

A model for outpatient lactation care

Introduction

Exclusive breastfeeding has the single largest potential to decrease child mortality of any other preventative measure.¹ In their 2012 Policy Statement on Breastfeeding and the Use of Human Milk, the American Academy of Pediatrics re-emphasized breastfeeding as an important public health initiative.² Many women struggle to obtain their breastfeeding goals. Perrine et al.,³ found that among women who prenatally intended to exclusively breastfeed, only 32.4% achieved their breastfeeding intention.³

Women typically experience these struggles in the early postpartum period when routine checkups with their pediatric provider are most frequent. Studies show that women are more likely to stop breastfeeding in the first month, when they experience such problems as sore nipples, perceived insufficient milk production, and infant feeding difficulties.^{4,5} Women reporting these breastfeeding concerns were at increased risk of using formula and giving up breastfeeding than women without these concerns. Many of these problems could easily be addressed during routine pediatric visits, as these visits typically correspond with the dates most breastfeeding women report breastfeeding concerns.⁵ The 2011 US Surgeon General's Call to Action to Support Breastfeeding specifically states that breastfeeding assistance should be routinely integrated into the practice setting.⁶

Obstetric, pediatric, and family-practice care providers are often in a time crunch to see as many patients as possible, and breastfeeding education as well as management of breastfeeding problems is time and labor intensive. Providers in these scenarios are significantly hindered from providing such care. In addition, these care providers typically lack the education and training to deal with breastfeeding issues.⁷

A lactation consultant in or near the pediatric office to provide lactation care can help women overcome breastfeeding difficulties and thereby increase the duration of breastfeeding.⁴ There should be a *zero zone of separation* between breastfeeding support staff and the breastfeeding dyad, with easily accessed and readily available lactation services at all times. Ensuring access to lactation consultants is an action step in the Surgeon General's call to action to support breastfeeding⁶ and under the Affordable Care Act, private insurers must cover professional breastfeeding support without cost-sharing.⁸

A plan for outpatient lactation care

Healthcare follow-up for mothers and babies should include *well breastfeeding care*. This term is borrowed from what we call regular newborn follow up appointments: "well baby care." The concept is similar in design: have routine breastfeeding check-ups at regular intervals, as is done for well-baby care. This model is also followed in prenatal care: women have routine check-ups at regular intervals to prevent problems, provide education, assure wellbeing and diagnose any abnormalities, rather than only seeking care when some pregnancy-related catastrophe occurs. Two recent clinical trials demonstrated that integrating contacts with an IBCLC into routine care increased breastfeeding intensity at 3months postpartum.^{9,10} Corriveau et al.,¹¹ found a statistically significant increase of at least 10% in exclusive breastfeeding rates when on-site lactation support was provided for all

Volume 2 Issue 2 - 2016

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Received: May 15, 2016 | **Published:** May 26, 2016

nursing mothers during their routine pediatric visits.¹¹

It is much easier, cheaper, and healthier to prevent problems than to fix them. In *The Economic Benefits of Breastfeeding*, Jon Weimer examined the potential cost savings for breastfed infants if the Surgeon General's recommended breastfeeding rates were realized. His analysis concluded that a minimum of \$3.6billion would be saved annually. Cost savings included direct costs, such as formula, medical care, hospitalization, and laboratory fees, and indirect costs such as loss of wages by parents attending to their sick child. This figure only represents estimated cost savings for the treatment of just three childhood illnesses (otitis media, gastroenteritis, and necrotizing enterocolitis) and as such is probably grossly underestimated.¹² In a comprehensive review examining costs to treat four diseases if infants were not breastfed, diarrhea, respiratory syncytial virus, insulin-dependent diabetes mellitus, and otitis media, Riordan estimated a range of \$1.1 to \$1.32 billion of extra health-care costs each year for not breastfeeding.¹³ Intangible benefits for breastfed babies include better vision,¹⁴ less need for braces, and fewer cavities.¹⁵

