October 2016

New York State Model Hospital Breastfeeding Policy: Implementation Guide

NEW YORK STATE OF OPPORTUNITY. Department of Health

Acknowledgements

The development of the first edition of this document was supported by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, American Recovery and Reinvestment Act of 2009, Communities Putting Prevention to Work State Supplemental Funding for Healthy Communities, Tobacco Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System DP09-901/3U58DP001963-01S2, Cooperative Agreements 5U58/DP001414-03 and 5U58/DP004903-03 from the Centers for Disease Control and Prevention, and the New York Department of Health. The second edition was supported by the New York State Department of Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the funders.

October 2016
Second Edition

Table of Contents

Background

Breastfeeding benefits infants by promoting overall health, growth and development, and by strengthening the bond between mother and baby. Breast milk helps protect infants from colds, gastroenteritis, lower respiratory infections and otitis media, and reduces the risk of food allergies, asthma, and Sudden Infant Death Syndrome (SIDS). Breastfeeding protects against chronic diseases such as diabetes in childhood and later in life.[1,2]

Breastfeeding has economic and environmental advantages. Breastfeeding reduces or eliminates the cost of formula for families. Because breastfed babies and their mothers tend to be healthier, families, businesses and health insurers save money.[1,3,4]

Breastfeeding saves lives, improves health and reduces costs. It is a public health issue. Improving breastfeeding rates is not the sole responsibility of individual women, rather governments, policy makers, hospitals, healthcare providers, communities and families all share responsibility. Health care providers and hospital staff can have a significant impact on improving breastfeeding rates by supporting breastfeeding women.[1,5] Women who exclusively breastfeed in the hospital, compared to those who do not, are more likely to exclusively breastfeed during the early postpartum period and to breastfeed for a longer period of time.[6-8]

The Risks of Not Breastfeeding

The risks of not breastfeeding are more than not receiving the benefits of breast milk, but include the risks from receiving breast-milk substitutes. Breastfeeding is defined as the physiological norm compared to all other types of infant feeding, and therefore, the burden of proof should be that feeding breast-milk substitutes is equal to breast milk rather than breastfeeding is best, ideal or optimal.

The newborn's gastrointestinal microbiota is a complex and dynamic ecosystem. Gut microbiota composition is under the influence of internal and external factors. Colonizing bacteria are derived from the mother, breast milk, and the hospital environment, and are influenced by the mode of delivery, hygiene measures, feeding habits and drug therapies, including antibiotics. Infant feeding choices directly influence microbiota composition. The addition of solid foods also profoundly impacts the microbial environment of breastfed infants.[9]

Breastfed newborns have a more stable and uniform microbiota composition. Breast milk supports long, healthy villi structures making the intestinal microbiome less porous to pathogenic bacteria and foreign and harmful antigens. Exclusively breast-fed newborns are colonized with the most beneficial gut microbiota. Relatively small amounts of supplemented formula provided

to a breastfed infant will shift the breastfed pattern to a formula-fed microbiota pattern. This change in the gut microbiota will promote the growth and absorption of pathogenic bacteria, which increases the risk of acute infections and chronic diseases and conditions from infancy through adulthood. Feeding infant formula disrupts the development of the infant's immune system. This is especially true for preterm infants because of their diminished ability to break down toxins and reduced gut immune function. Feeding infant formula to these at-risk infants can cause gut inflammation which could be critical to the health of the newborn.[9-11]

Infants who are not breastfed have increased risks of:[1,2]

- Gastroenteritis (diarrhea and vomiting)
- Hospitalizations from bronchitis or other respiratory diseases in the first year of life
- Otitis media
- Asthma (especially among those with a family history)
- Sudden infant death syndrome (SIDS)
- Atopic dermatitis
- Necrotizing enterocolitis among preterm infants

Children who are not breast fed have increased risks of:[1,2]

- Childhood obesity
- Type 2 diabetes mellitus
- High total cholesterol levels
- High blood pressure
- Leukemia
- Lower scores on intelligence tests

Women who breastfeed experience short- and long-term health benefits such as a faster return to their pre-pregnancy weight. **Women** who do not breastfeed their infants have increased risks of:[1,2,12,13]

- Postpartum bleeding after delivery
- Breast cancer
- Ovarian cancer
- Type 2 diabetes mellitus
- Metabolic syndrome
- Myocardial infarction
- Cardiovascular disease

The American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and American College of Obstetricians and Gynecologists (ACOG) recommend exclusive breastfeeding for the first six months of life, with continued breast milk feeding until one year of age, or longer, as complementary foods are introduced.[14-16]

Contraindications to Breastfeeding

The contraindications to breastfeeding are few, but it's important, that in the enthusiasm of promoting breastfeeding, that women's decisions to not breastfeed because of medical, psychological or personal reasons, be respected. For mothers who have a medical contraindication to breastfeeding, the decision not to breastfeed is further complicated if they come from cultures where breastfeeding is expected and their health condition has not been disclosed to others in their lives. Health care providers and staff must be sensitive to these women's concerns, and not inadvertently shame them or make them feel guilty for their decision and/or health condition. Furthermore, encouraging women who have contraindications to breastfeed to do so, may be malpractice.[17,18]

New York State Legislation and Regulations

All hospitals that provide maternity care services in New York (NY) must develop, update, implement and disseminate written policies and procedures annually to staff providing maternity or newborn care in accordance with title 10, NY Codes Rules and Regulations (NYCRR), § 405.21 – Perinatal Services[19] (effective September 2005, update effective January 2017) to assist and encourage mothers to breastfeed. Hospitals should have a procedure in place to regularly monitor the effectiveness of their maternity care, infant feeding and breastfeeding policies as part of their quality assurance process.

