Moderator Rachel Breidster: Hello and welcome to Breastfeeding Grand Rounds 2016. I’m Rachel Breidster and I’ll be your moderator today. Before we get started, I would like to ask that you please fill out your online evaluation at the end of the webcast – your feedback is important in planning future programs. Continuing education credits are available for CME, CNE, CHES, LCERPs and General CEUs after you take our short post-test, and other professional specialties such as registered dieticians may request the CEU certificate and provide it to their accrediting body. I also want to let you know that the planners and presenters of Breast Feeding Grand Rounds do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity, and no commercial funding has been accepted for this activity. As for today's program, we will be taking your questions throughout the program – Please send questions via phone to: 1-518-880-3516 or via email at bfgr.ny@gmail.com. We will get to these questions in the second half of the program.

This year’s focus is "Building a Continuum of Care to Support Exclusive Breastfeeding in New York State” and our guests are Dr. Ruth Lawrence, a Distinguished Alumna Professor of Pediatrics & Obstetrics & Gynecology at the University of Rochester School of Medicine; Ms. Patricia Jordan, the Assistant Director of the Bureau of Women, Infant and Adolescent Health at the New York State Department of Health; Ms. Deborah Gregg, the Nutrition Policy Coordinator in the Division of Chronic Disease Prevention at the Department of Health; and Ms. Kate Rose Bobseine, the Obesity Prevention Program Coordinator in the Bureau of Community Chronic Disease Prevention at the Department of Health. Thank you for joining us.

Good morning. Thank you so much for being here with us today. To get us started, Pat can you please share with us what the objectives are for today's show?

Pat Jordan: Today we’re planning on talking about three different initiatives that are ongoing in New York State at the provider level, at the community level as well as at the hospital level. And the intent is by viewing today's program the participants will be able to accurately describe components of each of the different initiatives and be able to discuss some of the benefits for enhanced collaboration at all three levels.

Moderator: Excellent. And can you tell me a little about why you focused on the continuum of care for exclusive breastfeeding?

Pat Jordan: Sure. The continuum of care really mirrors what we aim to do on an annual basis for the Grand Rounds – we focus it on the theme for the World Breastfeeding Week. In 2016, the World Breastfeeding Week theme is Breastfeeding: A Key to Sustainable Development. The sustainable development goals were established by the United Nations in 2015 and they focus on areas such as improving maternal and child health outcomes, reducing infant and child mortality, reducing hunger, poverty, and, you know, looking at the environmental level as well. So in today's program, we're really looking at trying to help moms sustain exclusive breastfeeding and creating supportive systems and practices that’ll breakdown any barriers that are known to get in the way for that. We know right now there is a big shift in New York State, and, really, across the country in regard to
breastfeeding care and support. Physicians and hospitals all recognize the importance of breastfeeding and they are making some real positive changes in that area. So the public health strategies we're going to present today will really show how the New York State health department is working with the WIC program, with the healthcare providers and with the hospitals in New York State to really support those changes and improve the breastfeeding care provided.

Moderator: With all that in mind, can you talk about what are we going to be discussing in depth today?

Pat Jordan: We have three particular areas that we are going to focus on today. We have the WIC Exclusive Breastfeeding Learning Community that was implemented starting in 2014 and ran through 2015. We have the Breastfeeding Friendly Practice Designation, and that began with a CDC obesity prevention grant in 2012 and is ongoing today. And the third component is the Breastfeeding Quality Improvement in Hospitals. That began its first pilot cohort in 2010 and is continuing and ongoing through 2018. So today’s panel is going to discuss these different interventions, how they are implemented and how have been successful in achieving positive outcomes.

Dr. Lawrence: And also talking about how these different initiatives can work together in this.

Pat Jordan: Yes, we will. Sustaining a system of education and support, working with OB/GYN [providers] and birthing hospitals, WIC clinics, pediatricians, family practice providers, really that synergy really gives women their best chance for a positive breast feeding experience. So we really want to help women meet their personal breastfeeding goals.

In 2011, the Surgeon General’s Call to Action identified some barriers to breastfeeding in the U.S. and our initiatives are working to break those down. The barriers include a lack of trained health care practitioners and lack of family and community support, as well as hospital practices that are detrimental to breastfeeding. So our Department of Health initiatives are addressing all of those barriers and all of those factors. Each initiative we've implemented is successful independently, however, when they are offered across the spectrum of care and there's a collaboration with providers and hospitals, the continuum is really enhanced to better support moms.

Moderator: Excellent. Thank you for setting the stage for us. Now, Dr. Lawrence, I'm going to turn to you, and you have been involved in our show for as long as we've been having this show. And so I'd like to talk to you a little bit this morning about the fact that we know there is a lot of evidence that demonstrates that exclusive breastfeeding has a lot of positive benefits both for mom and the baby. Can you review some of those important public health findings with our audience this morning?

Dr. Lawrence: Probably one of the best is that exclusive breastfeeding has been proven with public health strategies to have these benefits not only for the baby, which is what we always think about, but for the mother as well. The keyword is species-specificity. Now, that's a fancy way of saying that of the 4,000 mammalian species, they all make a special milk for their offspring. And the milk is designed so their baby grows the way it should. And that is true for the human [as well]. The human is the only one who drinks another species’ milk. But it provides therefore protection against infectious diseases and it provides for protection in the mother as well. And it improves even Sudden Infant Death Syndrome (SIDS), which is a tremendous question these days. Breastfeeding in all mammals is the physiological completion of the reproductive cycle – its part of what Mother Nature planned. And, it suppresses ovulation, which puts off another pregnancy a little bit as well.
Moderator: Certainly the benefits are well established. Can you talk to us about what the current research is telling us?

Dr. Lawrence: Well, there is much more research than there ever was. One of the things I find most exciting is the information about the development of the brain. We have known that babies who were exclusively breastfed do better developmentally, succeed intellectually better. But that is pretty soft data. But recently, investigators have been doing MRIs - Magnetic Resonance Imagery, which is a very complicated way of saying they are looking at the brain. And as you see on the screen - this is some of the data that's reported – what it shows is that the brains of infants who have been exclusively breastfed are much more developed than the brains of babies who have been formula fed. And this is not too surprising, because human milk contains nutrients the brain needs, including cholesterol. There is no cholesterol in formula. So we know that the brains are doing better. We have the hard data now.

Moderator: That's certainly very compelling. Now are there risks to not breastfeeding?

Dr. Lawrence: There are indeed. And that is a new way of expressing it – we've always said how good breastfeeding is. But the risks of not breastfeeding have been outlined. And mothers who do not breastfeed are at much greater risk of becoming obese, postpartum, and developing chronic diseases, particularly diabetes and some breast cancers. The more the mother breastfeeds, the better things are for her postpartum, and it also postpones another pregnancy. Babies who are not breastfed are at greater risk for diarrhea. The death rate in underdeveloped countries is 50% in the first year of life for babies who are not breastfed.

And another risk of not breastfeeding for babies is a change in the gut microbiome. We hear a lot about microbiomes today. Everybody is eating yogurt and so forth. But human milk sets the gut microbiome for life essentially. And this means that the baby is able to absorb things better, digest things better. We recognize that there are certain counter-indications to breastfeeding, however, and some circumstances where mothers cannot breastfeed. We need to be sensitive to that.

At some point down the road, if the quantity of donor milk is sufficient - in our own New York State the Milk Bank is just getting started - if there were enough milk, then a mother who cannot provide their own could obtain human milk for their baby. But that is down the road. The focus of today's presentation is on New York State initiatives that are improving the breastfeeding experience for a mother who can breastfeed, and to build on the partnerships across the care continuum, so we're working together so all women and children benefit from this kind of approach.

Moderator: Absolutely. Now, we recognize that there are some barriers that might exist to breastfeeding. So let me ask you as a physician - what are your thoughts on some of the barriers that mothers might face?

Dr. Lawrence: Well, training of healthcare professionals. And I must say that the American Academy of Pediatrics, ACOG, all of the healthcare professional groups, are working very hard on this, including the Academy of Breastfeeding Medicine, which involves all physicians around the world. And we're trying to raise their interest.

There are more and more physicians who are knowledgeable about breastfeeding, willing to listen, and willing to learn. But it takes a team. There is a recent research article about the discontinuity of breastfeeding, where people were not working cooperatively. And mothers leave the hospital in 48 hours with no safety net. And that is very critical. That is very important for where WIC comes in and develops that safety net. The physician orchestrates the care, but it takes a team at every stage.
of reproduction. And so today's program is going to focus on making these connections stronger. So that mothers are getting consistent messages and providers are working with other programs and handing off the care seamlessly.

Having said that, healthcare providers can't be the "captain of the ship." Mother must be the captain of her own ship, steering her own unique ship which has different cargo, different passengers and different destinations. Each mother has a different set of circumstances and goals. She has different waves and tides to navigate. We in healthcare need to be the lighthouse to help them navigate through their reproductive journey. And we can empower mothers to have confidence. And this is a very important word. Chele Marmet said 40 years ago, "Breastfeeding is a confidence game." That is part of what we do. We teach them how to breast-feed and ensure they have access to resources that support them. Parenting is a big job; feeding a baby is part of that big job.

**Moderator:** So we're saying mothers need to be the captain of their own ship, but support from the family and healthcare providers is also a really important component, then, to allow the mother to be that captain, correct?

**Dr. Lawrence:** That's right. Children don't grow up knowing about breastfeeding in our culture today. Breastfeeding is natural. But it does not always come naturally. Mothers have no models. They have never seen it done. Mothers need to understand the importance of breastfeeding, first of all, for themselves and for their infants. And mothers need to understand newborn behavior and feeding cues. Every baby is different. And they are certainly different from older babies. New mothers are experiencing this for the first time. It is frightening. Mothers need to learn how to breastfeed, how lactation works, physiologically. And they don’t learn that at home anymore. Being a new mother is not easy. Life is very different with a baby. It never goes back. And every mother wants to do her best for her child. We as a society need to do more mothering the mother, as they do in so many other cultures.

