm. What many parents did was they either put the baby in their bed between themselves and their partner thinking that body heat and the heavy blankets on the adult bed would keep them warm or they put adult blankets in the baby's crib to cover them up.

Well, the reality is young children don't have the neck strength and the head strength to move their head away. If you or I are laying in bed and the sheets get pulled up or the blankets get pulled up that they're obstructing our nose, we move our head. We take our hand and swat the blanket down, those sorts of things. An infant can't do that. When that happens to a baby, the carbon dioxide builds up. The baby begins to breathe that. They get depressed. That knocks out their drive to breathe and they eventually suffocate.

We were real concerned about this and said, "You know, we have to do something. It's our responsibility sending these babies home that they're safe." Three of the nurses on the unit came to me and said, "You know, we need a teaching program." We worked together and developed an evidence-based teaching program, and we looked at all the literature, came up with guidelines, and the program was basically role modeling in the hospital and then an information sheet that the parents received when they went home. This is the sheet. We kept it short, concise, to the point. Two sides of a single sheet of paper so they could find everything.

This picture, the more I look at it, I've done various presentations throughout time with this, really bothers me because this mother looks like she's half looking at that sheet and half marveling in the fact that she's got this wonderful new little person in her arms. I remember back when I was a new nurse. One of my preceptors in the hospital said to me, "Never let a mom look at her baby while you're trying to teach her something, even if it meant that you put the crib behind you and stood between her and the baby's crib because she won't pay
attention to you if she’s got that baby in her line of vision." That’s exactly what’s going on here.

Debbie Raines: The mom’s much more interested, and this is even a posed picture, so this woman knew that we were taking this picture for the purpose of using it. The other thing that happens and for any of you that have ever had children of your own, by the time you take that newborn home, you have piles of information sheets and pamphlets and books and lots and lots of advice that you have been given by family and friends and even those strangers on the street who think they can walk up to pregnant women and tell them how to have their baby and how to raise their children just because. One of the things that we were wondering is what happens?

These moms seem to understand when they leave us that it’s like they get to the front door of the hospital at the moment of discharge and something goes pop and all the knowledge leaves their body. We do a small little quality improvement study. We actually called moms three days after discharge and we asked them where their baby was sleeping. Did it sleep in a crib? Were there toys and blankets in the crib? Were they ever sleeping in an adult bed? Did they sleep on their back? These numbers look pretty good that most moms were doing what they had been taught to do.

However, this data was collected by an undergraduate student who was working with me at the time and because she wasn’t a licensed nurse, she needed to sit in my office while she did these interviews. Fortunately for the purpose of this study, she was a chatty young lady who developed relationships with these moms on the phone. The numbers really are not a true picture, I don’t believe, of what was going on in the home. For example, there was one mom. She called and one of the first questions in the interview guide was is this a good time to talk and the mom said, “Well, actually not. I’m just about to feed the baby. Could you call me back in an hour?”

The student said, ”Sure. No problem.” She waited an hour, called her back, no answer. We thought, ”Well, this lady just doesn’t want to talk to us.” About 10 minutes later, the phone rings. It’s that lady. She never fed her baby. They laid on the couch and fell asleep together. What woke her up was when the phone rang an hour later. Even though this woman told us that her baby always sleeps in its crib, which was true when she puts the baby down to sleep, she had in fact just spent an hour sleeping on the sofa with the baby in her arms. Again we got back to that. What happens?

We’re teaching them, we have data that I don’t have on the slides that the day they walked out of the hospital they knew all the right answers, but they don’t do the right thing when they get home. There’s also data from the Center for Disease Control that looks at babies dying from suffocation and strangulation. 85% of all deaths that occur in the first six months of life are related to accidental suffocation and strangulation. I mentioned at the beginning that the
Academy of Pediatrics Initiative was to decrease SIDS death and it in fact has done that. There's been a dramatic decrease, but the overall number of infant deaths during sleep have actually gone up.

