CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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The Breastfeeding-Friendly Pediatric Office Practice

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The landscape of breastfeeding has changed over the past several decades as more women initiate breastfeeding in the postpartum period and more hospitals are designated as Baby-Friendly Hospitals by following the evidence-based Ten Steps to Successful Breastfeeding. The number of births in such facilities has increased more than sixfold over the past decade. With more women breastfeeding and stays in the maternity facilities lasting only a few days, the vast majority of continued breastfeeding support occurs in the community. Pediatric care providers evaluate breastfeeding infants and their mothers in the office setting frequently during the first year of life. The office setting should be conducive to providing ongoing breastfeeding support. Likewise, the office practice should avoid creating barriers for breastfeeding mothers and families or unduly promoting infant formula. This clinical report aims to review practices shown to support breastfeeding that can be implemented in the outpatient setting, with the ultimate goal of increasing the duration of exclusive breastfeeding and the continuation of any breastfeeding.

BACKGROUND/CURRENT RECOMMENDATIONS

Breastfeeding has long been documented as the ideal method for feeding and promoting the optimal development of infants and children, with rare exceptions (see Recommendation 3 below). The American Academy of Pediatrics (AAP) describes breastfeeding as the normative method of infant feeding. There are countless medical, emotional, and economic benefits of breastfeeding as described in the 2012 AAP statement "Breastfeeding and the Use of Human Milk."[1] Benefits of breastfeeding include decreased risk of lower respiratory infections, gastroenteritis, otitis media, and necrotizing enterocolitis, the latter being especially important in preterm infants. Because breastfeeding is the norm for infant feeding, comparatively there are risks associated with the lack of breastfeeding, which include an increase in sudden infant death syndrome, obesity, asthma, certain childhood cancers, diabetes, and postneonatal death.[1–3] Breastfeeding promotes attachment and optimal

abstract

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cognitive development. In women, lack of breastfeeding is associated with an increase in the risk of breast and ovarian cancer, type 2 diabetes, heart disease, and postpartum depression.[4–7]

The AAP recommends exclusive breastfeeding for approximately 6 months, followed by continued breastfeeding for 1 year or longer, as mutually desired by mother and child.[1] The *Surgeon General's Call to Action To Support Breastfeeding*[8] in 2011 emphasized the importance of breastfeeding as a public health imperative. Breastfeeding is strongly promoted, supported, and encouraged by the AAP, the Academy of Breastfeeding Medicine,[9] the American College of Obstetricians and Gynecologists,[10,11] and the American Academy of Family Physicians.[12] Each of these organizations calls on its members to be actively engaged in promoting and supporting breastfeeding among their patients.

TABLE 1 The Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding-friendly policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within 1 hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming in: allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.[a]
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

[a] The AAP does not support a categorical ban on pacifiers because of their role in SIDS risk reduction and their analgesic benefit during painful procedures when breastfeeding cannot provide the analgesia. Pacifier use in the hospital in the neonatal period should be limited to specific medical indications, such as pain reduction, calming in a drug-exposed infant, etc. For breastfed infants, pacifier introduction should be delayed until breastfeeding is firmly established. Infants who are not being directly breastfed can begin pacifier use as soon as desired.

EPIDEMIOLOGY

The rate of initiation of any breastfeeding in the US population is 81.1% according to data from the National Immunization Survey (2016, birth cohort from 2013).[13] Although the rate of breastfeeding initiation approaches the Healthy People 2020 target[14] of 81.9%, only 22.3% of US infants are breastfed exclusively at age 6 months. There are significant disparities in terms of breastfeeding rates in the country; among black infants, only 66.3% are breastfed at all, and only 14.6% are exclusively breastfed through the first 6 months of life. Among Native American and Alaska Native infants, breastfeeding initiation is 68.3% and exclusive breastfeeding rates at 6 months are 17.9%. Mothers are more likely to breastfeed if they are married, have a college education, live in metropolitan areas, do not experience poverty, and do not receive benefits from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC provides targeted breastfeeding support and peer-counseling services for mothers who qualify for their services. Infants most likely to experience toxic stress are least likely to be breastfed. According to the 2005–2007 Infant Feeding Practices Study II, 85% of US mothers intended to breastfeed exclusively for ≥3 months; however, only 32.4% achieved their intended exclusive breastfeeding duration.[15]