**Moderator:** Okay, so with that information in mind, Pat, I'm going to turn to you and say given what we've talked about this morning, why did the New York State WIC Program want to develop a Breastfeeding Learning Community? Can you talk about that in the context of what we've been discussing?

**Pat Jordan:** As you just learned from Dr. Lawrence, there are many benefits for breastfeeding and exclusively breastfeeding. And WIC really wanted to see what we could do to increase the rates of exclusive breastfeeding in WIC moms. Based on the data out there, we knew that WIC moms were already doing a good job as far as initiation. The initiation rate of breastfeeding in WIC moms actually exceeds the Healthy People 2020 recommendations - Healthy People 2020 says 81.9%. So, the New York State WIC Program has exceeded that. But exclusivity remains low. The Healthy People 2020 goals for breastfeeding exclusivity at three months is 46.2, which is significantly higher than what we’re seeing. We also know that in WIC, about one-third of the moms actually start supplementing with breast milk substitutes or formula by the end of the first week postpartum. And that is really when the milk supply is still getting fully established. And we know that making changes in WIC can have a significant improvement in New York State because WIC serves more than 50% of all infants born in New York State. So we have the opportunity and, kind of, a responsibility here we feel, you know, to make a significant tremendous public health impact. So we’re looking to see what we could do to reverse the trend.

**Moderator:** Excellent. Now for viewers who might not be as familiar, what exactly is a "learning community," and specifically, the Exclusive Breastfeeding Learning Community or EBFLC and how did you select the various agencies that were invited to participate?
Pat Jordan: Good question. A learning community is a model where the members involved learn from each other. They learned from trainers and they set some specific goals for their agencies as to, you know, where they want to go and what they want to implement in order to get there. It really provides a significant amount of intensive support. And in this case, the goals that the agency set were all in relationship to increasing rates of exclusive breastfeeding.

Dr. Lawrence: I think it is important to note that the Academy of Pediatrics set up these standards over 20 years ago on exclusive breastfeeding - exclusive breastfeeding for six months, not six weeks or six days. Six months, nothing else but human milk

Moderator: That is important to note.

Pat Jordan: Yep. Thank you for that. So we actually ... as far as how we chose agencies that were selected to participate, we got a great outpouring from the WIC local agencies. We had thirty-one local agencies apply to participate. And so there was a very basic application that they completed identifying what staff would participate, why those members were chosen, what their role was in the agency. And then just a brief narrative to explain why that agency should be participating in the learning community. And then the WIC program actually contacted all of the applicants to ensure that they had the commitment from a real cross-section of staff, the interdisciplinary staff that would be involved in this. And, you know, it was important to look at agencies that had strong support for breastfeeding and agencies that maybe needed a little help with increasing their breastfeeding rates. We only were able to select twelve agencies in order to be able to go through the components with the size group that we had. And they participated in the trainings and the conference calls.

Moderator: How did WIC decide on the model for promoting exclusive breastfeeding?

Pat Jordan: The model we used was replicated from a project that Vermont had done. And it was called, "You Can Do It. WIC Can Help." And it was very successfully done in Vermont. And we heard a presentation from the Vermont WIC program right around the time that we were brainstorming and trying to set our goals for the year of what we could do to increase the exclusivity for breastfeeding. And in Vermont, the results exceeded what they were really looking for; their goal was to have at least a 10% increase in long term breastfeeding rates and they were able to exceed that. So, in New York, we wanted to see if we could replicate that, to see, despite all of our differences and demographics, and size and caseload, you know, what we might be able to do to organizational structure to put that in place in New York. Sessions were set up with two face-to-face meetings, five conference calls and local technical assistance as needed. And the agency teams that participated looked at their operating systems and environmental changes to see how they could promote and support exclusive breastfeeding in their agencies.

Dr. Lawrence: That motto is great – "You Can Do It. WIC Can Help." I think we have to keep that in mind all morning.

Moderator: Yeah, I think that is a really strong message. It's really empowering the mother but also recognizing the need for some additional support.

Pat Jordan: Right.

Moderator: What were some of the components of the program?
Pat Jordan: Well, first of all, in order to be enrolled in the intervention, the women had to be at least 18 years of age. They needed to express an interest in breastfeeding or at least be open and undecided what they were planning on doing for feeding their baby. And then the components were broken down based on the trimester. In the first trimester, we used a Breastfeeding Attrition Prediction Tool, which I'll continue to refer to as the BAPT. And that really assessed mom's education, confidence, and support. Then, in the second trimester, based on the results we saw with the BAPT, there was individualized targeted counseling provided, case conferencing in some cases, was provided based on need. And in the third trimester, the moms had the opportunity to participate in targeted group discussions with other moms that were part of the intervention. And then there was a strong component to reach out to moms as soon after birth as possible to provide that very early postpartum support. And then throughout the intervention, the WIC local agency staff conducted public health detailing with the healthcare providers in their communities.

Moderator: Now, can you tell me more about the Breastfeeding Attrition Prediction Tool? And, how did it help to enhance the effectiveness in promoting exclusive breastfeeding, both initiation and continuing duration?

Pat Jordan: The BAPT is a validated tool and it's used to assess, as I mentioned before, the woman's knowledge, confidence and social support about breastfeeding. It identifies women that might be at greater risk for stopping breastfeeding early, and it actually assigns a risk score once they have taken the evaluation. The score is based on how the women answered the questions, and, if the score is less than 20, it identifies the prenatal mom as being at a higher risk. And it really enables the staff to define the risks before the baby is ever born so the mom can get that early prenatal support. And I will tell you, the agencies that participated, they loved the BAPT tool. They felt that they really learned a lot from the moms by using that BAPT tool. And it really helped them hone in and steer the ship where they were going in working with those moms.

Moderator: So, the BAPT really gets at a woman’s feelings and her perceptions on the support she has available. How does the information gleaned from this tool help staff or impact the counseling provided to the mother?

Pat Jordan: Looking at not just the score, but how the mom answered the questions might identify say, for instance, mom’s knowledge about breastfeeding needed more help. So, they really would target the counseling based on what was identified. If we noticed that social supports were an area that needed to be honed in on, the counseling was tailored for the individual needs identified.

Moderator: And when did staff initiate case conferencing? What WIC agency staff were involved in the process?

Pat Jordan: Again, with the scoring, if there was a score below twenty, then it was an indication to do some of the case conferencing. And that really included the interdisciplinary staff at the WIC local agency – the nutritionist, the breastfeeding coordinator, the peer counselor. They would get together and have a discussion as to the best approach they should take to best support the mom. And in some cases, even when the BAPT score was above twenty, they might do some case conferencing based on a mom that might have identified some needs they thought needed to be focused on.

Dr. Lawrence: One person that’s on the team that maybe you might say something more about is the peer counselor. And the peer counselor is somebody at the same level as you are, with the same resources who has breastfed. And they are invaluable. All of us wonderful healthcare professionals think we know everything, but a peer counselor is a treasure.
**Moderator:** Absolutely. And I believe we heard some of that on the show last year and the value of having somebody right there in the mix with you, side by side.

**Dr. Lawrence:** And somebody you can see as a peer and an equal - you don’t want somebody with an engineering degree telling you how to breastfeed.

**Moderator:** So, it is good to get the message from all angles. We’ve got the physician with the medical advice, the peer who’s got the, "I can relate to what you are doing" piece, and then we've got this entire team that you are discussing. Everybody is supporting mom in making the best decision she can for herself and for the child.

**Pat Jordan:** The peer counseling program in WIC has been very successful – the moms are so appreciative that they have the peer counselors to talk with. It has been very effective.

**Moderator:** Great. How did the group discussions help the moms prepare for the hospital experience?

**Pat Jordan:** The goal for the targeted group discussions really was to help empower the moms. So that when they went into the hospital they knew what to expect in the hospital and they really knew how to advocate for themselves. They knew what they could ask for, they were more empowered to speak up and get what they needed. And also, we wanted to make sure that the moms knew they could get that early support from WIC from the day the baby was born. And really to support mom in identifying what her plans are, what her specific needs are, and to make sure that she knew that WIC could support her through that process. All women that participated in the group were women that completed the BAPT tool so they have the support of each other in that group as well.

**Moderator:** Excellent. Talk about early postpartum support and why it is important for someone to have multiple contacts available after the birth to continue this process?

**Pat Jordan:** Well, you know, I think as Dr. Lawrence mentioned before, right after having a baby there is a flood of emotions and it’s really a stressful time for a new mom. So getting that early assistance, that early reassurance, the opportunity to make referrals as needed early on. Mom needs that encouragement. She needs that support at that point. And also having a visit soon after the baby is born, in the WIC clinic she also has an opportunity to sit with that peer counselor and demonstrate what she’s doing and get tips and recommendations at that point. And actually [it helps] the baby, you know, to make sure they know that the baby is gaining the weight, growing, getting the proper nourishment, counting the dirty diapers, and just getting that reassurance and that, kind of, shot in the arm. So it contributes to mom’s success. And as Dr. Lawrence said earlier, we want mom to be steering her own ship. And by going through this process, it really helps enhance that.

**Dr. Lawrence:** They only spend 48 hours in the hospital and they are so tired that you could tell them three times something and it is hard to remember.

**Moderator:** Absolutely.

**Dr. Lawrence:** So we need that safety net.

**Moderator:** Yes, once you go home you have a whole other human life to keep alive and what
support do you have in place to make sure you know how to take care of your baby and take care of yourself?

Dr. Lawrence: Scary.

Moderator: I bet. [laughter] Now, I would imagine an important part of this intervention is building a continuum of care and working with healthcare providers to really bring it all together. Can you talk about that?

Pat Jordan: Sure. Throughout the intervention, the WIC local agencies that were participating conducted public health detailing and that is an effective method for reaching providers to deliver information and increase awareness of community supports. Through the public health detailing, WIC staff identified healthcare practitioners, primary care offices, hospitals, pediatricians and OB/GYNs that serve the population that they also see. And through public health detailing, they actually met with folks and shared with them what the resources are that WIC provides, what staff WIC has, and really helping them be aware of what the breastfeeding services there are so that they could, you know, better refer and actually see that there is breastfeeding support and champions in their particular community. It is not always the case that all the providers know exactly how comprehensive WIC is and what support is available. And, you know, we know, again as Dr. Lawrence mentioned earlier, AAP has addressed the importance of the collaboration across the spectrum, especially between the pediatricians and WIC in relationship to breastfeeding. So it really had a significant impact also on helping get the moms referred early into the WIC program.