In addition, NY Public Health Law, Article 25, Title 1, § 2505-a - *Breastfeeding Mothers' Bill of Rights* (BMBR)[20] was passed August 2009, effective May 2010. The statute specifies the rights of pregnant women and new mothers to be informed about the benefits of breastfeeding and receive support from health care providers and health care facilities during pregnancy, after delivery and after discharge. The law requires that the BMBR be conspicuously posted in all NY hospitals and birthing centers that provide maternity care services and on the NY State Department of Health's (NYSDOH) public website, and a copy be provided to all pregnant women at the time of pre-booking or time of admission. Two amendments have updated the BMBR. The first amendment, effective November 2015, requires that child day care facilities support breastfeeding and post the BMBR. It states that women have the right to breastfeed their baby at their place of employment or child care center in an environment that does not discourage breastfeeding or the provision of breast milk. The second amendment, effective January 2016, requires language from Labor Law § 206-c to be included in the BMBR stating that women up to three years following childbirth have the right to take a reasonable number of unpaid breaks or use paid break or meal time at work to pump breast milk.

In August 2009 (effective May 2010), under the authority of Public Health Law § 2803-j, the Commissioner of Health required that hospital-specific annual measures of newborn infant feeding and breastfeeding be added to the Maternity Information Leaflet and publically reported on the NYSDOH's public website. Under Public Health Law § 2803-j, hospitals and providers must provide pregnant women at the time they register and/or are admitted to the hospital with a copy of the Maternity Information Leaflet.[21]

The NYCRR Perinatal Services regulations and the BMBR are based on the evidence-based principles included in the *Ten Steps to Successful Breastfeeding*[22] and the *International Code of Marketing of Breast-milk Substitutes.*[23] NY legislation and regulations are the source of required components of the 2016 New York State Model Hospital Breastfeeding Policy.

Purpose of the NYS Model Hospital Breastfeeding Policy: Implementation Guide

In October 2011, the initial New York State (NYS) Model Hospital Breastfeeding Policy was disseminated. This revised NYS Model Hospital Breastfeeding Policy reflects changes to both Title 10, NYCRR, § 405.21 – Perinatal Services and Public Health Law § 2505-a.[19,20]

The goal of the NYS Model Hospital Breastfeeding Policy: Implementation Guide is to help NY hospitals that provide maternity services improve their written hospital breastfeeding policies and practices to be compliant with NY laws, rules and regulations and in turn, provide evidence-based maternity care practices and breastfeeding support in their hospitals. The Implementation Guide expands on the NYS Model Hospital Policy by including Strategies and Supportive Policy/Position Statements. Use the Implementation Guide when reviewing and revising hospital breastfeeding policies and conducting quality improvement work.

The Implementation Guide is divided into **11** policy sections and each section contains:

Review of the Evidence

Each policy section begins with a short review of the evidence in support of each of the *Ten Steps to Successful Breastfeeding*[22] and the *International Code of Marketing of Breast-milk Substitutes.*[23]

Required Components

The language in the Required Components must be included in written breastfeeding policies at all NY hospitals or birthing centers that provide perinatal or maternity care services in accordance with Title 10, NYCRR § 405.21, Public Health Laws § 2505-a, § 2803-j, § 2803-n, and § 4130.[19-21,24,25]

Recommendations

The language in the Recommended Components is not required by NY laws, rules or regulations, but they are encouraged as they have been supported by professional expert groups and U.S. and international government agencies including:

- Academy of Breastfeeding Medicine (ABM)
- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American College of Obstetricians and Gynecologists (ACOG)
- American Medical Association (AMA)
- Baby-Friendly® USA, Inc.
- Centers for Disease Control and Prevention (CDC)

- United States Breastfeeding Committee (USBC)
- U.S. Department of Health and Human Services, Office of the Surgeon General
- The United Nations Children's Fund (UNICEF) and World Health Organization (WHO)

Strategies

Improvement strategies for each policy section have been added to support efforts to improve hospital environments, systems, and practices to better support mothers to be successful in exclusively breastfeeding their infants. These strategies are also supported by the above expert groups and government entities. Over time, hospital policies need to be continually updated based on merging evidence-based research studies and published best practices. Our overall goal is to have policies, practices and procedures that support all healthy mothers and their infants, regardless of infant feeding method.

Supportive Policy/Position Statements from health care professional organizations and/or government entities are quoted from expert groups noted above.