CURRENT INITIATIVES TO INCREASE BREASTFEEDING RATES

There have been numerous initiatives to increase breastfeeding exclusivity and duration both in hospitals and in the outpatient setting. US hospitals accredited by The Joint Commission with maternity units that have at least 1100 births per year are required to report data on the Perinatal Care Core Measure Set, which includes a measure on Exclusive Breast Milk Feeding.[16] There have been major initiatives to increase the number of maternity facilities designated as Baby-Friendly. The first of these was Best Fed Beginnings,[17] a collaboration of the National Initiative for Children's Healthcare Quality, the Centers for Disease Control and Prevention (CDC), and Baby-Friendly USA, in a national effort to improve maternity care practices and achieve designation as Baby-Friendly. Through Best Fed Beginnings, hospitals implemented the evidence-based and AAP-endorsed Ten Steps to Successful Breastfeeding (Table 1), as established in the Baby-Friendly Hospital Initiative, developed by the World Health Organization (WHO)/United Nations Children's Fund.[18–20] Additional maternity care facilities are pursuing the Baby-Friendly designation by participating in EMPower Breastfeeding: Enhancing Maternity Practices,[21] in cooperation with the CDC's Division of Nutrition, Physical Activity, and Obesity, and in partnership with the Carolina Global Breastfeeding Institute and Population Health Improvement Partners. EMPower similarly provides support to hospitals in quality-improvement methodology and breastfeeding support to improve maternity care practices and achieve Baby-Friendly USA designation. The number of births in designated facilities increased from 2.9% in 2007 to 20.01% in January 2017,[22] surpassing the Healthy People 2020 goal of 8.1%.[14]

For the national breastfeeding targets to be met, outpatient support from pediatricians and other pediatric care providers is imperative. As more infants are

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being discharged from hospitals designated as Baby-Friendly and having successfully initiated breastfeeding, it is essential that the pediatricians with whom they will follow up are knowledgeable about breastfeeding and that their office practices are prepared to support these breastfeeding dyads. The *Surgeon General's Call to Action To Support Breastfeeding* lists specific action steps that apply directly to the pediatric outpatient practice (Table 2).

TABLE 2 Relevant Steps in the US Surgeon General's Call to Action to Support Breastfeeding

1. Give mothers the support they need to breastfeed their infants.
6. Ensure that the marketing of infant formula is conducted in a way that minimizes its negative impacts on exclusive breastfeeding.
8. Develop systems to guarantee continuity of skilled support for lactation between hospitals and health care settings in the community.
9. Provide education and training in breastfeeding for all health professionals who care for women and children.
10. Include basic support for breastfeeding as a standard of care for midwives, obstetricians, family physicians, nurse practitioners, and pediatricians.
11. Ensure access to services provided by IBCLCs.

Shown are action steps that apply directly to the pediatric outpatient practice, numbered according to the original steps in the Call to Action.[8]

Many pediatricians have little experience in clinical breastfeeding management. Analysis of an AAP Periodic Survey of Fellows regarding breastfeeding in 2004, compared with a similar survey in 1995, showed that pediatricians were less likely to believe that the benefits of breastfeeding outweighed the difficulties or inconvenience, and fewer believed that almost all mothers were able to succeed.[23] Unfortunately, more pediatricians in 2004 reported reasons to recommend against breastfeeding compared with the cohort who responded in 1995. A 2014 AAP Periodic Survey confirmed that some of these attitudes persist (unpublished data from American Academy of Pediatrics Periodic Survey of Fellows No. 89).