Moderator: Now, can you also talk about what local agency staff were involved with participating in the Learning Community?

Pat Jordan: Sure. As I mentioned before, at the WIC local agency there is a breastfeeding coordinator, there is the site coordinator, there is the peer counselor and there is the nutritionist or the nurse. You know, we call it the certified professional authority. And they all work in collaboration and conjunction to help support the exclusive breastfeeding. You will see it in the graphic on the slide that exclusive breastfeeding is at the center. And that is where, you know, their focus is. They are all working together to support that goal of increasing and enhancing a mom’s ability to do the exclusive breastfeeding. So this is the model that was used for the agencies that participated in the learning community.

Dr. Lawrence: Well, and they all need to be paid positions, particularly the peer counselor. Our experience is that with budget cuts, they drop the peer counselor. The peer counselor should not be a volunteer, but should be staff.

Pat Jordan: The peer counselor is a real core component. And it is important to, you know, have all of the pieces. Even though a site director/manager might say, well why do we need that person there? They are developing the system and the processes. And so there are a lot of factors that go into play. So it is not just the breastfeeding experts that are part of the team.

Moderator: Absolutely. Now, it sounds like this is a really comprehensive intervention looking at all of these different pieces of the puzzle. Can you describe how these different components come together to enhance both the initiation and duration of breastfeeding?

Pat Johnson: Well the learning community model was based on an assets approach to breastfeeding. And we know that moms need support, prenatally, while they’re in the hospital delivering their babies, postpartum, after their discharge. They can feel really overwhelmed, as we
talked before, and if they are not getting the knowledge and support prenatally to enhance their confidence and empower them to ask questions initially, then they are not really getting the support they might need. So we have to help them and their families to make them feel supported throughout the process. And really, the commitment in this initiative was to provide mom with the knowledge and support so she had the confidence and could be successful.

**Moderator:** What kinds of results is the WIC program seeing?

**Pat Jordan:** WIC looked at moms that are receiving a fully breastfeeding food package so that they could compare the intervention groups that participated to a controlled sample. And we're happy that the data, even at the preliminary stages, is showing that the intervention really does have the potential for a positive impact on exclusive breastfeeding rates. And we're seeing it might actually be more effective among African American women. So we're very excited about that. And especially since this intervention has the potential for reducing breastfeeding disparities as well.

**Moderator:** Excellent. What kind of feedback did you get from implementing this in WIC agencies?

**Pat Jordan:** We got a significant amount of feedback. The agencies that participated were very excited about being able to be part of this. They worked really hard in the process. They found that it really helped build staff counseling skills. It improved communication within their agencies, it enhanced their team work and it built relationships with healthcare providers. And they learned from other local agency staff involved in the intervention.

**Moderator:** So certainly it sounds like a lot of really promising successes. I imagine there also must have been some challenges in the process. So can you talk to us about that?

**Pat Jordan:** Sure. Enrolling moms in the first trimester was a bit of a challenge for some agencies because we realized that not as many moms are enrolled in the first trimester as maybe we would have thought if we hadn't honed in on that particular point. Staff buy-in, not that it was an issue, but staff needed to be trained. Staff needed to know, "We're going to change operations, we're going to change systems, we're going to be doing things in little bit of a different way." So they had to be prepared to be a little uncomfortable as the, you know, changes were being put into place. The length of the appointment was something they needed to focus on. They needed to make sure that the mom was scheduled so there was enough time where they could go through all of the components of the intervention. It kind of led to some more pre-planning. Again, when we talked about having that interdisciplinary team involved, sometimes the peer counselor might not be at the same location as some of the other staff so there were some logistical pieces to take into consideration. And another challenge was identifying when moms delivered because we want to connect with moms so soon after delivery, so really everyone at the local agency was involved with trying to find out when that mom delivered so they could reach out early on in the process.

**Dr. Lawrence:** Is there any incentive to come, a package a food package, or something like that, to come to mom during pregnancy?

**Pat Jordan:** Well, the food packages in the WIC program are provided – as I commented about for evaluation. We looked at moms getting the Exclusive Breastfeeding Package. The different food packages are based on whether mom is breastfeeding, exclusively breastfeeding. So yes.

**Dr. Lawrence:** But during the pregnancy does she get that? Is that the incentive to come to a visit during pregnancy?
Pat Jordan: The fact that she could get an enhanced food package?

Dr. Lawrence: For any food package?

Pat Jordan: Certainly. Yeah.

Dr. Lawrence: Of course, incentives are big today. [laughter]

Moderator: That's true. Can you share with us some helpful information or feedback you have received that would be helpful to other agencies that might want to replicate what you have done?

Pat Jordan: Sure. We learned a lot from piloting this intervention. And, training is something that you can't underscore enough. They really needed not to just train the folks working with the mom, but the whole staff. And flexibility - there was scheduling, a significant amount of scheduling changes and logistics that needed to be considered. Getting everybody on board to try and enhance those through early enrollment in the first trimester, you know, including the clerical staff. Making sure there was enough time for the appointments. Holding regular staff briefings as well, so that everybody was sort of on the same page and moving forward. There was that cohesiveness and being creative of trying to connect those brand new moms.

Moderator: What does WIC plan do now? Will there be another learning community? Will we be using the BAPT tool to assess all moms? What is to come?

Pat Jordan: The intent was to test the model from Vermont and replicate their successful practices. And once the evaluation is thoroughly completed, the WIC program is going to determine how some of those successes can be expanded to WIC agencies so that we can really continue the momentum. As I mentioned earlier, there were a lot more WIC agencies that really wanted to participate. So we know they are eager. The BAPT tool actually will be made available to all WIC agencies, because the agencies involved in the learning community found those tools to be really really valuable and helpful.

Moderator: Pat, thank you so much for everything you shared with us this morning. I think it has been a really tremendous asset, sharing with the audience the successes you have had, and it is very promising for what's to come in the future.

Pat Jordan: Yes, we're very excited about it. Thank you.

Moderator: Let's take a few minutes now to hear from Dawn Kempa, the WIC coordinator at the Long Island Jewish Medical Center, who was involved in the Exclusive Breastfeeding Learning Community.

Roll in - Dawn Kempa, RN, IBCLC, Northwell Health Long Island Jewish Medical Center

WIC: We've always had a very high breastfeeding initiation rate. But our exclusive breastfeeding rate has not always been so high. When we heard about the exclusive breastfeeding learning community, we were really eager to learn of objective ways to increase our exclusive breastfeeding rates with our WIC moms. The learning community pretty much had three prenatal touch points: when the mom comes in on her first visit, she would receive a questionnaire called the BAPT. A nutritionist would be able to assess her confidence level, her support systems and her knowledge pertaining to breastfeeding. And based on that questionnaire, on the second visit she would come in for targeted counseling with the same nutritionist. And on the third visit she would get together with the other
people in the study – the BAPT moms – for a facilitated discussion group. We would give her the how-to’s of breastfeeding and also what to expect when she delivered at the hospital.

Breastfeeding is always top priority in the WIC program, so most of our employees have breast fed their own babies. And when they heard about this, they were eager to be part of the study. We divided our staff into three teams. We named the teams: Rolling Down the River, My Cup Runeth Over, and Boobilicious. And we had binders that we set up to keep track of all the papers and when the WIC participants needed to come in. The teams consisted of a nutritionist, a peer counselor and a support staff that would call people to remind people to come in for their visits. People may forget what you teach them, but they won’t forget how you made them feel - nobody cares how much you know until they know how much you care. So, the BAPT showed that we care about our participants and what they knew as far as their knowledge of breastfeeding, their confidence levels and the support that they had. Just by giving them the BAPT, the questionnaire, they were able to fill that out and it showed that we cared about what they knew about breastfeeding. The case conferences really helped the nutritionist hone in on the mom’s confidence level was and support she had, and what knowledge she was lacking as far as breastfeeding goes. The peer counselor still did what they needed to do, with their calls like they do with every breastfeeding mom, but just having them all collaborate together really helped to focus on the education for the mom prenatally.

We would actually put Post-its in there based on the BAPT questionnaire on what the mom was lacking. So, "Oh, you can read this later – I highlighted it right here. And this will help based on the questionnaire you filled out on your first visit to WIC three months ago." So that was a big help and right before delivery, we would use the breastfeeding checklist, which actually gave a mom a plan how to feed the baby, it is kind of like a birth plan. And the hospital experience has a whole page on the back part of the book. And it tells about the hospital experience, the magic first hour, the skin-to-skin, the rooming in approach. And we discuss all that in the facilitated discussion group with the mom.

I really think the whole plan of how you are going to feed your baby while you are pregnant is really important for a mom to know what to expect in the hospital. I really think the BAPT tool should be used with a mom whether she's nine weeks pregnant, 33 weeks pregnant or even in a prenatal breastfeeding discussion group or a class. It really shows that we care about her confidence, her support and her knowledge pertaining to breastfeeding. She'll never forget we gave her that questionnaire – that will always stick with her. All the teaching that we did is reinforced at the hospital now. They come back and they do not take the formula and they are exclusively breastfeeding because they are doing the skin-to-skin and being imprinted in the delivery room so they are able to breastfeed in the hospital and not be hypoglycemic and need supplementation, medically necessary supplementation, because of all they have learned ahead of time at WIC.

There was a whole piece to the Exclusive Breastfeeding Learning Community about public health detailing and because of that we were able to go to our pediatric offices and OB offices and the PCAP programs and basically present a lunch and learn or a breakfast and learn about the how-twos of breastfeeding and what's new and as old as time in breastfeeding. So of course, we highlighted what WIC was doing as far as the learning community in that and we were able to share with them what's going on in all of our surrounding hospitals and what's going on in their institution so they would be on board with what we're doing. Also the residents through the Coen's Children's Medical Center do an orientation to the community outreach and they pass through WIC with that, and let
them know what WIC gives as far as breastfeeding help to their patients.