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

A main organizational facilitator in the implementation of the Ten Steps to Successful Breastfeeding (Ten Steps) is having formal, written breastfeeding policies and protocols that are delineated as the standard of care and publicly available to the hospital staff. Whereas, having outdated and/or inconsistent breastfeeding policies or lack of enforcement of current policies are barriers to the implementation of the Ten Steps. A coordinated breastfeeding committee or task force with motivated, credible leaders, a shared vision, and engagement of multidisciplinary partners and staff from all levels of the organization is optimal in the promotion of a breastfeeding-friendly organizational culture.[26]

Required Component:

a. The hospital must develop, update, implement and disseminate annually written policies and procedures to staff providing maternity care or newborn care to assist, encourage and support the mother to breastfeed. (NYCRR)

Recommendations:

- ✓ The hospital maternity staff will use current evidence-based research to annually review and update the hospital's written breastfeeding policy.[27]
- ✓ The hospital will establish and maintain a hospital breastfeeding team/committee/task force to identify and eliminate institutional barriers to breastfeeding. The hospital team should be interdisciplinary, culturally-appropriate for the population served, and composed of the following individuals and groups:[27,28]
    - hospital administrators;
    - physicians and nurses;
    - lactation consultants and specialists;
    - nutrition and other appropriate staff;
    - community breastfeeding support program staff; and
    - mothers and family members.
- ✓ The hospital breastfeeding team will institute methods to approve policy updates and verify that maternity care practices stay consistent with the hospital breastfeeding policy.[27,28]
- ✓ The hospital will ensure that all hospital department policies are compatible with the promotion, protection and support of breastfeeding and their breastfeeding policy.[29]

Strategies:

- ☐ Designate a staff member to lead and work with the hospital breastfeeding team to provide oversight for the implementation of hospital breastfeeding policy, conduct periodic reviews to assure adherence to policy, and update the hospital breastfeeding policy based on recent scientific evidence.[28-30]

- ☐ Implement Quality Improvement (QI) projects to collect data on policy compliance.[31]

- ☐ Post the Ten Steps to Successful Breastfeeding and the hospital's adherence to the International Code of Marketing of Breast-milk Substitutes prominently in all patient areas serving women, mothers and their families.[29]

Supportive Policy/Position Statements
AAP: *"Peripartum policies and practices that optimize breastfeeding initiation and maintenance should be compatible with the AAP and Academy of Breastfeeding Medicine Model Hospital Policy."* (Policy Statement)[14]
ABM Protocol #7: *A written breastfeeding policy will be developed and communicated to all healthcare staff. The "name of institution" breastfeeding policy will be reviewed and updated biannually using current research as an evidence-based guide."* (ABM #7)[27]
CDC: *"Maternity care practices that support breastfeeding include developing a written breastfeeding policy for the facility…"* (CDC Guide)[32]
U.S. Surgeon General: *"Maternity care of high quality will be delivered to all patients only if standards are consistently applied to every mother and infant."* (Call to Action)[1]

2. Train all health care staff in the skills necessary to implement this policy.

Health care providers have an important role in influencing and supporting a woman's decision to breastfeed her infant, yet insufficient training and skills are a major barrier to clinicians feeling competent in discussing breastfeeding with their patients. Hospital staff need continuing education opportunities to become competent in breastfeeding knowledge and management, and to maintain lactation counseling skills.[26,28]

Required Components:

a. **The hospital must designate at least one person, who is thoroughly trained in breastfeeding physiology and management, to be responsible for ensuring the implementation of an effective breastfeeding program. (NYCRR)**

b. **At all times, there should be available at least one staff member qualified to assist, encourage and support mothers with breastfeeding. (NYCRR)**

c. **The hospital must provide someone trained in breastfeeding to assist mothers when they need help, inform them about their breastfeeding progress, and help counsel them to improve their breastfeeding skills. (BMBR)**

d. **The hospital must provide mothers with assistance from someone specially trained in breastfeeding support and expressing breast milk if an infant has special needs. (BMBR)**

Recommendations:

- ✓ At least one hospital maternity staff member will be an International Board Certified Lactation Consultant (IBCLC). The number of lactation counseling staff should be based on the number of annual births, the perinatal level of the hospital, and minimum International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting.[33]

- ✓ All staff with primary responsibility for the care of mothers and their infants will complete comprehensive training on breastfeeding physiology and management, with annual updates, competency verification, and completion of continuing education in breastfeeding and lactation management.[29]

- ✓ All physicians and other health care providers who have privileges to labor, delivery, maternity and nursery/newborn care will complete a minimum of three credit hours of training in breastfeeding management based on their role.[29]

- ✓ All health care professionals who provide patient care will have minimal knowledge, skills and attitudes (the value of delivering breastfeeding care and services) necessary to protect, promote and support breastfeeding and facilitate the breastfeeding care process.[34]

- ✓ All staff outside of maternity such as pharmacists, social workers, anesthesiologists, radiologists, dietary and housekeeping will receive training based on their job description and workplace exposure to breastfeeding mother/infant dyads.[29]

- ✓ All staff who have contact with pregnant women, mothers, and/or infants, will receive orientation on the hospital's breastfeeding policy on arrival and training within 6 months.[29,34]

- ✓ The hospital will support training maternity staff on mother-friendly care that supports breastfeeding success, including encouraging support persons to be present during labor and birth, using non-drug pain relief methods, and employing invasive procedures only when required based on a birth complication.[34]

- ✓ The hospital will support training maternity staff on maternal and infant health conditions that are contraindications to temporarily or permanently not breastfeeding or expressing breast milk and include any patient contraindication for feeding breast milk in maternal and infant admission orders and discharge summaries.[14,29,30]

Strategies:

- ☐ Designate a staff member to lead and work with the hospital breastfeeding team to assure that all staff receives necessary training and assessment of their competencies around breastfeeding, as appropriate.[28-30]