Szucs et al[24] found that there were gaps in providers' breastfeeding knowledge, counseling skills, and professional education and training. The authors showed that providers' cultures and attitudes affected breastfeeding promotion and support and that the providers used their own breastfeeding experiences to replace evidence-based knowledge and AAP policy statement recommendations. Both the Academy of Breastfeeding Medicine (ABM)[25] and the US Breastfeeding Committee[26] have published recommendations regarding the education and training of health care professionals, including pediatric care providers, in breastfeeding support and management.

The ABM's clinical protocol "The Breastfeeding-Friendly Physician's Office: Optimizing Care for Infant and Children"[27] details specific steps that a practice can take to become more breastfeeding friendly. These guidelines can inform the guidance for pediatric offices. Corriveau et al[28] sought to determine whether implementing a program based on this clinical protocol affected breastfeeding rates within the pediatric primary care setting. Even with a diverse patient population, rates of both initiation of and exclusive breastfeeding increased after the implementation of the ABM breastfeeding-friendly protocol. Feldman-Winter[29] outlined methods to increase breastfeeding initiation and duration in "Evidence-Based Interventions To Support Breastfeeding." In a comprehensive evidence review for the US Preventive Services Task Force, Chung et al[30] provided evidence that breastfeeding interventions, including both pre- and postnatal interventions, were more influential than either alone and that interventions including a component of lay support, such as peer counselors, are more effective than usual care in increasing short- and long-term breastfeeding rates. The US Preventive Services Task Force recommends interventions during pregnancy and after birth to support breastfeeding and concludes that coordinated interventions can increase breastfeeding initiation, duration, and exclusivity (Evidence Grade B).[31]

THE BREASTFEEDING-FRIENDLY PEDIATRIC OFFICE PRACTICE

Because of the importance of breastfeeding to maternal and infant health outcomes, all pediatric care providers should aim to improve breastfeeding rates in their practices, with the goal of achieving the AAP breastfeeding recommendations for exclusive breastfeeding until approximately 6 months, followed by continued breastfeeding for 1 year or longer, as mutually desired by the mother and infant.[1] Pediatric care providers should help mothers identify and reach their own breastfeeding goals.

The following evidence-based recommendations for the pediatric outpatient practice should be considered as part of the practice-improvement process to increase breastfeeding rates to meet or exceed the AAP recommendations and the Healthy People 2020 goals. These recommendations provide guidance for clinical care and are not intended to imply a standard of care, nor does this report provide a strict weighing of the evidence:

1. Establish a written breastfeeding-friendly office policy that includes the provisions as outlined in this document and in Table 3.[27,32,33] Provide a lactation room with

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supplies for employees who breastfeed or express breast milk at work. This room could also be used by breastfeeding mothers (refer to recommendation 12). Collaborate with the entire team, including colleagues and office staff. All employees should be aware of the policy, and copies of the policy should be provided to all staff, including anyone who answers the telephone or retrieves messages, such as front office staff.

2. Train staff in the skills necessary to support breastfeeding, especially nurses and medical assistants.[33] Identify ≥1 breastfeeding resource personnel on staff. If possible, consider employing an International Board Certified Lactation Consultant (IBCLC), or a nurse or other staff member trained in lactation support. Trained staff members may be able to perform much of the routinely provided breastfeeding support under the guidance of the pediatrician or other health care provider. The staff should be aware of community resources, including IBCLCs and other lactation support personnel, especially if one is not available in the practice (see recommendation 15).

3. Become knowledgeable regarding the rare but true contraindications to breastfeeding, which include infants with the classic form of galactosemia, maternal HIV or antiretroviral therapy, untreated active tuberculosis, human T-cell lymphotropic virus type I or II, use of illicit drugs, or mothers undergoing chemotherapy or radiation treatment.[34] Most maternal medications are compatible with breastfeeding. Specific drug information can be verified through the National Institutes of Health Toxicology Data Network, LactMed, which is accessible online or through a mobile device application.[35]

4. Introduce the subject of breastfeeding as early as possible, ideally with prenatal visits and early postpartum visits.[27] Use open-ended questions to inquire about feeding plans for the child, such as "What are your thoughts about feeding your baby?" or "Tell me about your previous infant feeding experiences." Encourage attendance by both parents and/or partners at all visits, and consider discussions with grandparents or other important decision-makers in the family.[36]

5. Encourage breastfeeding mothers to feed newborn infants only human milk and to avoid offering supplements, including formula, glucose water, or other liquids, unless medically indicated.[1] This education ideally should begin prenatally, in anticipation of the newborn infant's stay in the maternity hospital, and should continue through the early postnatal visits.