Ideally, lactation care for all women should begin during the first trimester of pregnancy.¹⁶ Women who receive prenatal education, postpartum visits, and telephone contacts with a lactation consultant are more likely to breastfeed through week 20 and at a higher breastfeeding intensity.⁴ After delivery, instead of just episodic care when a problem occurs, breastfeeding support would be provided continuously. The lactation consultant would work with the mother to eliminate barriers to breastfeeding, provide education, prevent problems, and enhance the mother's confidence. Lactation care would then continue until the time of weaning.¹⁶ There are areas where this model is in practice: a study out of a busy pediatric practice in Virginia demonstrated a significant increase in exclusive breastfeeding rates when breastfeeding education was given prenatally and routine lactation care was provided during pediatric *follow up*.¹¹ Another clinic found increased breastfeeding rates, as well as decreased incidence of disease in children under one year of age, when their office staff was trained in basic breastfeeding support and implemented steps similar to the WHO's "Ten steps to successful breastfeeding".¹⁷

Breastfeeding is foundational to health; it affects the lifelong health of the individual physically, emotionally, and mentally, both for babies and mothers.¹⁸ It should therefore be foundational in healthcare and covered by healthcare premiums. Health care dollars are spent on treating diseases and conditions that could have been effectively prevented by breastfeeding. In order to appropriately

address this preventative health care gap and the excessive costs that result, consumers, health care providers, insurers and employers need to be able to access IBCLCs to provide services and protect quality of care.¹⁹

Breastfeeding also impacts long-term health through its role in preventing obesity. One of every 3 adults is obese, and almost 1 in 5 children. This problem is costing the health care system an estimated \$117 billion annually.¹⁹ Obesity is a condition that is very difficult to correct; health detriments have already set in by the time the person has become overweight. Breastfeeding has been shown to reduce childhood obesity.²⁰⁻²³ Helping women successfully breastfeed will not only reduce obesity but its associated morbidities and costs.

Routine lactation care is very cost-effective as well as cost saving. Breastfeeding reduces healthcare costs and is a wise healthcare investment. Breastfeeding is good for managed care: \$1.3 billion more is spent by insurers, including Medicaid, to cover sick-child office visits and prescriptions to treat the three most common illnesses—respiratory infections, otitis media, and diarrhea—in the first year of life for formula-fed infants versus breastfed infants. One study showed that increased access to IBCLCs resulted in greater continuation of breastfeeding and a \$149-per-delivery reduction in cost for planned hospital care, planned follow-up visits, and unplanned care costs.²⁴

Building breastfeeding education into prenatal office visits, and ongoing lactation care into postpartum and pediatric visits, would take care of the financial aspect by including its billing along with the office visit. There are billing codes in the International Classification of Diseases, Ninth Revision, Clinical Modification that are associated with infant feeding and can be submitted for insurance reimbursement for a paired encounter. This reimbursement occurs for follow up lactation visits with routine well-baby checkups, and when needed for problems, is coupled with a medical exam and then billed to insurance.¹¹

Women in today's society largely lack a model for breastfeeding. There isn't the cohesiveness of the larger family unit that is more typical in other societies, where younger women view relatives breastfeeding, and see breastfeeding as a normal part of life. Information regarding breastfeeding isn't routinely shared by obstetric care providers during prenatal visits for any number of reasons. Providers may be limited due to time constraints or a lack of knowledge regarding breastfeeding.²⁵ In addition, it may not be considered a priority by the obstetric care provider, or the provider may assume that women already have basic breastfeeding knowledge.

Integral to this model of care is the expanded view of the IBCLC as a healthcare professional and a member of the healthcare team. The IBCLC is part of a collaborative team, with knowledge and skill to contribute as a viable, trusted, and valuable resource to healthcare in disease prevention, health maintenance, and as a consultant in her field of expertise. In this model, lactation care would become a regular part of an individual's healthcare.