- ☐ Provide and require that all nursing staff with primary responsibility for the care of breastfeeding mothers and infants complete at least 20 hours of training on breastfeeding and lactation management. Training should cover all of the Ten Steps to Successful Breastfeeding,[20] the International Code of Marketing of Breast-milk Substitutes,[21] and include a minimum of five hours of supervised clinical experience within six months of hire.[28-30]

- ☐ Provide mandatory orientations and annual update sessions to ensure that all newly-hired and current staff are aware of the advantages of breastfeeding, disadvantages of not breastfeeding, and infant and maternal contraindications to breastfeeding. Training sessions should acquaint staff with the hospital's infant feeding/breastfeeding policy and services to protect, promote, and support breastfeeding.[28-31, 34]

- ☐ Provide and document training on breastfeeding to non-clinical staff tailored to their job description and degree of exposure to breastfeeding mothers.[28, 30]

- ☐ Consider low-cost training modalities such as including breastfeeding education in staff meetings, sending key staff to "train the trainer" programs, offering in-house training, and providing self-study training modules and web-based training.[28]

Supportive Policy/Position Statements
AAFP: *"Despite growing evidence of the health risks of not breastfeeding, physicians, including family physicians, do not receive adequate training about supporting breastfeeding."* (Position Paper)[16] ***AAP: "****Role of the pediatrician: Become knowledgeable in the principles and management of lactation and breastfeeding, develop skills necessary for assessing the adequacy of breastfeeding, and support training and education for medical students, residents and postgraduate physicians in breastfeeding and lactation."* (Policy Statement)[14] ***ACOG:*** *"The benefits of breastfeeding, as well as patient education, counseling, and support strategies, should be emphasized during training of residents in obstetrics and gynecology, family medicine, and pediatrics. Ongoing education also should be promoted for all women's health care providers and hospital staff involved in childbirth."* (Committee Opinion)[35] ***CDC:*** *"Health care professionals working in maternity care need in-depth knowledge and skills directly related to breastfeeding and lactation management."* (CDC Guide)[32] ***U.S. Surgeon General:*** *"Action 9. Provide education and training in breastfeeding for all health professionals who care for women and children."* (Call to Action)[1]

3. Inform all pregnant women about the benefits and management of breastfeeding.

Education on the value of breastfeeding, importance of exclusive breastfeeding, and the basics of breastfeeding management prior to delivery contributes to mothers being better prepared and motivated to initiate breastfeeding in the hospital. Consistent, culturally-sensitive breastfeeding education and lactation counseling and support throughout the perinatal period, including participation in hospital-affiliated or community-based breastfeeding education classes, individual professional counseling and support and peer support, helps build confidence and positively increases the duration and prevalence of breastfeeding, including exclusive breastfeeding.[26,28,29,36-38]

Required Components:

a. The hospital or hospital-affiliated clinics must provide each maternity patient with complete information about the nutritional, medical and emotional benefits of breastfeeding for mother and baby and the possible impacts of not breastfeeding, in order to help her make an informed choice on how to feed her baby. (NYCRR and BMBR)

b. The hospital or hospital-affiliated clinics must participate in and provide or arrange for effective prenatal activities including conducting effective community outreach programs either directly or in collaboration with community-based providers and practitioners who provide prenatal care and services to women in the hospital service area. Activities and services of a prenatal program must include but not be limited to the following: (NYCRR)

- **active promotion of prenatal care during each trimester;**
- **initial visit with complete history, physical/pelvic examination, laboratory screening, initiation of patient education, nutrition screening and counseling, and prenatal risk assessment;**
- **arrangement for follow-up care and education;**
- **psychosocial support services as needed;**
- **ongoing maternal and fetal risk assessment; and**
- **HIV counseling and/or testing.**

c. The hospital or hospital-affiliated clinics must assure the availability of prenatal childbirth classes for all pre-booked women which should address as a minimum: (NYCRR and BMBR)

- **the anatomy and physiology of pregnancy, labor and delivery;**
- **infant care and parenting;**
- **infant feeding cues and feeding on demand;**
- **breastfeeding including preparation to breastfeed, common problems and solutions;**
- **maternal nutrition;**
- **the effects of smoking, alcohol and other drugs on the fetus;**

- **what to expect if transferred; and**
- **the newborn screening program with the distribution of newborn screening educational literature.**

d. The hospital or hospital-affiliated clinics must <u>not</u> use educational materials which refer to proprietary product(s) or bear product logo(s), unless specific to the mother's or infant's needs or condition, or distribute any materials that contain messages that promote or advertise infant food or drinks other than breast milk. (NYCRR)

e. The hospital must provide breastfeeding information to a family member or friend when a patient request is made to staff. (BMBR)

f. At the time of pre-booking or attendance at prenatal childbirth education classes or at admission, the hospital must provide copies of the BMBR and the maternity information leaflet. (NYCRR , BMBR and PHL § 2803-j)

g. The hospital must include a copy or abstract of the existing prenatal record in the medical record for each maternity patient. The prenatal record must include maternal history and health, results of physical examinations, maternal and fetal risk assessments, and if done, maternal HIV, Hepatitis B and Group B strep testing. (NYCRR)

h. The hospital must include, at minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments as part of inpatient maternity care. (PHL § 2803-n)

Recommendations:

✓ The hospital will incorporate education about breastfeeding in all routine prenatal group classes, taught by a certified lactation counselor. [27,31]

Prenatal education, regardless of the mothers' infant feeding decision, will include information about: [27,31]

- the benefits of breastfeeding, contraindications to breastfeeding and risks of formula feeding;
- breastfeeding as the normative feeding for infants and young children unless medically contraindicated;
- how breastfeeding impacts on mother's and infant's/children's health outcomes; and
- the anatomy and physiology of lactation.