**Moderator:** So Deb, welcome and thank you so much for joining us this morning. Now I understand that you are going to talk more about the role of the healthcare provider and the Department of Health's Division of Chronic Disease Prevention has been working on an initiative to help healthcare providers better serve women who are making decisions about how to breastfeed or how to best take care of their babies. Can you talk to us about this initiative?

**Deb Gregg:** Yes, I’d love to. The New York State Breastfeeding Friendly Practice designation was developed as part of the Breastfeeding Erie County Project, and we received funding from the Breastfeeding Supplemental [funding] from the CDC and this work was part of an extension of our obesity prevention work. One of the project goals was to increase community support surrounding breastfeeding and we worked with 14 community agencies. The goal was to link prenatal care with hospital care, hospital care with post discharge care, and also that community support. The goal was to increase breastfeeding in the City of Buffalo and in Erie County, located in Western New York. Basically the boots on the ground were the P2 Collaborative of Western New York and the United Way of Buffalo and Erie County. Staff actually went out and actually did on-site visits and public health detailing like what Pat mentioned where they had with the learning collaborative. The Department of Health worked as far as training opportunities and worked with them so they could have training for their healthcare providers and also for community staff that were in Erie County.

**Moderator:** Excellent. Now, can you tell us about the aim of the Breastfeeding Friendly Practice Designation?

**Deb Gregg:** The overall goal has to be increasing exclusive breastfeeding, and we want to increase duration. But we wanted to engage practices in a breastfeeding continuum of care - one thing is we designed the designation to complement the Ten Steps of Successful Breastfeeding. Also, we wanted to recognize practices that have adopted our Ten Steps – the New York State Ten Steps for a Breastfeeding Friendly Practice. It can be used as a marketing tool, the designation. In fact, one practice from Erie County, and obstetrical practice, indicated that they have a really increased case load since they became designated. So it is good for providers and it is also good for the moms and the babies.

**Moderator:** Now, what is the importance of primary care? When we are talking about promoting supporting and protecting breastfeeding, I think a lot of us think of the obstetrics. So, what is the importance of primary care?

**Deb Gregg:** I think it is all the partners working together - we have the obstetricians who tend to see the mothers in pregnancy, and they have chances to see the mother all throughout a pregnancy and they can start that conversation with the mother about infant feeding choices. We have the pediatrician that sees the infant in the hospital and also at that 48-72 hour period. They are very critical because they can find and talk to mothers about their concerns and issues and that critical period in that first week postpartum, especially those first time mothers. Family care physicians also have a role. They see the mother and the family, pre conception, during pregnancy, postpartum and also in between pregnancies. So their role is important. But in the United States, only about 6% of primary care family physicians actually see mothers as part of their prenatal care. But we need to think about all the partners that are out there, so we’re talking about the midwives, any community-based professionals, lactation consultants, the WIC program and the peer counselors that were just mentioned by Pat and Dr. Lawrence. So they are very important as being a part of this whole picture and filling in the gaps in care.
**Moderator:** Thinking about partnership, how can obstetric providers steer the prenatal journey in a positive direction?

**Deb Gregg:** Well, I had stated they are part of that first conversation. On the initial visit, they have a chance to actually do a breast exam to determine if the mother has any risk of being unable to breastfeed. They can find out if the mother breastfed previously. They can find out if there were other successful pregnancies where the mother actually breastfed, or if or she didn’t, what happened? What was the decision making process? What kind of support system does that mother have? And ask the question about what their feeding choice might be. But they see them throughout the pregnancy period which is important because they have those multiple visits. It is also important that the obstetrician talk and encourage the family, not just the mother, to attend prenatal classes. Maternity staff have told me that a lot of times the mothers are coming in to delivery and haven’t attended any prenatal education. So there is a quick learning curve that has to happen right on the delivery table, so that’s problematic. Also we want to share [information for those in] WIC, if a mom is in WIC, they can go and attend prenatal breastfeeding classes as part of the WIC program. Prenatal education is very important. One other things to emphasize is creating that birth plan together. If the obstetrician can work with the mother and create that birth plan, then the mom will be more prepared for the hospital delivery. If she knows about skin-to-skin, what’s going to happen in the first hour after birth and if she knows about rooming in, then she’s going to feel more prepared for that birth experience.

**Moderator:** Now, what helps physicians with the work? Do they get recommendations? How do they know what to advise the mothers?

**Deb Gregg:** One of the things that just came out lately was the Committee Opinion and it was from ACOG. It was released in February 2016. And one of the things I really like is a statement in there that lactation is a two-person activity. So it is about care and the care continuum – exactly what we’re talking about today. Obstetricians are important for passing the information about the mother on as part of the prenatal records. Also important is communication with the other healthcare providers the mother is seeing after the obstetrician.

**Dr. Lawrence:** And that is what the work of the Academy of Breastfeeding Medicine comes in, because it is an organization of obstetricians, pediatricians, all sorts of healthcare physicians, and they need to be talking to each other.

**Moderator:** Right, absolutely. We need to get everybody at the table having the same conversations and sharing the same information. I think that is a lot of what we’re talking about today is building that collaboration to support mothers. Now, it sounds like what you are describing, similar to the approach in WIC, the OB practices are trying to help mothers get prepared for what is that hospital experience going to be like. So can you talk about what would be the optimal hospital experience?

**Deb Gregg:** Well I just wanted to mention too that the peer counselors are very important, because they can really fill that gap in the care process too, with the mothers.

**Moderator:** Absolutely

**Deb Gregg:** So healthcare providers should be supporting the maternity care practices that are evidence-based. A mother should know her rights and her choices when she gets to the hospital - to know that a lactation consultant will be available to talk to and to help her, and also that she will receive post-discharge support. All that is key. In the hospital, IBCLCs are very important, and managers can refer to staffing recommendations because they need to look at their breastfeeding
care and if they have staffing for the IBCLCs that is based on their perinatal hospital level, their patient case load and whether they are seeing patients, in-patients as well as outpatients, they can figure out what their needs are based on their mother-infant dyad. Another thing is that WIC peer counselors are making rounds in hospitals, and that is proving to be very beneficial. What they do is they take some of that workload off of the nursing staff, because the nurses are very busy. So they can talk about latch and positioning and have that mom become more assured that she’s actually transferring milk. And if they’re more confident in the hospital, then they are going to do better after they are discharged.

**Moderator:** That makes sense. How do perceived attitudes of hospital physicians affect breastfeeding decisions? Tell me about how patients feel about what their providers say and maybe how they say it?

**Deb Gregg:** In one study of physicians, prenatal physicians and hospital staff, if they expressed a preference for breastfeeding it really changed whether a mom was breastfeeding at six weeks or not. So 77 to 73%, as you can see from the graph. If there was perceived neutrality, only about 54 to 41% of women were breastfeeding at six weeks, so this perceived neutrality increases the risk of not breastfeeding. Also, 8% of obstetricians in another study said their advice wasn’t that important, but of the mothers in that study, 39% of them said that, yes, the doctor’s advice was important. So I think the takeaway is that positive messages about breastfeeding by the obstetrician and the hospital staff really do influence what decisions the mother makes and how long their duration might be of breastfeeding.

**Moderator:** Absolutely. It certainly appears that way. Now what is the role of the pediatric provider in this continuum of care?

**Deb Gregg:** One thing that mothers can do – and I understand that some mothers don’t do this – they can ideally see that pediatrician, choose the pediatrician before they deliver and establish that relationship with her and her family. That’s ideal, like I said. But the pediatrician is in the hospital. If they make those bedside assessments, their support system might be there in the room with them, so they can have a discussion about how breastfeeding is going when they are doing the infant assessment. The physician can make sure that the mom is confident about a latch and positioning and milk transfer. Also they can make sure the post discharge appointment at 48-72 hours is on the books. And if they know that the baby and mother are high risk, they might want to see that mother and baby sooner than that 48-72 hour. Also, they could be observing a breastfeeding session actually in the hospital.

**Moderator:** Just like with the WIC Breastfeeding Learning Community, really having that knowledge, that confidence and support - we’re saying these are really important for a mother’s success and it stands to reason that women who are not part of the WIC program then are really relying on their healthcare providers to set the stage for supportive practice and really building that continuum of care.

**Deb Gregg:** Yes. That is correct. They have to rely on the healthcare provider more. And they might be also, if there is availability of peer groups in their neighborhood, a lot of that peer support in drop-in centers and Baby Cafes are also important to help that mother, because moms that are there that are pregnant can go to the drop-in centers too. You just don't have to be there as the breastfeeding mom.

**Dr. Lawrence:** And the hospital does not discharge the patient until they know where a mother is going to be followed up. And if she has nothing, she goes to the pediatric clinic. But then there is the
car seat business and everything else that they have to learn. Poor mom is overwhelmed. So it has to be repeated and reinforced.

**Moderator:** Absolutely. Now, Deb, we’ve discussed the role of different providers and women’s perceptions of receiving advice from them but what about the types of interventions that work to support breastfeeding?

**Deb Gregg:** Well, in 2008 the U.S. Preventive Services Task Force did a systematic review of the research out there and they were looking to see whether or not primary care interventions were important for promoting and supporting breastfeeding. The evidence they looked at showed that interventions do increase initiation, duration and exclusive breastfeeding. So it is also important that they found that the interventions were done – if they were done prenatally as well as postpartum – that both of those time periods were really important. And, just to mention that any time there is system changes going on, it is always good to have leadership involved for sustainability.

**Moderator:** Absolutely. Now, given this information, what would you say is the greatest influencer of whether a woman decides to exclusively breastfeed her baby?

**Deb Gregg:** Well, they found that individual or group education had the greatest effect of any single intervention on both initiation and duration. Then, when you looked at the combination of education, with that personal support in person or with telephone support, they found that it was more effective than support alone, and those also increased duration and initiation. Written materials - just giving them out alone or in combination with the education – the booklets, the discharge packets, that they didn't significantly increase breastfeeding. Also, I'd like to mention that the discharge packets – the bags that may or may not have samples in them - the promotional materials that are commercial. They were detrimental. So that affects breastfeeding too.