Barriers

Barriers to this model of readily available lactation consultant contact include space, time, and money. Lactation care should be local and easily accessible. The United States Lactation Consultant Association states, "a family with breastfeeding issues needs access to lactation support locally and quickly with minimal effort".¹⁹ Patients should have access to lactation support any time they have

needs on an ongoing basis. People pay high premiums for their health insurance; they ought to have lactation support as a covered benefit just as any aspect of healthcare. Breastfeeding is a major contributor to health, and saves healthcare dollars. Spatial considerations relate to having an area in the outpatient setting where the IBCLC could view and evaluate breastfeeding. In addition, the IBCLC, as a healthcare professional, should have office space within easy access of obstetric and pediatric providers for utilization of patients as well as access by medical professionals for consultations with the IBCLC.

Outline for implementation

Have a lactation consultant in the OB office for prenatal education for all prenatal patients, and anticipatory guidance for those with a history of problems or health conditions which predict possible problems. Lactation care would start with a first trimester assessment/education visit. Research indicates that 50%-75% of new mothers make a decision about the method for feeding their baby in the first trimester.²⁶ Next, there would be a third trimester visit to discuss more specific aspects of breastfeeding, the impact of birthing practices, and recommendations for the early postpartum period. It is recommended that more efforts be concentrated on women in the final days of pregnancy to answer questions and reduce anxiety about breastfeeding issues.⁵ The prenatal setting is ideal for the discussion regarding the impact of birth interventions and medications on breastfeeding. A recent study of 6,410 mothers found that mothers who had unassisted vaginal births, or who did not have pain medications or epidurals, were more likely to be breastfeeding.²⁷ With this information, mothers can make informed choices and plans for their birth, labor support, and methods for coping during labor that would best support her breastfeeding goals. (See Table 1 for suggested topics for discussion during prenatal office visits.)

Have the lactation consultant in the pediatric office to see the breastfeeding dyad along with well newborn checks. These *well breastfeeding checkups* could prevent many problems for mother and baby and cut down on problem-oriented visits. The importance of a lactation consult at the newborn visit is demonstrated in studies showing that such contact during early breastfeeding can significantly increase breastfeeding duration for that infant and may encourage breastfeeding for subsequent births.²⁶ The IBCLC answers questions and addresses issues or concerns. Mothers are given assistance with latching and positioning, and educated about milk production. This is especially important over the first two weeks of the infant's life. Breastfeeding concerns during this time period were shown by one study to be significantly associated with increased risk of stopping breastfeeding.⁵ The pediatric provider would perform the well-child exam, and then the IBCLC would see the couplet to check on breastfeeding during all regular appointments (Table 2).

The lactation consultant would be available for problem oriented appointments in either the OB clinic or the pediatric clinic. These appointments would be scheduled by the providers or the patients who call in to the clinics with breastfeeding difficulties.

The lactation consultant would have an email contact as well as her own dedicated phone line with message capacity. This could be called the *Lactation Line*. These would be used for phone calls and emails from patients and providers with questions and problems. The lactation consultant could answer calls from patients with questions stored in the voicemail, receive urgent calls when on shift, and take calls for making appointments. She can also take calls from providers

with questions.

The lactation consultant would conduct a weekly Mothers' Support Group. Support groups have been demonstrated to increase breastfeeding rates and provide necessary peer support as well as a venue for professional guidance with questions and problems.²⁸ The lactation

consultant would have open time slots available for urgent IBCLC visits on a drop-in basis. Drop in time could be used for urgent problems that cannot wait for a scheduled visit; this time would accommodate immediate needs and perceived immediate needs.

Table 1 IBCLC visits at the prenatal clinic

Suggested topics/areas to assess during prenatal visits:

First trimester: This visit would occur in the prenatal office/clinic setting.

Meet 1:1 with moms prenatally to discuss breastfeeding.