✓ The hospital will make available prenatal education, including individual and group lactation counseling and support, starting in the first trimester, to pregnant women at hospital-affiliated clinics and services, and as part of coordinated educational programs in the community.[29]

✓ At individual prenatal visits, the hospital staff will explore issues and concerns with women who are unsure how they will feed their babies or who have chosen not to breastfeed. Efforts will be made to address the concerns raised and each woman will be educated about her options. For women for whom breastfeeding is contraindicated, clinic staff will not counsel them to breastfeed

and will fully support them to develop responses to why they are not breastfeeding and to help avoid feelings of guilt.[27,29]

- ✓ In addition, prenatal hospital-affiliated clinics and unaffiliated educational programs will provide education around the following topics:[29-31]

  - the importance of exclusive breastfeeding for the first six months; with continued feeding of breast milk until age one year or longer,
  - pain relief methods for labor, including non-pharmacologic methods;
  - the importance of early skin-to-skin contact for the mother and baby;
  - the importance of early initiation of breastfeeding;
  - rooming-in on a 24-hour basis;
  - feeding on demand or baby-led feeding;
  - frequent feeding to help assure optimal milk production;
  - the effect of formula supplementation on milk supply; and
  - manual expression and effective latch and milk transfer.

- ✓ The hospital will inform all potentially income-eligible women about, and facilitate referrals to, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) which offers nutrition, breastfeeding education and peer support during the prenatal and postpartum periods.[1,32]

Strategies:

- ☐ Provide educational resources including posters and artwork that show breastfeeding as a norm, are free of images related to formula feeding (i.e. bottle, formula company logos/mottos, etc.), and present concise informative messages about breastfeeding in obstetric care waiting rooms, ultrasonography, laboratories, and other locations where pregnant women visit within the hospital.[28-30,39]

- ☐ Ensure literature and promotional items produced by infant formula companies are <u>not</u> used in any in-patient and outpatient settings within the hospital or at affiliated practices or clinics.[27,39,40]

- ☐ Work as a team to develop original prenatal educational materials about breastfeeding and disseminate within the hospital, at affiliated practices or clinics and health care organizations in the community.[28]

- ☐ Conduct breastfeeding education in the patient's native language, whenever possible, assess the patient's literacy level, when appropriate, and provide instructional materials that reflect the cultural and ethnic background, education, age and language of the patient population.[34,39,40]

- ☐ Protect families from false or misleading advertising and provide non-commercial, accurate and unbiased information so families can make informed infant feeding decisions.[29,30]

- ☐ Foster working relationships with staff from community breastfeeding partners (i.e. La Leche League, WIC Programs, lactation consultants, etc.) to form community-clinical linkages and coordinate patient education services on-site.[28,29]

- ☐ Develop processes to ensure the prenatal summary is forwarded to the hospital and available at the time of delivery. The summary should include:[27, 39, 40]

  - whether infant feeding/breastfeeding has been discussed;
  - if there are any contraindications to breastfeeding;
  - whether the mother intends to breastfeed (exclusive or not and estimated duration); and
  - the infant feeding plan, if developed.

- ☐ Consult evidence-based resources as necessary on medication safety such as LactMed from the National Library of Medicine: (http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm) for questions regarding breastfeeding and medication.[31]

- ☐ Consult updated evidence-based resources on contraindications to breastfeeding due to maternal or infant health conditions and the safety of medications.[14,41,42]

Supportive Policy/Position Statements

AAFP: *"Family physicians have the unique opportunity to emphasize breastfeeding education beginning with preconception visits and continuing through prenatal care, delivery, postpartum care, and during ongoing family care."(*Position Paper)[16]

ACOG: *"The advice and encouragement of the obstetrician-gynecologist and other obstetric care providers are critical in assisting women to make an informed infant feeding decision."* (Committee Opinion)[41]

CDC: *"All hospitals that routinely handle births should have staff with adequate training and knowledge to help with breastfeeding education during the intra-partum period for all mothers."* (CDC Guide)[32]

4. Help mothers initiate breastfeeding within one hour of birth.

Mother-infant, skin-to-skin contact and the initiation of breastfeeding within the first hour after vaginal delivery and two hours after a cesarean delivery have been shown to have positive effects on maternal and infant health outcomes including increased breastfeeding exclusivity and longer duration. Post-delivery placement of the naked infant on the mother's bare chest provides a place of warmth, nutrition through breastfeeding, early-mother-infant attachment, and better cardio-respiratory stability. Separation lowers the newborn's body temperature and heartbeat, and increases stress hormones and crying. Skin-to-skin contact is even more important for premature newborns and infants delivered by cesarean section.[31,43-46]

Required Components:

a. **Unless medically contraindicated or unacceptable to the mother, hospital maternity staff must allow the newborn to remain with the mother as the preferred source of body warmth providing maximum access after the birth, whether the delivery is vaginal or by cesarean section. (NYCRR and BMBR)**

b. **Hospital maternity staff shall encourage, assist and support mothers to breastfeed within one hour of birth which shall include placement of the newborn skin-to-skin for breastfeeding immediately following delivery unless contraindicated. (NYCRR and BMBR)**

c. **The hospital shall prohibit the application of standing orders for anti-lactation drugs. (NYCRR)**