**Dr. Lawrence:** And in doing all this they need to consider the significant other, and all of this discussion ought to include the pair, because one of the number one reasons the mother ends up not breastfeeding is because their significant other decided it wasn't what he thought she should do.

**Moderator:** The fathers of the babies are very important, and grandmothers, too. Grandmothers and mothers-in-law are important.

**Dr. Lawrence:** Right

**Deb Gregg:** We're in a generation, so, we have this gap where the mothers might not have a mother that was breastfeeding.

**Dr. Lawrence:** Yes

**Deb Gregg:** And now more sisters are breastfeeding and their daughters are breastfeeding and so that's part of the process.

**Moderator:** Now, the provider’s education and advice and assistance are all very important in breastfeeding and increasing the likelihood that a woman will decide to breast-feed. What is the evidence base for New York State’s Ten Steps to a Breastfeeding Friendly Practice?

**Deb:** Well, in our Ten Steps, we looked at position statements, guidelines, recommendations from
lots of different expert groups. Two of the main resources that we used as foundation were two of the Academy of Breastfeeding Medicine’s Clinical Protocols - one on Creating a Breastfeeding Friendly Physician’s Office, and one on Hospital Discharge. Also, the American Academy of Pediatrics has some wonderful resources on the Internet. And we also looked at materials from other states. So we tried to look at developing our Ten Steps so they would also complement the Ten Steps of Successful Breastfeeding.

**Moderator:** And can you talk to us about what the Ten Steps are?

**Deb Gregg:** Yes, I don’t want to really go over point by point every one of the Ten Steps but I would like to share that all of the ten steps are focused on positive breastfeeding messages, supporting an office environment and also making sure that support systems are in place. I just want to mention two main steps that a lot of hospitals – excuse me, a lot of practices don’t have a breastfeeding policy like hospitals do. So developing a policy means they have to start from scratch, and that can be a challenge in a busy office - who’s going to do that?

**Moderator:** Absolutely.

**Deb Gregg:** The next part is training all staff. Everybody in the office needs to be on the same page as far as breastfeeding support - that receptionist that sees mom when they are checking in, and the mom might be breastfeeding in the waiting room. Also the mom that calls in on the phone and the receptionist gets called and she needs to know how to triage the call and who in the office they need to talk to. Having training for all the staff takes time, and so getting everybody up to snuff can be one of the challenges of the Ten Steps. I want to talk about the next five steps - the two I’m going to focus on are steps 9 and 10 because they are important to today’s conversation. One, the office has to have a system in place so that they know what happens in their community and who they can refer to; they need to have working relationships in that community and not just give mother a list of resources and tell them to call them if they have a problem. It needs to be more that everybody is working together and one of the things that we’re going to have highlighted today from a practice in Plattsburgh is that they are going to talk about their process map. Also, community partners that are awesome to point are the La Leche League, and of course, WIC. We’ve talked a little bit about Baby Cafes, about the drop-in centers and we can’t forget the day care providers

**Dr. Lawrence:** And the [La Leche] League is celebrating 60 years this year, and they are the original peer support.

**Deb Gregg:** They are.

**Moderator:** Well congratulations to them - that’s certainly noteworthy. Can you talk to us about how a healthcare provider in New York State can become a Breastfeeding Friendly Practice?

**Deb Gregg:** Let’s review the designation process. The first thing we usually recommend to practices is they look at the Implementation Guide. The implementation Guide was developed so that each step of the Ten Steps has strategies listed, and they need to fill out a pre assessment that would be looking at what happens in their office, what their practices are and going down ad looking to see what strategies they have implemented, things that they had in progress and things that they may be need to work on. Maybe they want to develop a lactation room, an actual dedicated space. They need to work with the breastfeeding champions in the office and other staff as part of their healthcare team to determine how logistically they are going this. Maybe they need art work or they maybe they need to go through and look at what kind of materials they are giving out to mothers - are they commercial free or not? All of that is part of the processes. So basically, when they feel like
that they have implemented all of the Ten Steps, they fill out the post assessment form and they write their breastfeeding policy. That policy and the post assessment are sent to us and the Department of Health staff look at it and we give feedback to the practices either in an e-mail or a phone call and talk to them. If they are designated, we send them a congratulations e-mail and we also might talk to them on the phone. They will receive a letter, some resources, and also they will be added to the Department of Health website by the county they reside in.

Moderator: Excellent. And what resources are available to help practices that might be seeking this kind of designation?

Deb Gregg: Well, on our website there are four documents. There is an introductory letter, which has instructions for the designation process. We have the Ten Steps handout which is very basic. We have the Implementation Guide, as I've stated, that is more detailed and has references and talks about all the different strategies. And the Assessment Form - the Assessment Form is used both for pre- and post assessment. And, I also need to point out as part of the assessment process that for an implementation to be designated as a Breastfeeding Friendly Practice, there are minimal strategies they need to implement. We hope that the practices they are implementing are more than just those basic strategies, because there are a lot of things that practices can do to make their practice be a more of a neutral office and more comfortable for any mom to make an informed decision.

Dr. Lawrence: So anyone could contact the website and get the information?

Deb Gregg: Right. Yes.

Dr. Lawrence: So everybody could be designated eventually.

Deb Gregg: Right. We haven’t had a midwife practice contact us yet – we’re waiting, hoping for that. Also federally Qualified Health Centers can be designated as a breastfeeding friendly practice. Right now we have 35 designated practices and their sites listed on our website. I just want to point out, based on the pilot projects, we created original documents. We have since, based on feedback from local health department staff and from the practices themselves, made some modifications and so those are newly posted on the website, so people should be using the new forms and looking at the new letter.

Moderator: Excellent. Now, moving ahead, Deb, can you talk to us about your plans to expand this initiative in New York State?

Deb: Well, our goal is to spread this State-wide. We are state-wide, but we want to have more than 35 practices, because there are a lot of practices across the state of New York. We've reached out to the New York City department of health, the Brooklyn Empowerment Zone - we'd like to have practices in the city that are involved in this designation. An exciting thing that just happened is that we have a funding opportunity, it is called Creating Breastfeeding Friendly Communities, and that's been posted. Our goal with that is to have communities developing more, or expanding, their breastfeeding coalitions, more breastfeeding friendly practices but also a designated healthcare baby center - excuse me, day care centers and day care homes. Also we want community organizations to be working with work sites. And, we want to establish baby cafes. So that is all part of that, and any New York State organization - their deadline is August 24th for this funding opportunity and we're very excited.

Moderator: Excellent. Thank you so much for everything you have shared with us this morning. We
really appreciate your contributions to the show. Let's take this opportunity to show how a small rural community practice – Plattsburgh Primary Healthcare Providers - has approached becoming a breastfeeding friendly practice.

**Rollin/Carolyn Brunelle, LPN, CLC, Plattsburgh Primary Care Health Partners & David Beguin, MD, PhD Plattsburgh Primary Care Health Partners:** Becoming a breastfeeding practice has inspired us to move forward with more energy, offering more services and getting support to more of not only mothers but fathers and entire families. There are more needs than we really had anticipated, so we keep raising the bar to meet the needs of the families.

Mostly we made a more welcoming office for it - art work and a breastfeeding room – and that brought with it a change even in the collective understanding of the staff. We both had a mentor in the hospital who worked pretty hard to improve breastfeeding – Lisa Pap, she was a nurse there for a long time. She didn't have an official role as a breastfeeding guru, but she acted like it. She spent a lot of time working on many of the issues and so we recognize that after leaving the hospital, that's where the big risk comes in. If you'd be willing to start, then once you get home, it gets very difficult. So, follow up phone calls from the hospital are fine for data gathering, but are not adequate to keep people breastfeeding. They come now for their Day 4 visit or two days after discharge for many pediatric reasons but very clearly the primary one is to support healthy feeding. And that's at a point where mother's milk comes in, sleep deprivation is starting to be a real factor, the baby naturally cries all night, and that's disturbing, especially if it is a first child. And not unusual for the pediatric nurse or lactation consultant to walk into a room of tears because it is not going well. It is such an excellent time, then for helping with latch, recognizing baby cues, reassurance that the weight is adequate. So typically, if I go in first there's a lot of tears, but if I go in after Carolyn has been there as the lactation consultant, there’s a lot of smiles and radiance, it’s a tremendous change. If they're discharged at Day 2, by the time they come and see us at Day 4, we were finding that a lot of moms had stopped nursing – they were actually bottle feeding because, many examples, they didn't think they had enough milk, they thought the baby was hungry, they had, you know, painful breasts. And so, in the process map, we make a one day discharge phone call to them to try to reach out to them on Day 3 or the day after they have been discharged to see how their first night was, if they feel they have to come in sooner, so that we can head off some of those problems before they throw in the towel for breastfeeding. So part of that process map is showing the staff what they can do on the weekend if they have a mom that needs help, where we can tap them into services.

Breastfeeding in our community has resulted in very low rates of admissions for illnesses in the wintertime. That is intentionally a byproduct of having everybody breastfeeding. When we have to admit babies in the wintertime, it's almost always, like in the rest of the state, for bronchiolitis – but breastfeed babies almost never get admitted for bronchiolitis – they're just so well they don't need that.

**Laura Thornton, RN and mother:** My name is Laura. I'm a first time mom. This is Luke - he's 3 months old. And before I had him, Carolyn met with my husband and me and talked to us for a good length of time and that was very impressive and felt more supportive to me. And then Dr. Beguin spent a long time chatting with us as well. So, I felt comfortable coming here and once we had our baby, things were really well for a long time, for four weeks. Then we started having some issues and it was really helpful to come here and have them say things are okay. You know, you are doing good, keep going. Giving us suggestions and being able to come and check in. I thought I knew a lot more than I did, which I think a lot of people
experience. Nothing is going to be what you thought it was, so just that reassurance totally changed our breastfeeding relationship.

**Moderator:** So good morning, Kate Rose. Thank you for joining us on the show. We're very excited to have you here.

**KateRose Bobseine:** Thank you very much. Good morning.

**Moderator:** I understand we're going to be talking about how breastfeeding can be promoted, protected and supported in hospital settings. Can you talk about the work that New York State is doing in that regard?