Debbie Raines: It's because babies are suffocating and strangulating related to things in their crib and the position that they're placed in. As I talked about earlier, that they can't move the blankets off their face or change their position easily to get air. We were left with another question, what's going on? Why does knowledge that they have as they leave the hospital not actually being put into practice in their homes? What's happening? We did another small study, factors influencing parent's adherence to safe sleep guidelines.

We called moms 10 days after discharge and asked them about their baby's sleep and who they had gotten advice from other than the doctors and nurses and midwives who had cared for them. Grandma was the big culprit because grandma ... We tell mothers, "Go home and get people to help you. Have your mom come in. Have your mother-in-law come in. Have your aunts and your sisters and whoever. You need help with this baby because you need sleep," and all that stuff. Grandmas come in and grandmas have good intentions and I don't want to sound like I'm putting down grandmas at this point, but guess what? When these grandmas had their babies, they were told to put their babies on their tummies to sleep, to put the baby under a nice warm blanket when it was cold outside. All the things that we're now saying don't do. Grandmas were a big influence. The other thing that some mothers said to us is by 10 days they're exhausted. They've got a baby who's not sleeping at night. If they're breastfeeding or had an episiotomy or have any physical discomforts related to the birth process, those are still all in play. As one woman said to us, "I just can't argue with my mother-in-law. It just wasn't worth it."

If her mother-in-law or the baby's grandma said, "Do this," she was doing it. The other thing that came out in that study was all the images and the things that are advertised and marketed for new parents. You should have a crib that looks like this picture in the slide with the nice bumpers and all the toys for the baby to look at and pretty blankets and so forth. In fact, every one of those things in that crib, with the exception of the baby, is a hazard for that baby suffocating and strangulating during its sleep. The crib needs to be empty.

Crib bumpers are probably one of the worst things because kids somehow get themselves scrunched up in the corner with their nose into the bumpers and then they can't breathe. They have much lesser chance of hitting their head on the side of the crib than they do of suffocating in the crib bumper. Now we had some information that parents knew, but they weren't able to do it because there were all these other influences. We thought about how do we deal with this. We know that these moms are overwhelmed with the amount of stuff they get to take home that has educational information on it.
Debbie Raines: We also know that the generation that is currently having babies, those people in their 20s and 30s, are not real big on reading. They're the generation that grew up with the internet. I had an experience about 10 years ago. I was implementing a freshmen reading program at the university where I was working at the time. We went to orientation sessions, as the new freshmen and their parents were standing in lines for various things and we'd be trying to market and promote our freshmen reading program.

I remember, and it wasn't just one, there were a handful of them, parents who said to us, "Oh, my child doesn't like to read, so they'll never read the book." I think to myself, "Then why are you paying tuition to send them to college?" This is not a generation that grew up reading everything to get information. We wanted to help develop something that would be appropriate to how these people seek information and also something that they could share with other people in their homes.

Because when we would say to moms in our two previous small studies, "Did you show your mother-in-law or did you show grandma the information sheet," they'd be like, "Yeah, it's in that pile of stuff or my husband put everything in a bag when we left the hospital and I haven't had time to sort it out yet." I get that when they have a new baby in the home. So how could we overcome that problem? We made a video. It's a two minute video. I'm not going to show it to you here, but if anybody wants to see it, I'd be glad to share the link. It's a two minute video that says how your baby should be sleeping.

We tell them why because the biggest thing we heard was that grandma said the baby's going to choke if you put him on his back. We have the images in here that show the changes in the airway and that it really is safer for the baby to be on their back, not their tummy. We made this video. It's available on the hospital website. The nurses as part of the discharge process help patients download it to either their laptop, their smartphone, whatever device they would like it on, as many devices. We encourage them to take this and then show it to those people.