Recommendations:

- ✓ Hospital maternity staff will document a mother's infant feeding method. If there are contraindications to breastfeeding and/or the mother has requested to formula feed or not breastfeed, or not receive any additional breastfeeding information and/or support, this will be documented in her medical record, the infant's medical record, and on the bassinet.[27]

- ✓ The hospital will facilitate early skin-to-skin contact and allow the initial breastfeeding opportunity to take place in the delivery room and continue during transport from delivery to the recovery room or postpartum area.[27,31]

- ✓ Hospital maternity staff will promote, support and protect exclusive breastfeeding throughout the hospital stay, unless medically contraindicated or the mother indicates that she has chosen not to breastfeed.[27]

- ✓ Hospital maternity staff will place all newborns skin-to-skin immediately following birth regardless of the planned feeding method, unless there are medically-justified reasons to delay contact.[27]

- ✓ Hospital maternity staff will place the newborn skin-to-skin after a non-emergent cesarean birth while the incision is being closed as a distraction to clinical procedures and to give the mother a greater sense of control.[31,44]

- ✓ Hospital maternity staff will document the duration of skin-to-skin contact time immediately after delivery and during the hospital stay.[31]

Strategies:

- ☐ Encourage immediate and extended skin-to-skin contact to help establishment of breastfeeding, adjustment to extra-uterine life, thermoregulation, and prevention of hypothermia and hypoglycemia.[31,43]

- ☐ Adjust room (delivery, recovery, birthing, etc.) temperature, as appropriate, and support skin-to-skin contact to prevent hypothermia.[43]

- ☐ Dry and place infant on mother's bare chest immediately after birth, covering both infant and mother with warmed blankets.[31]

- ☐ Emphasize to family members and primary support person(s) present at hospital the importance of uninterrupted skin-to-skin time for the mother and infant.[31]

- ☐ Place infant skin-to-skin as soon as mother is stabilized after a cesarean delivery and if needed, have other family members or support persons provide skin-to-skin contact until the mother becomes available.[31]

- ☐ Perform routine tests and other procedures, such as heel-sticks or medication administration, while mother and baby are skin-to-skin and/or breastfeeding.[31]

- ☐ Promote breastfeeding by delaying eye prophylaxis and Vitamin K administration up to 6 hours to allow for uninterrupted mother-infant skin-to-skin contact until the first breastfeeding is accomplished.[27,48]

- ☐ Schedule routine events such as infant bathing, weighing, examinations, medications, and diapering after the infant's first breastfeeding session.[27,29,31]

- ☐ Assure continuous physical, emotional and informational support from skilled professionals such as birth doulas and midwives trained in the art of labor support during and just after birth.[31]

Supportive Policy/Position Statements
AAP and ACOG: *"Infants should be placed in direct skin-to-skin contact with their mothers immediately after delivery and should remain there until the first breastfeeding is completed."* (Guidelines for Perinatal Care)[47] ***ABM Protocol #5:*** *"The healthy newborn should be given directly to the mother for skin to skin contact until after the first feeding...Such physical contact provides the infant with optimal physiological stability, warmth, and opportunities for the first feeding."* (ABM #5)[48] ***CDC:*** *"Infants whose first breastfeed is delayed because of being weighed, measured and cleaned do not breastfeed as long as infants who are immediately put skin-to-skin with their mother or put to the breast within the first hour after birth."* (CDC Guide)[32]

5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.

Interventions starting in pregnancy, continuing during the birth hospitalization and postnatally after hospital discharge are the most effective in promoting and supporting breastfeeding. Professional breastfeeding support in the hospital, focused on empowering mothers with skills and knowledge, can increase breastfeeding initiation and duration.[49,50]

Early breastfeeding assessment and support are necessary when the mother and infant are separated because the preterm or sick infant needs special care such as placement in neonatal care or the mother's health is compromised. Special efforts in the Neonatal Intensive Care Unit (NICU), that have been shown to be effective, focus on early initiation of breastfeeding or expression of breast milk, facilitation of skin-to-skin contact, peer support, and the provision of family-centered care which accommodates the parents' presence and participation in their infant's care. Interventions providing skilled professional support from trained lactation staff has been shown to be cost-effective. Depending on the infant and/or mother's situation, breastfeeding or milk expression can be challenging due to dyad separation, patient transfers, staff workloads, and the design and medicalized nature of NICUs.[49,51-53]

Required Policy Components:

a. The hospital must provide an education program as soon after admission as possible that addresses the following subjects related to breastfeeding: (NYCRR and BMBR)

- **nutritional and physiological aspects of human milk;**
- **the normal process for establishing lactation, including positioning and attachment, common problems associated with breastfeeding and recommended frequency of feeding (breastfeeding on demand);**
- **the potential impact of early use of pacifiers on the establishment of breastfeeding;**
- **diseases (contraindications for breastfeeding), medication or other substances which may have an effect on breastfeeding, including any drugs that may dry up their milk; and**
- **information about safely collecting and storing human milk (hand-expressed or pumped breast milk).**

b. The hospital must allow mothers to breastfeed their babies in the neonatal intensive care unit (NICU) unless medically contraindicated. If nursing is not possible, every attempt must be made to have the baby receive their mother's pumped or expressed milk. (BMBR)

c. If a transfer to another hospital providing a higher level perinatal care necessitates separating the mother and high-risk newborn, mothers who have chosen to breastfeed should be encouraged to maintain lactation and breast milk should be available made to the newborn. (NYCRR)

d. If a mother or baby is re-hospitalized in a maternal care facility after the initial delivery stay, the hospital must make every effort to continue to support breastfeeding, and to provide hospital grade electric pumps and rooming-in facilities. (BMBR)