- 1) Explore intent,
 - 2) Birth options (impact of birth practices & medications on breastfeeding, what helps, what hinders),
 - 3) History of breastfeeding prior infants:
 - a) Did patient breastfeed any previous infants?
 - b) Were there previous breastfeeding problems?
 - c) What is her attitude regarding the success of breastfeeding?
 - 4) Physical assessment if warranted (breasts, nipples)
 - 5) Applicable health conditions.
 - 6) Medical conditions that may affect breastfeeding:
 - a) History of hormone-related infertility
 - b) Contraception use
 - c) Hypothyroidism
 - d) Diabetes
 - e) Polycystic Ovarian Syndrome
 - 7) Current meds if applicable
 - 8) Recommended resources for medications during lactation:
 - a) *Medications and Mother's Milk* by Thomas Hale: Medications are discussed regarding safety in breastfeeding and supportive research. Risk categories from the safest (L1) to contraindicated (L5).
 - b) Infant risk center
 - c) *LactMed* website; public website, also a phone app
 - 9) History of breast surgeries/breast trauma
 - 10) Anticipatory guidance and discussion of time off from work/school.
 - 11) Encourage attendance at a breastfeeding class.
 - 12) A social history including substance abuse, depression, etc.
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Table Continued..

Suggested topics/areas to assess during prenatal visits:

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- 13) Are others (i.e. baby's father, mother's mother, friends, etc.) supportive of breastfeeding?
- 14) Third trimester: meet 1:1 with moms for discussion of the basics of breastfeeding and expectations of the early breastfeeding period:
- a) Latch,
 - b) Positioning,
 - c) First three days (first day possible sleepiness, next 2 days probable cluster feeding and high needs for contact, milk changes),
 - d) Colostrum, purposes of colostrum (small amounts match baby's stomach size; thick substance prevents aspiration while infant learns to coordinate suck/swallow/breathing, immunological properties, all he needs),
 - e) Explain anticipated weight loss ("water loss," not body mass)
 - f) Feeding cues.
 - g) Baby-led feeding frequency and duration,
 - h) Skin to skin contact,
 - i) Undisturbed time together,
 - j) Rooming in,
 - k) Second night expectations,
 - l) Self attachment.
-

Table 2 LC visits at the pediatric clinic**Suggested topics/areas to assess during well newborn checkups:**

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- 1) 3 Day Visit:**
- a) Jaundice
 - b) Dehydration
 - c) Weight (normal weight loss is WATER loss, not body mass)
 - d) Milk onset; milk changes; early period for building milk supply
 - e) Assess feeding, check supply, swallowing.
 - f) Discuss foremilk, hindmilk, finish first side first.
 - g) Engorgement; swelling
 - h) Stools
 - i) Assess breasts/nipples
 - j) Feeding patterns, intake, check for frequent feeds
 - k) Positions – feeding positions that allow for maternal rest/sleep.
 - l) Encourage rest; discuss lifestyle changes
 - m) Sibling issues
- 2) 7 Day Visit:**
- a) Weight gain
 - b) Output – wets and stools
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Table Continued..

Suggested topics/areas to assess during well newborn checkups:

3) 7 Day Visit:

- a) Talk about nights, infant sleep.
- b) Assess for questions regarding feeding positions.
- c) Discuss avoiding bottles, pacifiers.
- d) Check for problems, engorgement.

4) 2 Week Visit:

- a) Assess weight gain,
- b) Assess feeding pattern,
- c) Is baby back with birth weight or above?
- d) Talk about exclusive breastfeeding for the first 6 months,
- e) Plans for back to work or school, pumping, feeding options.
- f) Talk about infant fussy periods, growth spurts.
- g) Contraception, oral contraceptives & milk supply, breastfeeding as contraceptive

5) 1 Month Visit:

- a) Discuss infant development,
- b) Tummy time,
- c) Infant sleep,
- d) Feeding patterns,
- e) Normal expectations

6) 2 Month Visit:

- a) Discuss normal expectations,
- b) Infant development,

7) 4 Month Visit:

- a) Going back to work,
- b) Complementary foods,
- c) Sleep patterns/naps,
- d) Continuing breastfeeding,
- e) Brain development.
- f) Teething/biting.
- g) Discuss growth and development,
- h) Feeding issues.