When grandma says, "Put him on his tummy," the mom can just say, "Hey, mom look," as people walk around with their smartphones all the time will do. They can just click it. It's two minutes. It's short. It's to the point and it's like, "Oh, I didn't know that." I've actually run into the grandparents of people ... Not people that were in our study, but other people who said, "I never knew that the guidelines had changed." It's a way for the parents to then educate other people who are caring for their baby, which gets us to the current study of does format matter.

We know from the literature that the majority of patient education materials are written well above the reading level of most patients. This is very true in a parenting setting with new parents. I happen to be at a Catholic-based hospital. They will give care to anybody. We get the 14 and 15 year olds. Buffalo has a
A fair number of refugees and immigrants who can't get care from some of our for-profit hospitals in the city because they don't have insurance. They can come to Catholic health and we will take care of them. We have a wide range. The other issue is language barriers.

Debbie Raines: A lot of our refugee and immigrant patients do not speak English, so to hand them a handout that's written in English doesn't do them a whole lot of good. There's also data that Americans express a preference for getting news on a screen as opposed to a paper source and only two in 10 adults get news from print sources. When we ask patients, "Where do you go when you need to look something up," they don't go to something that's on paper. They go to the internet and they google it. Among adults 18 to 64, the internet is the most common source to access health information.

Using all these things, the idea for creating a video really started to take on some credibility and some significance. The purpose of this particular study was to determine new mother's preferences for format of their educational materials. We asked them what format do you like and then we also did a comparison of the paper-based teaching and the video teaching in terms of the understandability, the helpfulness and the attention keeping qualities of the different modalities. It was a descriptive cohort study. Our first cohort was collected ... The data was collected between July and October 2015 and the second cohort was July to October 2016.

First cohort was the paper teaching. The second was the video teaching. We did them separately so that we didn't have any risk of contamination or somebody getting a little bit of one and a little bit of the other. Some people look at this and say, "Well, why didn't you just keep going after October?" Well, remember I said we were in Buffalo and July to October in Buffalo looks something like this. But if we had continued the data collection and done the second cohort November to February, it looks something like this. These different weathering conditions do influence how people sleep in Buffalo. I can tell you myself.

As it's gotten cold this week, the blankets come out, the thick comforters, all those of kind things, and same thing if you have a newborn in the home. We wanted to keep the weather as not an influencing factor, so we chose to wait and do it July to August on two consecutive years. It also gave us a chance to make a complete changeover in the way the nurses were approaching and delivering the teaching and the materials to the patient. Our sample obviously were new mothers. Some people say, "Well, what about the fathers?"

Well, fathers are not always consistently involved both in the family life, as well as in the discharge teaching. Just for the purposes of having a consistent sample, we limited this to mothers. We looked at them within 24 hours of discharge so that we had mothers who had completed the in hospital teaching process, and the mother had to be going home with her newborn. If the baby was in the intensive care unit, was having a delayed discharge for any kind of
reason, then that patient was not included in the study. Our demographics are pretty typical of the new parenting population.

Debbie Raines: Moms ranged in the age from 17 to 46. Because women when they have a baby are considered emancipated minors, that's how the 17 year olds got into the sample. Some people look at that and say, "How'd you do research without people being 18?" It's because they gave birth and it's in their mothering role. One thing we thought in the demographics that might make a difference was how many other children a mother had. A first time mom obviously is much more inexperienced than somebody who's having her fourth, fifth or sixth child. We measured that. In cohort one, 54% of them were first time mothers. Oops, sorry.

There's a typo. That's cohort two is 53% of the mothers were first time and statistically that makes the two cohorts similar. The procedure was they were visited in the hospital prior to discharge. The data collection verified that they had received the teaching from the nurses. Measured those two demographic variables of age and whether it was their first baby or subsequent, and then the four specific research items, which looked at attributes related to the format and what was their preferred format. We actually asked them about preferred format first so that it wasn't influenced by anything else that would take place during the data collection.