**KateRose:** Sure. I'd love to. So the New York State Department of Health works a lot with hospitals through the Breastfeeding Quality Improvement in Hospitals, or BQIH, initiative, which is a learning collaborative. The learning collaborative involves cooperation, communication and teamwork across prenatal, intrapartum and postpartum units, and providers who are providing care to mothers and babies in the hospital. It also is important to note that it involves partnerships with community and peer support programs such as WIC, as we’ve heard a lot about today, who support these families both before and after hospital discharge. And I did want to mention that, while the work I'm going to be talking about today is specific to New York State outside of New York City. But New York City also has their own hospital learning collaborative. They have been doing really wonderful work to remove barriers and enhance supports for exclusive and prolonged breastfeeding for moms in New York City. And I also want to mention as well that we know that not all hospitals will have the opportunity to have such intensive sport as BQIH hospitals get through the learning collaborative, but a lot of the work being done in these hospitals can also be done in hospitals who don't have that opportunity and they can also work to improve the care they are providing to moms and babies.

**Moderator:** Excellent, thank you. Now, can you start us off by sharing some statistics that will help paint a picture of how New York State is doing in terms of breastfeeding rates?

**KateRose:** I'd like to call your attention to a graph that compares New York State data to the Healthy People 2020 goals. Healthy People 2020 is a set of national goals designed to improve the overall health of Americans, and we're trying to achieve this by preventing disease and by promoting health equity and eliminating health disparities. As you can see on this graph, the blue bars represent the Healthy People 2020 and the red bars are New York State data on healthy infants that's collected through birth certificates. If you look at the first bar, which is any breastfeeding, you will see that New York State actually does pretty well with making sure that the vast majority of their infants are receiving some breast milk. But as you look across the graph, you will see that in other areas of measurement we have a lot of room for improvement. I wanted to, in particular, call attention to the two bars that are in the red rectangle: this is for exclusive breastfeeding at two days, and I want to highlight this because at this point, we know that most moms and babies are still in the hospital, so the policies and procedures that hospitals have in place are really impacting this measure and also the exclusivity and duration of breastfeeding for moms and babies.

**Dr. Lawrence:** That bottle of formula in the middle of the night that we have been struggling with for a long time.

**Moderator:** Absolutely. And, I think that is something we're hearing more and more about and hopefully programs like this are helping to shift some of that culture now. What other data do you
have about how women feed their babies during the birth hospitalization?

KateRose: So, we know that in 2014 – that is the most recent birth certificate data we have on healthy infants – we know that unfortunately almost about half of these healthy infants were being supplemented with formula, so as Dr. Lawrence mentioned, you know, maybe its happening in the middle of the night, or its happening at different times during the hospitalization, so, these are babies that are being breastfed, but are also being supplemented. So this is really impacting exclusivity. Unfortunately with these numbers, we also know that New York State is actually performing the worst of any state in the nation, so this is an area where we really see a lot of room for improvement and we want to make an impact in the hospitals to increase exclusivity and, again, duration of breastfeeding for moms and babies.

Moderator: So in acknowledging that certainly we do have room for improvement, how is the State working with hospitals to make that happen to increase breastfeeding rates and exclusivity?

KateRose: The State is working a lot with hospitals through the BQIH – Breastfeeding Quality Improvement in Hospitals initiative. This is a partnership actually between the New York State Department of Health and the National Institute for Children's Health Quality, or NICHQ. NICHQ is a national leader in this work, and have been doing work nationally and also in other states to improve breastfeeding rates. So, they are considered a leader in quality improvement, especially with children’s health issues. As I mentioned, it is a partnership that has been ongoing. It was first established in 2010. This partnership works with participating hospitals to build and sustain systems changes to achieve the Ten Steps to Successful Breastfeeding. We heard Debbie mention earlier the Ten Steps and this is an evidence-based set of actions hospitals can take. It was developed by the World Health Organization and UNICEF. Implementing these ten steps in hospitals should increase the exclusive breastfeeding rates among healthy newborns and we’re hoping specifically to do that in New York State. We’re also doing this by creating hospital environments that support breastfeeding and we’re also looking to reduce disparities in New York State breastfeeding rates, especially among low income women who participate in WIC and Medicaid.

Moderator: Now, can you tell us a little bit more about how the BQIH is implemented in hospitals and how hospitals engage in this work?

KateRose: So hospitals engage in this work first by putting together a multi-disciplinary team that can work towards improvement. This team gets together – I’m going to talk a little more about who will be on the team – but this team gets together to set some hospital-specific goals. So they really decide what they want to tackle in their hospital to improve the care they are providing to moms and babies around breastfeeding. Then, they test and implement changes to see if, you know, if they are working towards their goals in a positive way. They share results with each other, and then also, as part of the BQIH, they get one-on-one quality improvement advice from a quality improvement advisor through NICHQ. Then, they also have the opportunity to share their challenges, their successes, you know, the barriers and facilitators to this work with the other hospitals that are participating in the BQIH.

Moderator: Now you mentioned that this work is implemented by using a multi-disciplinary improvement team. Who would be appropriate to be on that team?

KateRose: So, it is really important to recruit a very robust team. We know from experience that having this team is a really key component to this success of this work. We know that the work can’t be done alone and so these teams can come together to facilitate the work together, and team
members should include a senior hospital administrative leader. We know that these leaders can really be key to implementing the work and making it sustainable. We also look to hospitals to recruit physician champions. So we’ve heard how important obstetric providers and pediatricians and family medicine doctors can be to informing mom’s decisions to breastfeed. They are in the hospitals too, so we need to engage them as champions in this work in the hospital to make sure that other physicians are on board and really carry the message of the importance of breastfeeding. We also look to the hospitals to include nurse managers, lactation support people. And, as Dr. Lawrence mentioned, you know, we know there are shifts, so there are the night nurses and sometimes night nurses, I think, get a bad rap for maybe being the people giving formula, but it is important to acknowledge that everyone giving care to the moms is so important. Getting the message about how their support is really key to the success of breastfeeding.

We also look to hospitals to include a quality improvement specialist and someone who works in IT. So the quality improvement specialist can really help with the data collection and dissemination and linking the goals of the BQIH to the overall goals of the hospital. The IT person can be so helpful because a lot of this work can be integrated into the electronic medical records. So, if you have an IT person on board that can really improve the likelihood that you will get those changes inserted into the EMRs in a real timely manner. It is also important to look outside the walls of the hospital, such as recruiting a mother partner - someone who’s given birth in the hospital within the last few years. It is important to try to engage a mom who’s not a member of the hospital staff, so someone who’s a little bit more objective, but their feedback on what their experience is like in the hospital can be so helpful to the work that you are doing, and also being sure to include community partners like WIC and La Leche League. They can really help as we’re trying to establish that continuum of care.

**Dr. Lawrence:** Well it is quite a bit like baby friendly hospitals and I’m sure members of our audience who are baby friendly hospitals are saying, well wait a minute, we’ve done that. What they haven’t done, perhaps is connect them with WIC on the outside. So, I think your last point is very important.

**Moderator:** Absolutely. Now, we’re just going to move ahead a little to talk about the timeline. It sounds like hospitals can achieve a great deal of work with a strong team that checks in frequently and uses the data to measure improvement. Can you talk about how the BQIH has worked with hospitals in New York State to take on the challenges of quality improvement as it relates to breastfeeding?

**KateRose:** As I mentioned, this partnership has been established since 2010. In 2010 there was a pilot cohort of 12 hospitals who worked with the Department of Health and NICHQ to start implementing this work in their hospitals and we saw a lot of success in that pilot. So the work that was done there really helped to inform Cohorts A and B, as we called them, of the initiative. So the second cohort started in October 2014 and just wrapped up earlier this year. Right now we’re in the third cohort of the BQIH, Cohort B; that just started in May of 2016 and we’re really excited. We actually have 21 hospitals who have taken on the challenge.

**Moderator:** Excellent. Can you tell us briefly about the successes participating hospitals have experienced while participating in the BQIH?

**KateRose:** Yes. I would love to. First, I’m going to highlight the fact that we saw some consistent successes in both the pilot and Cohort A. We saw improvements in the percentage of infants who were fed only breast milk, so that is the exclusive breastfeeding I was talking about. We also saw improvements in the percentage of breastfeeding infants rooming in, so that’s moms and babies who are spending at least 23 out of 24 hours together in the hospital and this can really facilitate
the breastfeeding relationship. And then we also saw improvements in the percentage of infants initiating breastfeeding within one hour for a vaginal delivery and two hours for a C-section delivery. So it was really exciting to see those results and then in Cohort A, we also saw additional successes. We saw an increase in the percentage of mother-infant dyads who were feeding on cue, so that was moms who were recognizing the cues the babies were giving them and they were able to immediately kind of put them to the breast and breastfeed. And we also saw an increase in percentage of the mothers and infants who were receiving a breastfeeding assessment. That means they saw a lactation person in the hospital who came in and maybe did a latch assessment and helped really increase their confidence of what was happening with the baby and that it was going in a positive direction. So very exciting results.

Moderator: Very exciting and it sounds like a lot of successes among your participants. What can we expect to see with the final cohort of the BQIH?

KateRose: I mentioned we’re now embarking on the final cohort. Twenty-one hospitals have signed on to participate and we actually last week on July 26th we had our first in-person learning session. So hospital teams from across the state came to engage in that. Each of the hospital teams brought – a lot of them brought about six to eight people – so we know they are putting together these really robust teams – a lot mother partners in the room and WIC representatives. The excitement and enthusiasm for the work was really tangible. It is really exciting to think about all of the successes that these hospitals could have. We did for this cohort, we really wanted to place a higher premium on recruiting a mother partner and also engaging WIC because we know how important they are. We heard about peer counselors earlier and the help they can provide before and after the hospital stay. So we really wanted hospitals to engage with WIC for this cohort and are very excited to see what will happen during the final stage.

Moderator: And it’s really wonderful to hear people are so dedicated to this work and really committed to working on the challenges of improving care for mothers and their babies in hospitals. What does this mean for our viewers? Are there takeaway messages that you would like to share?