6. Work with committees within the local hospital or birthing center to implement breastfeeding-friendly care.[1,17,18] Provide the hospital or birthing center with your office policies regarding breastfeeding. If the facility is not aware of the WHO/United Nations Children's Fund Ten Steps to Successful Breastfeeding, the pediatrician can provide education and help to develop breastfeeding-friendly order sets for the hospital. Encourage the facility to pursue the Baby-Friendly USA designation so that mothers and infants are exposed to maternal and newborn care that supports and encourages breastfeeding, beginning with skin-to-skin care in the immediate postpartum period and early initiation of breastfeeding.[20] Show support for breastfeeding during hospital rounds by reinforcing the benefits of breastfeeding, encouraging exclusive breastfeeding, educating about the importance of frequent breastfeeding, and assessing the adequacy of breastfeeding. During rounds, either evaluate a feeding directly or review the chart for documentation of adequacy of feeding. Encourage mothers to attend breastfeeding classes. Advocate for lactation consultation for mothers who are experiencing any breastfeeding problems or who have concerns.

TABLE 3 Summary of Breastfeeding Supportive Office Practices

1. Have a written breastfeeding-friendly office policy
2. Train staff in breastfeeding support skills
3. Discuss breastfeeding during prenatal visits and at each well-child visit
4. Encourage exclusive breastfeeding for ~6 months
5. Provide appropriate anticipatory guidance that supports the continuation of breastfeeding as long as desired
6. Incorporate breastfeeding observation into routine care
7. Educate mothers on breast-milk expression and return to work
8. Provide noncommercial breastfeeding educational resources for parents
9. Encourage breastfeeding in the waiting room, but provide private space on request
10. Eliminate the distribution of free formula
11. Train staff to follow telephone triage protocols to address breastfeeding concerns
12. Collaborate with the local hospital or birthing center and obstetric community regarding breastfeeding-friendly care
13. Link with breastfeeding community resources
14. Monitor breastfeeding rates in your practice