8) 6 Month Visit:

- a) Development
 - b) Sleep
 - c) Teething and breastfeeding
 - d) Complementary feeding, Baby-Led Weaning method of introducing solids
 - e) Breastfeeding toddlers
 - f) Weaning
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All office staff and all healthcare providers would be trained in the basics of breastfeeding. This would allow consistent information to be given to the breastfeeding mother from all sources within the office setting. Providers should be on the same page about breastfeeding. Information from healthcare providers makes a substantial impact upon the patient. Inconsistent information is damaging and confusing to the patient.²⁹ Evidence-based practice and education should be the standard. This requires all healthcare providers to be educated and up to date. Require all healthcare providers in contact with pregnant women, mothers, and babies to take a basic breastfeeding course. This could be an approved on line course, or a live class or webinar. The Academy of Breastfeeding Medicine's (ABM) clinical protocol, "The Breastfeeding-Friendly Physician's Office, Part 1: Optimizing Care for Infants and Children," provides practical steps toward implementing breastfeeding support in the outpatient setting. These steps were derived from the scientific evidence behind the WHO and United Nations Children's Fund Baby-Friendly Hospital Initiative.⁷

It would be beneficial in high volume centers to have a Certified Lactation Counselor in addition to an IBCLC in the office. This trained professional would answer basic breastfeeding management questions from staff and patients to help diminish the load upon the lactation consultant and deal with issues that do not need to be referred to the IBCLC. Smaller offices without a big demand for the lactation consultant would do well with a single IBCLC on site. Having office staff educated and trained in lactation care would greatly enhance the provider's practice and provide a tremendous asset to the clinic. If

problems outside of normal are encountered, the CLC trained provider would refer/schedule a problem oriented visit with the IBCLC.

Baby-Friendly guidelines would be observed in the office setting. This health initiative from WHO/UNICEF promotes evidence-based practice in maternal/infant care. Observation of the Baby Friendly Ten Steps to Successful Breastfeeding greatly enhances breastfeeding. Data from around the world clearly indicates the positive impact of implementation of the Ten Steps on breastfeeding initiation, duration, exclusivity, and related child health outcomes.^{3,18,30} The ABM's clinical protocol, "The Breastfeeding-Friendly Physician's Office, Part 1: Optimizing Care for Infants and Children," details how to implement steps to provide lactation care in the office setting that are patterned after the Ten Steps to Successful Breastfeeding^{7,31} (Table 3).

The local hospital birthing center would contact the IBCLC when discharging a patient with breastfeeding issues in order to provide information and schedule a follow-up problem-oriented appointment. If the patient was discharged with a written infant feeding plan, a copy would be faxed to the IBCLC as a reference tool. This would allow the IBCLC to evaluate the effectiveness of the feeding plan and adjust it for the infant's current needs. Birthing center staff would also fax a copy of the delivery record. This would allow assessment of infant weight changes and possible effects of delivery interventions, medications, and type of delivery on the infant's feeding behavior. Several studies have shown the impact of birthing practices and medications, including anesthesia, on the infant's ability to breastfeed as well as milk onset and initial volumes.^{5,32-35}

Table 3 The ten steps to successful breastfeeding

The 10 Steps to Successful Breastfeeding³¹

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
 2. Train all healthcare staff in the skills necessary to implement the policy.
 3. Inform all pregnant women about the benefits and management of breastfeeding.
 4. Help mothers initiate breastfeeding within one hour of giving birth.
 5. Show mothers how to breastfeed and maintain lactation even when they are separated from their infants.
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Summary

Breastfeeding is essential to health maintenance, and should be a regular part of prenatal, well baby, and postpartum checkups. Lactation care should be readily available, local, and covered by insurance. The IBCLC is an essential member of the healthcare team. A lactation consultant in outpatient OB and pediatric clinics would be a valuable asset to the health and education of the family, from the prenatal period and continuing through weaning. Costs would be recaptured in the billing process for the provider visit. This model for outpatient lactation care is a win-win scenario for patients, staff, providers, and the long-term health and wellbeing of our society.

Acknowledgements

There are no other authors or contributors to this article.

Conflict of interest

The author declares no conflict of interest.

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