Recommendations:

- ✓ Hospital maternity staff will observe mothers' breastfeeding sessions several times per day and provide additional support, if needed, to ensure successful breastfeeding.[27]
- ✓ Hospital maternity staff will conduct and document breastfeeding teaching and assessment including latch, position and any problems encountered at least every shift and, whenever possible, with each staff contact with the mother.[27]
- ✓ Hospital maternity staff will conduct and document a formal assessment of breastfeeding including position, latch and milk transfer to evaluate breastfeeding effectiveness and anticipate breastfeeding problems during the last eight hours prior to discharge.[31,54]
- ✓ Hospital will provide close observation of the mother/infant dyad by trained professionals to help prevent complications associated with insufficient milk transfer.[54]

Separation

- ✓ The hospital will develop and implement protocols for early breast milk pumping, hand expression and skin-to-skin opportunities if an infant is separated from the mother due to medical indications such as prematurity.[27]
- ✓ Hospital maternity staff will ensure milk expression is begun as soon as possible but not more than 6 hours after birth and when medically appropriate, the mother's expressed milk is given before any supplementation with breast-milk substitutes as part of standard routine care. For high risk and special needs infants, manual expression is begun within one hour after birth.[29]
- ✓ Hospital maternity staff will instruct mothers of infants in the NICU on how to hand express their milk and use a hospital-grade breast pump to keep up their milk supply until their infant is ready to nurse.[27,28,30]
- ✓ Hospital maternity staff will teach mothers proper handling, storage and labeling of human milk and how to maintain storage facilities for expressed milk.[27,49]
- ✓ Infants will be fed mother's expressed milk until the medical condition allows the infant to be breastfeed on demand.[27,31]
- ✓ The hospital will provide medical orders (prescriptions) for electric breast pumps and referrals to local breast pump rental services for mothers who require extended pumping.[27]

- ✓ The hospital will support increased staff education and skills, use of electric breast pumps, and private lactation areas to increase mothers' comfort and frequency of breastfeeding in the NICU.[52]

Strategies:

- ☐ Establish a team to standardize methods of breastfeeding assessment, instruction and documentation.[28]

- ☐ Ensure that a trained physician, nurse or lactation consultant (IBCLC) conducts and documents a functional assessment of the infant at the breast within eight hours (or sooner) of birth and at least once every 8-12 hours until mother and infant are discharged by utilizing a breastfeeding assessment tool, such as the LATCH Breastfeeding Assessment Tool.[31,48]

- ☐ Train peer counselors who have been successful at breastfeeding to make rounds and spend time observing, assessing, and providing the basics of position and latch.[28]

- ☐ Allow mother to position her infant and achieve latch herself to improve self-efficacy and increase breastfeeding success upon leaving the hospital. Provide guidance only if necessary.[31]

- ☐ Assist mothers with different cultural traditions and taboos by enlisting an important family member and/or support person and adapting cultural beliefs to facilitate optimal breastfeeding.[40]

- ☐ Address and document all problems raised by the mother such as nipple pain, ability to hand express, perception of inadequate supply, and any perceived need to supplement and refer to lactation consultant if needed.[54]

- ☐ For optimal breastfeeding education and assistance, provide one IBCLC full-time equivalent (FTE) per 783 breastfeeding mother/baby dyads as inpatients, one IBCLC per 1292 breastfeeding mother/baby dyads as outpatients after discharge, and one IBCLC per 3915 breastfeeding mother/baby dyads for telephone follow-up after discharge.[55]

- ☐ Monitor feedings including signs of milk transfer, hydration status (intake and output), baby's weight, signs of jaundice or hypoglycemia, and any perceived problems raised by the mother.[48]

- ☐ Conduct infant assessments in the mother's room and monitor the number of hours rooming-in to avoid unnecessary separation.[27,48]

- ☐ Avoid use of the word "bottle" since bottles can imply formula feeding and bottles may contain expressed or donor breast milk.[31]

- ☐ Provide increased attention to at-risk dyads to diminish the risk of neonatal dehydration, weight loss and decrease the need for supplementation.[31]

Separation

- ☐ For hospitals with a NICU, create and implement breastfeeding policy specific to infants in neonatal intensive care.[51]

- ☐ For optimal breastfeeding education and assistance, provide a minimum of one IBCLC full-time equivalent (FTE) per 235 infants admitted to the NICU and one IBCLC per 818 NICU breastfeeding infants as outpatients after discharge.[55]

- ☐ Initiate expression of breast milk as soon as possible on the day of delivery (ideally in less than six hours after birth).[27,29,30]

- ☐ Educate mother on both manual and mechanical expression since a combination of both may provide optimal milk production. Provide use of an electric breast pump, and instruct mothers to pump as often as the infant would nurse during the time that the infant and mother are separated and stress the importance of not missing expression during the night.[27,48]