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7. Schedule the first newborn visit by the third to fifth day of life, or approximately 24 to 48 hours from the time the newborn infant is discharged depending on the length of the hospital stay. At office visits, incorporate anticipatory guidance that supports exclusive breastfeeding until infants are approximately 6 months old, followed by continued breastfeeding for 1 year or longer, as mutually desired by the infant and mother.[1] Anticipatory guidance should include appropriate guidance about weight-gain expectations with the use of appropriate growth charts, such as the WHO growth standards for ages 0 to 2 years recommended by the CDC.[37]
8. Educate mothers regarding the provisions of the Patient Protection and Affordable Care Act (Pub L No. 111-148 [2010]), which cover access to breastfeeding support services, breaks to breastfeed or pump at work, as applicable,[38] and the ability to obtain breast pumps through insurance.[39]
9. Provide mothers with anticipatory guidance about returning to work. Workplace support in the pediatric practice and in other work environments can be optimized through the implementation of guidance from the Health Resources and Services Administration Maternal and Child Health Bureau's Business Case for Breastfeeding.[32] Provide information and education to mothers about both the expression and the storage of human milk, which may include providing parents with handouts detailing the recommendations regarding expression and storage.[40]
10. Have the front office staff advise the family, when the first follow-up appointment is scheduled, that the pediatrician or other trained office staff may wish to observe a feeding during the first visit, so that the family will be aware. Encourage the family to let the staff know when the infant is ready to feed while waiting for the appointment. For the first and subsequent appointments, feedings should be observed when the mother identifies any breastfeeding problem, or if weight gain is not appropriate.
11. Provide appropriate educational resources for parents.[41,42] These resources could cover, at a minimum, the benefits of breastfeeding for mother and child, AAP recommendations for duration of breastfeeding, education regarding feeding cues, how to tell whether the infant is getting enough milk, latch and holding techniques, and a list of peer support groups and local breastfeeding resources. The literature should be culturally sensitive and appropriate for the literacy of the patient population. Consider linking to appropriate resources on the practice Web site. Avoid distributing literature provided by manufacturers of infant formula.
12. Allow and encourage breastfeeding in the waiting room.[33] Display noncommercial posters and pamphlets that encourage mothers to breastfeed in waiting areas and examination rooms. Include graphics that show diversity and include fathers, who are valuable partners in the success of the breastfeeding dyad. Do not interrupt or discourage breastfeeding, either in the waiting room or in the examination room. Provide a comfortable, private area for mothers to breastfeed if they prefer privacy. This room may include a rocking chair, pillows, music, water fountain, or whatever helps to create a warm and relaxing environment. An examination room may suffice as a private room for breastfeeding.
13. Eliminate the practice of distribution of free formula and other infant items from formula companies to parents.[43,44] In accordance with the WHO International Code of Marketing of Breast-milk Substitutes,[45] the storage of formula supplies, which may be purchased by the practice as applicable for formula-fed infants, should be out of the view of patients. The breastfeeding-friendly pediatric office practice should not accept gifts (formula and other feeding supplies, pens, writing pads, calendars, mugs, etc) from companies manufacturing infant formula, feeding bottles, or pacifiers. Consumer publications that advertise infant formula or have tear-off cards or inserts to receive free or discounted formula should be discouraged.
14. Train staff to follow telephone triage protocols to address breastfeeding concerns and problems. Train staff on providing appropriate breastfeeding telephone advice, including when to refer to an IBCLC or to a physician with special expertise in breastfeeding management.[46] Telehealth consults may be an option in some locations.
15. Acquire or maintain a list of community resources and be knowledgeable about referral procedures. Refer expectant and new parents to peer, community support, and resource groups.[33] Get to know peer and community support groups in your area. WIC breastfeeding support services, La Leche League International, and peer counselors are

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some options. Not all groups may provide evidence-based information, so it is useful if the pediatric care provider or members of the clinic staff have attended and maintain good communication with the leaders of these support groups. Consider inviting successfully breastfeeding mothers to join any advisory groups associated with the practice.

16. Frenulum clipping of the tongue/upper lip has become a popular practice, which may improve infant latch and the effectiveness of breastfeeding and milk transfer. Work closely with local lactation consultants or breastfeeding specialists to determine if frenotomy is appropriate. If so, refer to otolaryngologists and/or dentists with experience in clipping the frenulum in a timely fashion, if the physicians in the practice do not perform the procedure.

17. Collaborate with the obstetric community to develop optimal breastfeeding support programs, because it is clearly documented that a mother's decision to breastfeed starts in the prenatal period and, in many cases, before pregnancy.[10,36]

18. Provide support and education to local child care centers on the importance of breastfeeding and the handling, storage, and feeding of expressed human milk.[47]

19. Monitor breastfeeding initiation and duration rates in the pediatric practice. Be able to access state and national trends as tracked by the CDC through the National Immunization Survey[11] and hospital practices through the Maternity Practices in Infant Nutrition and Care biannual survey data.[48]