KateRose: Yes. It is important to remember, as I said, that hospitals can take this work on even if they don’t have access to a collaborative. And although this is still considered kind of cutting edge work, there are more and more hospitals taking this on. In New York State, there are 45 hospitals outside of the city and 27 hospitals who are in the city who are taking on this work. Then, nationally there are hospitals as well. So we know there are mentors out there who we – and NICHD can help facilitate communicating with mentors so you can get started. So, similar to WIC’s motto, “You Can Do This; WIC Can Help,” hospitals can take this work on. It is important to start with one small step, so one of our NICHD members pointed out, rightly I think, that there are Ten Steps - you can start small, you can start with one step and go from there. It is important to recruit a team as I said. We know from experience this is such a key component of the success and we recommend that, you know, to people who want to take this work on to find and be a champion. So there are champions everywhere, physicians, hospital leaders, people in the community and then, you know, you yourself if you are interested in this work you can really be a champion. So having champions on this team, getting excited about this work can be really key, and then gathering and sharing your data. So collecting some baseline data, finding out how you are doing on some of these steps and collect data on a regular basis so you can check in to see if the changes you are making, you know, if they are making an impact in your hospital and then share that data back with your team to keep the motivation and excitement going. So lots of small things that hospitals can do to really improve the care they are providing.
Moderator: Excellent. Well thank you so much for all of the information you have shared with us this morning. It is certainly very promising and very exciting. Now, to better understand the impact of breastfeeding quality improvement in hospitals, we recently spoke with Dawn Frank, the lactation consultant coordinator at North Shore University Hospital.

Dawn Frank, RN, IBCLC NorthShore University Hospital: I had been hearing what was going on through the collaborative through mothers of my colleagues. My expectation was that it was going to be a lot of work, I knew that. But I knew that we would be able to do great things once we had the ability to dedicate resources to what needed to change. When moms and babies experience birth, the very best thing to get them breastfeeding is to put them skin-to-skin. While we had a skin-to-skin initiative and babies were going skin-to-skin before the collaborative, it wasn’t until the collaborative that they really stayed skin-to-skin at least an hour or so or until the first feeding. We changed all that because through the collaborative we came up with the idea of – from one of our great labor and delivery nurses – Wait for the Weights. From that the care changed in labor and delivery. So that now almost all of our vaginal deliveries go skin-to-skin for at least an hour until the first feed and even upwards of 70% of our C-sections are now doing that. That is really a very big change and a very positive one. The mothers say they love it. Right from the beginning, we had our chief of neonatology, Dr. Regina Spinizola, be part of our collaborative and she’s been very very instrumental in getting upper management involved so that we can get things to change.

It’s been our experience that we’re lucky in terms of having our pediatric hospitalists also having been part of our team. Our director has allowed some of our assistant nurse managers, both from the regular maternity floors and from labor and delivery, to be participants. It was huge having them there because, while staff was involved, it wasn’t until management was really part of the program that we can get changes to actually happen. When we were talking about the skin-to-skin project, one of the assistant nurse managers who’s very tech savvy, she was really very IT-on the ball, she was able to put into charts the progress that they were making piece by piece on this in terms of putting the babies skin-to-skin. So that really helped the staff to see what their progress. It was a way we could look at our data and be able to see that we were making changes happen. It was very very helpful to have that happen - that and the fact that the hospitalists were on board with helping us to keep babies from getting unnecessary formula supplementation made a very big difference.

When the joint commission changed their core measures and made breastfeeding exclusivity a core measure, we did a very very large educational program and involved many staff nurses so the lactation team would provide information to the breastfeeding champions and the breastfeeding champions would roll it out to the staff. Besides the lactation team seeing patients, now we were involved in all these initiatives to try to roll them out to as many nurses as we have - we reached a couple of hundred nurses in our maternity group as well as a few hundred in the labor and delivery nurses group. To roll out changes among that many people is really very difficult, so we also found that the amount of time that we had to put into it to meet the requirements of the BQIH collaborative in terms of data collection, in terms of reporting, in terms of collaborating through the different groups, was time consuming. So, it was great work that we were doing, but it was hard.

We really learned to use data – we really weren’t very good at the beginning and when we reviewed our ‘Ten Steps’ assessment, we really thought we were pretty good before we started. And then, as we gathered data and showed ourselves where we really stood, we learned a lot about how much more we needed to do. The data collection had a really huge impact because it helped us to show the things that we knew were happening but that we
couldn’t prove that were happening until we had data, so the data was a huge thing. The other thing was that BQIH taught us to use a PDSA format whereby you identify a problem and make an assessment of it, you try it out and then you act on what you have learned. So that was very, very helpful, because we were doing so many things and we wanted to change so many things to be able to sort of whittle down to learn to work on one thing at a time and get that accomplished.

We really learned through the collaborative to make our focus smaller, to learn from what we were doing and then to go on to be able to complete some of the things that we wanted to do. For example, through the hospitalists working on the collaborative, we came up with a program whereby all the interns have to take the 20 hour course that comes from the state, and then after that, they spend a three or four hour block with the lactation team whereby we talk about how they need to be part of the team to make things better for mothers and babies.

We realize that we’re really in the midst of a paradigm shift from the fact that most people accepted that formula feeding was of no consequence and really didn’t make much of a difference. And now we’re shifting our thinking and involving our partners so that we are getting to the point where we do realize that formula makes a difference, and unless it is medically necessary, we want to provide a supportive environment whereby mothers and babies are getting the support they need to keep to exclusivity. Our pediatricians are now part of the team rather than part of the difficulty. We have also taught mothers in our skills fair to use manual breast expression and we’re trying to get every nurse on board to be able to do that with moms so that in the event a baby does need supplementation, the supplementation first and foremost would be breastmilk, rather than formula. We’re really seeing a change in that regard. Now, when I look at the data every day, or when we do our statistics, I can actually see baby after baby who’s had five mills of breast milk or ten mills of breast milk, until they get rolling and then go on to breastfeed. So, that is a really big change that has been very very helpful and it all came from this collaborative and the support of our institution.

Moderator: Certainly very exciting information - let’s take a look at one more clip that summarizes how important collaboration is for building relationships that foster positive change in our healthcare settings.

Rollin/Susan Vierczchalek, MD, New York Milk Bank: Skin-to-skin is a name we gave to this concept of keeping mothers and babies together, we’ve learned so much about how important it is not just for breastfeeding but for bonding, for brain development. These little newborns, you know, those neurons are connecting and remodeling 300 cells a second in that period. So it is – the feeding and the nutrition is also the nurturing and the bonding that is so important. As far as the human race goes, that’s been our – one of our survival mechanisms throughout – you know, throughout all of history. It is only really the 20th century that we started separating mothers and babies after birth, and in the 21st century, we’re trying to get back to keeping them together and working with the moms here at Bellevue, particularly in our low – you know, most of them come from low income backgrounds, most of them work and employment is a huge barrier. So many new moms say they don’t even want to try because they are going back to work in one week, two weeks. I saw a mom and baby once in the clinic, four days old, and asked her if she would like to see one of our lactation counselors and she said "No, I have to go do work this afternoon." We need to recognize that moms from different backgrounds have different challenges, so we really need to work on our communication skills and both language, both different
languages and just in the way we address it, to be sure that we address their concerns. And moms need more resources after they leave the hospital, especially our low income moms. WIC does a terrific job with peer to peer counseling. In different areas there are various home visiting programs, to really expand some of those to really help support our moms so they can meet their goals.

Dawn Frank, RN, IBCLC, NorthShore University Hospital: We’ve really again been so fortunate - our WIC partners were part of the collaborative right from the start, and we’ve learned so much from them and shared a lot of our information on what we provide for patients so that they can teach the same thing prenatally and following up when the patients come back for WIC care. In addition, we have used one of the loving support teaching models that came out of the WIC and we’re using that in our Skills Fair to help nurses to speak to moms in a way that they will accept, talking about breastfeeding in a way that’s positive, so that mothers then will be able to be taught in a way so that they will choose the better health for their baby by breastfeeding. It is working out really well, and we’ve really done some really good things together with WIC.

Dawn Kempa, RN, IBCLC, Long Island Jewish Medical Center: Also, I would definitely say you should, as the WIC coordinator or breastfeeding coordinator, you need to be involved in the community in all of these quality improvement projects going on – with Baby Friendly, Breastfeeding Quality Improvement in Hospitals, the Breastfeeding Task Force, Breastfeeding Friendly Clinics – all these [initiatives] WIC needs to be involved in. We can do our part prenatally to have moms know what to expect in the hospital and then they go to the hospital and it actually happens where they are doing the skin-to-skin they learned about, and rooming with the baby. They have their family involved – the grandmother, the partner, the husband, the boyfriend – staying with them in the room so they are able to even stay with their baby even after a C-section and can exclusively breastfeed their baby. They need to know about that prenatally, though, so they know what to expect in the hospital, then, of course, linking in the community and the pediatric clinics afterwards to tell them what WIC has to offer and what they need to be doing in their clinics to help us.

David Beguin, MD, PhD Plattsburgh Primary Care Health Partners: Some is the actual dollar resources for art work and for setting up a breastfeeding room, but it is also that sort of moral support [to say] that, “Yes, this is a legitimate thing to be doing – you guys are most of the way there, these are the other pieces you still need to work on to achieve the breastfeeding friendly status.

Carolyn Brunelle, LPN, CLC, Plattsburgh Primary Care Health Partners: The health department has also provided funds for training of more CLCs in our area and it’s very encouraging because the more CLCs we have in our area the more supportive – support we can give these moms. We developed a breastfeeding process map here in our office, but then the Clinton County Health Department had a Breastfeeding Coalition Group and we brought our map to the Clinton County Coalition Group and they sat down and looked at it and they loved it. So then they took that idea and they put together their own county breastfeeding process map which includes all of the lactation clinics at the local hospital, the doctor’s office, WIC and the home visiting nurses program. It is all tied in together so that, and also the LaLeche League. There are phone numbers for them to contact and the health department took that map and really expanded that map and it’s been a great tool to use for people in the community.