Analysis was descriptive statistics by the cohort to get the demographics to make sure our cohorts were equivalent and then ANOVA to compare the cohorts. Here are the findings of the attributes of the different teaching materials. The first cohort, which received the paper materials and everything is in the 3.5 to 3.85 range. This was a five point scale with five being graded was easily understandable, very helpful and it kept my attention the whole time. They're sort of just above the midpoint. The second cohort, which received the video teaching, had much higher scores for all three of these aspects.

The scores are statistically significantly different if you look at the F statistics at a p of .00. There was a difference. These were not the same people looking at two different things. These were two different cohorts just evaluating them and that's an important differentiation to make. The question that was really interesting was how do you prefer to receive information about parenting skills. In both cohorts, technology, internet-based material was the preference. It was even higher in the moms who received the paper-based teaching from us. Over 61% of the combined two cohorts wanted stuff on the internet or internet-based.

Paper and brochures were the next most common with 29 people in the first cohort, 30 in the second cohort. Then group classes were preferred by a few and other were those people who wanted some combination of these things. Some of them wanted it on the internet, but they also wanted a handout or they wanted a group class that was recorded so they could watch it later or that
sort of thing. A couple of them came up with completely other things that they wanted, but that was a very small part.

Debbie Raines: I think the important part of this is that over 60% of these mothers wanted something that was internet-based or technology-based as opposed to the paper and other kinds of things that we traditionally use. If you'd walk through most healthcare facilities, especially the traditional acute care hospitals, lots of our stuff is on paper. There's some changes out in the community. If you ever go to those like urgent care centers, they usually have TV screens that are playing some kind of video or internet health information. Most of what we give to individual people is a piece of paper or a booklet. Some of the conclusions from this:

Patient education methods need to be consistent with the way people are learning and accessing information. If people are not reading things, then we need to take a second look at whether or not handing them a handout is the best way to do it. Technology-based materials offer the opportunity for patients to take discharge instructions with them and to see the behavior in live action. If you've ever been a patient of any sort in a hospital with something done and especially as our insurance guidelines have made hospital stay shorter and shorter, you get a whole lot of information in a really short period of time.

Even some of the best patients go home and can't remember what somebody told them. If they can go back and rewatch the teaching about newborn sleep or whatever their condition is, it may be helpful to them. The video also allows these new parents to become advocates for their newborn's well-being because they can share this material with other caregivers who will be putting their babies to sleep. Starting off with those family members who are in the home, grandma, grandpa, Aunt Susie, whoever. But also, we've encouraged parents that if you put your baby in daycare when they turn six weeks old, make sure that those people in the daycare center know how to do it.

If they don't, pull out your phone and show them the video. We've been doing some work here in the community with some of the daycare centers that we've actually been going in and doing some in-service type education with their workers and the people who are actually interacting with these children about some safety things. Parents are ultimately the protectors of their newborn. Knowing that other care providers are using evidence-based practice is important to preventing these accidental deaths due to strangulation or suffocation during infant sleep.

Parents, even if they're not the ones who put the baby to sleep in a way that resulted in them suffocating or strangulating, still have enormous amounts of guilt that something happened to their baby even if it was in the care of another person. These are just the references for some of the data that I put in here. I just wanted to give credit to the Sisters Hospital Foundation actually gave us funding to produce the Safe Sleep Baby video. The research itself was supported.
by an agreement from the American Association of the Colleges of Nursing and the Centers for Disease Control on a population health grant that allowed us to do this research.

Debbie Raines: This actually is available in a head of print publication at the moment in clinical nursing research. Again if anybody wants that, I'd be glad to share it. Thank you and I guess if there's any questions.

Marsha: Thank you, Debbie. This is a very useful talk, very useful information. If anybody has any questions, feel free to unmute yourself and ask or you can use the chat if you would prefer that.