BARRIERS TO IMPLEMENTING BREASTFEEDING-FRIENDLY OFFICE PRACTICES

There are challenges to implementing the steps as outlined above for the breastfeeding-friendly pediatric office practice. Breastfeeding care delivered by physicians in the outpatient practice may be limited by lack of knowledge, skills, time, and cultural sensitivity.[23] Breastfeeding management and counseling can be both time consuming and labor intensive. In many health care systems, especially in the United States, practice revenue currently is dependent on volume of visits and patients seen instead of the outcomes of those patients. The AAP Section on Breastfeeding has developed a guide on coding and billing[49] as a tool to optimize reimbursement for time spent in breastfeeding support in the office. Coding guidance also is available through the American College of Obstetricians and Gynecologists for maternal conditions.[50] If additional office visits are required beyond those covered for well-child visits, then diagnosis codes should be used for conditions such as jaundice, newborn feeding problem, infection associated with lactation, etc. Extended visits that require repeated evaluation of breastfeeding and extensive counseling should be billed according to time-based codes.

Even if payment were not an issue, time constraints may be. Complicated breastfeeding problems may require immediate attention and can monopolize staff time and space. Some of these more complex issues may exceed the knowledge level or skill set of the general pediatric care provider. Identifying health care providers and lactation support personnel in the community as sources for referral is important for timely intervention. Lactation support personnel may be limited in certain geographic distributions, especially rural areas, as well as in certain communities. There are different skill levels among lactation support personnel. These may include, among others, volunteer or paid peer counselors, lactation educators, certified lactation counselors, IBCLCs, and breastfeeding medicine specialists. The extent of training required by the lactation specialist may vary depending on the needs of the mother and/or infant and the particular clinical or community setting. There exists a need for greater availability of culturally appropriate and ethnically diverse lactation support personnel in a variety of community and health care settings. Home visitation, where available, is a family-friendly way to provide lactation support. Pediatric care providers need to be knowledgeable about common complications that can affect both mother and infant and either treat these conditions in the mother or become aware of obstetrician/gynecologists, family physicians, or breastfeeding medicine specialists in the community who are comfortable and knowledgeable in treating the maternal conditions.

Clearly, there will be obstacles to implementing the steps outlined in this report; however, these obstacles are not insurmountable. With ongoing advocacy for the support of breastfeeding, there should be fewer barriers over time.

FURTHER RESEARCH

It would be valuable to study the cost-effectiveness and impact of the routine presence of trained lactation support personnel, such as IBCLCs, versus no specific lactation support in the outpatient pediatric practice on breastfeeding exclusivity and duration. In addition, further research is needed on the effectiveness and intensity of other interventions to support breastfeeding, such as in-person

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consultation, group sessions, online resources, or use of telehealth, as well as community support interventions. Another area for research is the best method for improving pediatric care provider education in breastfeeding management and support during undergraduate and graduate medical education, as well as continuing medical education for practicing physicians. Education of other members of the health care team who may interact with breastfeeding mothers or children is also important. Finally, similar to the research published in *Pediatrics* entitled "Evaluation of an Office Protocol To Increase Exclusivity of Breastfeeding,"[28] in which the authors evaluated the ABM's clinical protocol for the Breastfeeding-Friendly Physician's Office,[27] an evaluation of the impact of implementation in pediatric office practices of the steps outlined in this clinical report on rates of exclusive breastfeeding and duration of breastfeeding would be beneficial.

CONCLUSIONS

The benefits of breastfeeding and the potential risks of not breastfeeding are numerous, and increasing breastfeeding initiation, duration, and exclusivity has been the focus of multiple recent initiatives in the health care setting, workplace, and community, as recommended by the *Surgeon General's Call to Action To Support Breastfeeding*. With national goals as outlined in Healthy People 2020, an increase in overall breastfeeding initiation, and more Baby-Friendly–designated hospitals, the need for increased support from all members of the health care team is clear. The pediatric care provider is well suited to play a primary role in this effort. The steps outlined in this document provide clear and concise ways for the pediatric office practice to support breastfeeding mothers, infants, and families; increase breastfeeding exclusivity and duration in their patients; and improve health outcomes for the population.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
ABM: Academy of Breastfeeding Medicine
CDC: Centers for Disease Control and Prevention
IBCLC: International Board Certified Lactation Consultant
WHO: World Health Organization
WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

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