Jennifer Ustianov, MS, BSN, RN, IBCLC, National Institute for Children’s Health Quality:
It’s so important to pull together a very strong team whenever you go to make a change. That team then brings a voice from all different perspectives. So when we are working with hospitals in a collaborative, we recommend that they have a multi-disciplinary team that is pulled together, because we need to hear from providers. We need to hear from nurses. We need to hear from all of the stakeholders, but most importantly, we need to hear from partners outside of the walls of our hospitals. So that means we focus in on community-based resources and our mothers. How much more important is it that we have a voice from a mother that actually helps us inside a hospital remember what it is like to receive that care and then go home? For hospitals that aren’t involved in collaboratives, I think you could do the very same. I think it is not as common for us to reach outside the walls of our hospitals and ask for those partners to sit at the table with us and talk about what we need to improve, but it is so important to have their voice; when we start creating an education pamphlet and we as a medical professional sit down and say, "I think this is what needs to be in it," and we design it. Then, if we hand it to a mom and she says, "Gee, that won’t resonate with a lot of the population that is in our community," that is a valuable tool to have at the table as we plan and execute our changes so they actually are worthwhile and really make a difference.

**Moderator:** So, now that you have had the opportunity to hear from three leaders in the New York State Department of Health and from Dr. Lawrence, who is a constant inspiration to all breastfeeding advocates, let’s hear from a very important leader in New York State, Dr. Howard Zucker, the Commissioner of the New York State Department of Health.

**Howard A. Zucker, MD, JD, Commissioner, New York State Department of Health:** Breastfeeding is a public health priority because there is strong evidence that exclusive breastfeeding saves lives. It also improves health and cuts healthcare costs. Despite the evidence, the rates of exclusive breastfeeding are low in New York, below national health care goals. In 2014, 87% of New York mothers initiated breastfeeding but only 43% of them were exclusively breastfeeding by the time they left the hospital. In fact, half of all breastfed infants were receiving infant formula during the hospital stay – that’s often unnecessary and undermines breastfeeding. New York State has responded with laws and regulations that require increased support for exclusive breastfeeding. The health department is working with hospitals and providers to implement system changes and encourage moms to breastfeed exclusively.

We want to reverse our high rate of formula supplementation and extend breastfeeding well into the first two years of a child’s life. Healthcare providers play a critical role. Patients trust their physicians and rely on them for information and support. Healthcare providers have opportunities to talk to pregnant women about breastfeeding throughout their pregnancy. From the very first prenatal appointment, providers can help ensure women and their families are fully informed when they develop their birth plan and make informed breastfeeding decisions. Hospitals that implement evidence-based practices and enable skin-to-skin bonding right after birth build the mother’s confidence. When doctors and nurses help mothers understand newborn behavior and feeding, moms can be reassured that their body is responding to their baby's needs. Pediatric providers who are knowledgeable about breastfeeding can answer questions for mothers. They can make sure women receive the lactation support they need without turning to breast milk substitutes.

New York Governor Andrew Cuomo included the Paid Family Leave Act in his executive budget because it is the right thing to do. One of the main reasons women stop breastfeeding exclusively is because they have to return to work. With paid family leave,
New York is demonstrating its commitment to families. Working mothers and fathers will have partial wage replacement, which allows them to stay home and bond with their newborn. Research shows that mothers with paid family leave are more likely to exclusively breastfeed and to do so for a longer period of time. Breastfeeding rates increased markedly in California when they implemented paid family leave. This act will also help reduce breastfeeding disparities in New York, especially among lower wage workers. New York has strong laws in place that protect the rights of mothers to breastfeed in public, in day care facilities, and at work. After three years after she gives birth, a mother can take reasonable break time to express milk in the workplace. These laws apply to all employers, regardless of the number of employees. The Child and Adult Care Feeding Program has a breastfeeding friendly designation for day care centers and homes - providers must train and meet established standards to get the designation. Currently 14 hospitals in New York have been designated Baby Friendly. More are working to achieve the designation and both New York City and New York State health departments are working with hospitals to increase baby friendly hospitals statewide. New York is also working to provide breastfeeding support for women and babies in WIC. WIC serves more than 50% of all infants born in New York State. The Exclusive Breastfeeding Learning Community pilot appears to improve exclusive breastfeeding rates among women enrolled in WIC. This is especially true for women in ethnic and racial groups with the lowest rates of exclusive breastfeeding.

By identifying potential barriers to successful breastfeeding, providing targeted support to women and strengthening collaborations with healthcare providers, we can reduce breastfeeding disparities among WIC participants. And, recently, after many years of hard work and advocacy by staff and volunteers, we licensed the New York Milk Bank in 2016. The Milk Bank will increase the opportunity for New York hospitals to provide human donor milk that’s been carefully screened to medically fragile infants. This will increase breastfeeding rates and save infants’ lives.

If we want to change the culture we need to change the conversation around breastfeeding. Supporting mothers to successfully breastfeed is our collective responsibility – not just that of the woman. Policymakers and providers need to make sure breastfeeding and lactation support are available to all women, regardless of their background or circumstances. As leaders in public health, we must take action to make exclusive breastfeeding the norm not the exception. We also need to protect the public from harmful commercial interests. We need to recognize the negative impact that infant formula advertising has on parents and how it undermines exclusive breastfeeding.

Building a continuum of care is essential. We must work with our clinical and community partners to ensure women receive continuous, skilled lactation support across disciplines and settings. The public health strategies presented today demonstrate how each of us doing our part and then collaborating across the healthcare system impacts the quality of patient care. Change can be difficult. It requires the dedication of staff and leaders like you who care about the health and wellbeing of mothers and babies. I challenge each of you to be an agent of change. Take the information and resources presented today to make changes in your organization that inspire, encourage and support mothers to make the decision to breastfeed.

Moderator: So we've really covered so much information in today's show and it is really exciting to hear all of these different initiatives and how folks are coming together across the state. So before we take some questions, I know Dr. Lawrence there were some thoughts you wanted to share on the key messages and information we've shared on today's show.
**Dr. Lawrence:** One of the things is of course we've talked about New York State and it is a wonderful program that has great success. But there are a lot of people out there who don’t live in New York State, and they need to hear how they can begin this process. Many of them are Baby Friendly, but how do you contact WIC across the country?

**Moderator:** So, let's hear from our panel. For those who have been involved in these efforts, how can people find out more information about what we've been doing here in New York State?

**Deb Gregg:** Well the New York state website has a lot of information. Just to go search and you can put in "breastfeeding." And it will pull you to our new breastfeeding page - it's just been updated about two months ago, and all these topics are covered in that particular page.

**Moderator:** Excellent.

**Pat Jordan:** And the other comment that I would make [is that, for information ] across the country, there is the national WIC association [which] has a website. The process that we replicated in New York was from Vermont, and that was a special project grant. So information from across the country for what WIC programs are doing, a lot of that can be found on the national WIC website and then individual states can be contacted.

**KateRose Bobseine:** And also for work in the hospital, so as Dr. Lawrence mentioned, there is the Baby Friendly Hospital Designation which is a national designation, also based on the Ten Steps ...

**Dr. Lawrence:** International.

**KateRose:** International, thank you - based on the Ten Steps to Successful Breastfeeding. So that is a great resource and then also NICHQ has been doing this nationally – they've had a couple learning collaboratives. So that is another great place to visit to learn more about this work and how quality improvement work can be done in hospitals – in New York State but also nationally and internationally, as well.

**Moderator:** Excellent as we move to bring this initiative and important work across the country and expand our audience. We have a few questions from the audience. The first is how long is considered ideal for exclusive breastfeeding? Surely by the two year mark solid food would be part of a child’s diet. Does exclusive breastfeeding refer only to the exclusion of formula as a way to feed babies?

**Dr. Lawrence:** Well, that is a very important point and the Academy of Pediatrics has addressed this, because their proclamation says exclusive breastfeeding for six months, then adding weaning foods for the next six months. So they project you should breast-feed for at least a year. And then they say for as long thereafter as mother and baby wish, not putting a cap on it. But the child is introduced weaning foods at six months, as suggested, and take it from there.

**Moderator:** All right. Another question, I’m from another state and have a question about the tool kits. What do other states or organizations need to do if they want to use the content of a tool kit but tailor it to their facility or practice?

**Pat Jordan:** Others can maybe respond from their perspective, but from the WIC perspective a lot of the materials that we put together for the public health detailing, we looked at resources that the Vermont program had used and looked to see what we had that might be somewhat similar to that,
or developed some materials. But any of the materials that were used in the New York State WIC Program – if agencies or programs want to contact the New York State WIC Program, we often reciprocate with permission to allow people to modify and use some of the materials we've developed.

**Moderator:** Excellent.

**Deb Gregg:** And we could would do the same thing; we would want them to reference us that it was developed by New York State and then they could adapt it to their uses.

**Moderator:** Excellent, and I believe all of the resources that we've talked about today are available as links on our website, so for audience members watching who want more information, all of this can be found on our website as well. I believe we have time for one more question: I am a breastfeeding peer counselor from Virginia Beach WIC and I was wondering how we could get copies of the BAPT and breastfeeding checklist. This is a great idea.

**Pat Jordan:** Just contact New York State WIC program and we'd be happy to provide the information.

**Moderator:** Okay. Any other closing thoughts or last minute ideas - we have just a few minutes left in the show before we close.

**Dr. Lawrence:** Well, I think we've had a very important discussion and I think it is very important to emphasize that although we did talk about New York State - and I didn't mention Rochester the whole morning [laughter] - that it's adaptable across the country and around the world. Baby Friendly is around the world. And all of these programs are international.

**Moderator:** Absolutely. What a wonderful message to close on. Thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs, and continuing education credits are available. To obtain CME, CNE, and CHES, LCERP or general education credits, learners must visit the program webpage and complete an evaluation and the post-test for today’s offering. Please join us on September 15th for our next Public Health Live program. Additional information on upcoming webcasts and relevant public health topics can also be found on our Facebook page. Don't forget to like us on Facebook to stay up to date! This webcast will be available on demand on our website within two weeks of today's show. I'm **Rachel Breidster**. Thanks for joining us for Breastfeeding Grand Rounds!