Josh Bernstein: Hi, Debbie. Josh Bernstein. Really enjoyed your presentation. Reminds me this is one more subject I know very little about. I'm a born skeptic, but I'm also kind of a conditioned skeptic. I place a little bit of the blame there on just the healthcare industry in general. I used to have a friend who's an orthopedic surgeon. He said, "Half of everything we're doing right now is wrong and we just don't know it yet." I believe that that is true. I believe it translates to other fields. This reminds me of what I'm supposed to eat. I'm told that butter's bad and I've grew up half my life thinking butter's bad and then now I'm told butter's good.

Then I'm told sugar's bad and eat sugar-free stuff and I grew up part of my life avoiding sugar. Now I'm told real sugar is good because the artificial sugars are bad. Long story short, I'm told that babies should sleep on their belly and now I'm told babies should sleep on their back. This is not for me. This is for other people. Do you think that there's a level of skepticism or I hate to use the word mistrust, but I'm struggling to quote the right word, that's out there that when a person like myself or you or someone who's an expert in their field says, "This is what you need to do," that they are immediately skeptical?

Debbie Raines: Yes, but I think that we and I'm thinking of nurses in particular, but anybody who's educating patients have a responsibility to do more than say, "This is what you need to do." I can't walk into you and say, "Okay, Josh, your baby now needs to sleep on its back. I don't care what anybody else tells you. I'm the nurse. I'm telling you that. Do it," because you're going to be skeptical and you're probably going to say, "Who in the world does she think she is?" But I think that when we go through the information about why it's better, I mean I've had grandparents ... It was actually at a celebration of nursing thing and their kid was getting an award.

Their adult kid who's a nurse was getting an award. The two parents came over to me after we had unveiled ... We had sort of a premiere of our video at that event. They said, "You know, I never knew that and that was really interesting about the airway," because all of a sudden that caught their attention that something that we had been telling people and had been doing was different. We had a picture that showed them how it worked differently.
That particular woman, she was a mom of seven grown children herself and one of those children had just recently had a baby, and she's like, "Can I have a link to that so I can go home and show it to my daughter who had the baby?" It's like, "Sure. We can get you a link." I think it's more than just telling people what to do. It's telling them what to do and explaining why that needs to be done. I think there's lots of things. You mentioned your orthopedic surgeon friend. I was just analyzing data last night that looks at using rocking chairs after knee replacement surgery.

Our data has a significant decrease in the number of blood clots in people's legs when they use a rocking chair as opposed to when they lay in bed with what's called a continuous passive motion machine that bends the knee for them. I think that looking at some more not really natural, but less technology oriented interventions sometimes has real purpose.

Josh Bernstein: Real quick, just out of personal curiosity, and I realize that this is not something that is new this year or last year. This isn't made recent. This was new in 2010 or 12, the guideline?

Debbie Raines: Yeah. The first guideline came out in 2010.

Josh Bernstein: There you go. Around that time period, just out of personal curiosity, were you met with any kind of resistance or backlash? Because I can picture the person saying, "Are you kidding me? I've been doing it the wrong way for years with my other children?" Do you see what I'm saying?

Debbie Raines: Oh, yeah. I mean I'll tell you myself because I've been around long enough that when I went to nursing school and when I started practicing, babies laid on their tummy. End of discussion. All of a sudden to flip them over on their back, it was like, I can't do this. I'd stand there staring at these kids like I expect them to vomit any minute and choke and turn blue and all those sorts of things. Yeah, there was. Part of the lag in the implementation of this community acceptance was that nurses weren't accepting it, providers weren't accepting it.

There's a study in the medical literature that pediatricians were not teaching mothers this because they didn't believe it, because they have been trained and educated and practicing for years the other way. It's like, "Uh-uh. This isn't right," even though it was their professional organization that changed the guidelines.

Josh Bernstein: I'm sorry. That's funny. This is a serious issue, but sometimes I just have to laugh. We create our own skepticism.

Debbie Raines: Mm-hmm (affirmative).

Josh Bernstein: I guess patient education the right way as you suggested is the key.
Debbie Raines: Well, yeah. I think the more important message out of this and we're talking about it at the hospital, we need to make more videos for more different things. It's not this topic that's so important. I mean it's important to me because these are the patients I take care of and I really do care about newborn babies, but the person who's going home with congestive heart failure. I could tell you a list of stories where a nurse tells somebody with congestive heart failure, "Go home and weigh yourself every day," but they never ask, "Do you have a scale? Can you see well enough to read the numbers that are down at your toes?"

One of my favorite stories was when I was in Virginia and Virginia has some very rural areas. For major medical things, you have to come into Richmond and be cared for at the hospital there. They had a family who came from way out in the middle of rural, rural Virginia where there's not even a stoplight in the town. The person was going home with some wound care and they taught the person and his wife who had come in and who was just the perfect wife to take care of him that you needed to take this equipment, put it in the top rack of your dishwasher and run the dishwasher with hot water. The family all sat there and said, "Yes. Yes, we understand."

They gave the teach back talk to the nurse who was doing it and so forth, and they left with this glowing review. They were so well-taught. They knew everything they had to do. Well, they go home. The home care nurse goes out there and finds the wife standing outside over an open fire boiling a pot of water and dipping the stuff in the pot of water. These people not only didn't have a dishwasher, they didn't have running water in their home, but nobody asked that question because in the city of Richmond, we have running water and most of us have dishwashers. It comes back to we can't just ...

Healthcare went through something back in the late '80s, maybe early '90s that everything had to be documented. We got so standardized that you did this little checklist and you checked everything off. The person's telling that you told them everything, but we never looked at did they learn anything, were they able to do it, did they have the resources to do it. I mean that's the next step that we're looking at in terms of this research and where does this go next.

Josh Bernstein: Reading between the lines, Debbie, yes, I have running water. I feel like that was the question you were trying to ask me not being answered.

Debbie Raines: Thank you. I'm glad you do.

Josh Bernstein: There's the margin.

Dilo Kponi: Thank you, Debbie. A quick question. My name is Kponi. I like to know when you said you guys discharge and they discharged a baby, right? I like to know is there any way they perform some sort of screening test before they discharge them?

Debbie Raines: Screening test for what?
Dilo Kponi: Screen like to check the thyroid levels and make sure the babies were fine before they're discharged?

Debbie Raines: Yes. Yeah. There's a number of screening tests. They're mandated by the state, and it varies a little bit state to state. We do what's called a metabolic screening test in New York State and most states do some sort of metabolic screening. Exactly what's in it varies. You do that. All children need to have a hearing screen before they leave the hospital. They have what's called a cardiac screen where it's a kind of quick way to determine whether or not the child may have a congenital heart disease that doesn't present immediately at birth with cardiac and respiratory complications.

Dilo Kponi: Thank you.

Debbie Raines: Mm-hmm (affirmative).

Marsha: We've got a question from Kathleen that says, "Didn't the Back To Sleep campaign start in the 1990s? I'm wondering why it took so long for the guidelines to change?"

Debbie Raines: It was talked about earlier, but the official guidelines came out in 2010 and were actually updated in 2015 I believe it was. There had been talk for a good decade and a half before we actually changed them that maybe babies were getting their noses stuck in the mattress and the sheets and those sorts of things and breathing in the CO₂, which was causing problems, but the definitive guidelines did not come out until later.

Marsha: Does anyone else have any questions? Anybody? Okay. I'm starting to get thank you's in the chat. All right. Well, I think that nobody has any questions, so I think we're done. Debbie, thank you so much. This is a very informative talk and very good, well presented. We appreciate it.

Debbie Raines: Great. Thanks for the opportunity.

Marsha: Thank you.

Josh Bernstein: Thanks, Debbie. We appreciate it.

Dilo Kponi: Thanks a bunch.