- ☐ Remind mother that she may not obtain a lot of milk or even any milk during first few attempts at pumping.[27]

- ☐ Encourage discharged mothers to express breast milk at home and bring to the hospital for use by the baby and maintain storage facilities for expressed milk.[49]

- ☐ Encourage the mother who is discharged from the hospital before her infant(s) {as in the case of a sick infant(s)}, to spend as much time as possible with her infant(s) and practice skin-to-skin contact. When possible, allow mother to stay in the hospital with infant.[49]

- ☐ Offer parents opportunities to room-in, actively participate in care decisions, and take over infant's care in preparation for hospital discharge.[51]

Supportive Policy/Position Statements

ACOG: *"All hospitals should have trained personnel available to provide breastfeeding support and should offer 24-hour rooming in to maximize the interaction between the woman and her newborn."* (Special Report)[56]

CDC: *"Access to support from health care professionals such as doctors, nurses, or lactation consultants is important for the health of the mother during pregnancy, after giving birth, and after release from hospital."* (CDC Guide)[32]

U.S. Surgeon General: *"Action 1. Give mothers the support they need to breastfeed their babies."* (Call to Action)[1]

Separation

ABM Protocol #3: *"If mother-baby separation is unavoidable, established milk supply is poor or questionable, or milk transfer inadequate, the mother needs instruction and encouragement to pump or manually express her milk to stimulate production and provide expressed breast milk as necessary for the infant."* (ABM #3)[57]

ABM Protocol #5: *"If a neonate needs to be transferred to an intermediate or intensive care area, steps must be taken to maintain maternal lactation. When possible, transport of the mother to the intermediate or intensive care nursery to continue human milk feeding of the neonate."* (ABM #5)[48]

ACOG: *"Separation of mother and infant should be avoided whenever possible, especially during the early establishment of lactation (first 3 weeks). If it is known in advance that hospitalization or a trip, for example, will require the mother to be separated from the infant for more than a day, careful planning can ensure that the ability to breastfeed will be preserved and breast milk will be available to the infant."* (Special Report)[56]

Baby-Friendly Step 7: *"If the baby is kept in the nursery for documented medical reasons, the mother should be provided access to feed her baby at any time."*[29]

6. Give infants no food or drink other than breast milk, unless medically indicated.

The early introduction of formula to supplement breastfeeding infants by hospital staff is significantly related to exclusive breastfeeding and negatively impacts breastfeeding. Initiating breastfeeding in the delivery room decreases the likelihood of formula supplementation. Before supplemental formula feedings begin, a formal assessment should be conducted to verify if formula supplementation is warranted. There are many inappropriate reasons for supplementation such as a tired or sleeping mother and/or fussy infant. One of the top reasons breastfeeding mothers request formula is the concern about not producing enough breast milk. Breastfeeding education and assistance provide by skilled professional lactation consultants is crucial to increase maternal confidence and breastfeeding self-efficacy and to decrease formula supplementation.[23,57-60]

Required Policy Components:

a. **The hospital must restrict supplemental feedings to those indicated by the medical condition of the newborn or mother. (NYCRR)**

b. **Hospital maternity staff must inform mothers if her doctor or the infant's pediatrician is advising against breastfeeding before any feeding decisions are made. (BMBR)**

c. **The hospital must allow mothers to have her baby <u>not</u> receive any formula feeding and to have a sign on her baby's crib clearly stating that her baby is breastfeeding and that no feeding of breast milk substitutes of any type is to be offered. (BMBR)**

d. **The hospital must provide individual training in formula preparation and feeding techniques for mothers who have chosen formula feeding or for whom breastfeeding is medically contraindicated. (NYCRR)**

e. **The hospital must report infant feeding data (breast milk only, formula only, both breast milk and formula, other or unknown) within five days of birth on the NYS or New York City birth certificate as prescribed by the NYS Commissioner of Health. (PHL § 4130)**

Recommendations:

- ✓ The hospital will track exclusive breast milk feeding according to the Joint Commission's Perinatal Care Core Measure PC-05 and document exclusion criteria (medical conditions as reason for not exclusively feeding breast milk).[29,31,57]

- ✓ The hospital will develop policies to address the choices, volume and methods of supplemental formula feeding and protocols for evidence-based medical indications for supplementation such as hypoglycemia, weight loss and hyperbilirubinemia.[29,57]

- ✓ The hospital will educate staff and health care providers on common situations when breastfeeding management is necessary and supplementation is not indicated, and situations when there are infant/maternal indications for supplementation in term, healthy infants.[57]

- ✓ If a breastfeeding mother requests formula, the hospital maternity staff will explore the reasons for this request, inform mothers of the risks of supplementation to establishing and sustaining breastfeeding prior to non-medically indicated supplementation. Staff will document that the mother has received this information and made an informed decision.[27,29]

- ✓ Hospital maternity staff will provide a specific medical order when formula is provided to a breastfeeding baby and document the reason(s) for the provision of formula, the route of administration (i.e., spoon, cup, syringe, etc.), the form of supplement, and the amount given in the infant's medical chart.[31]

- ✓ If possible, breastfed infants who cannot nurse at the breast will be fed in a manner that is consistent with preserving breastfeeding (i.e., by cup, dropper or syringe).[27,29]

- ✓ Hospital maternity staff will not place bottles in or around the breastfeeding infant's crib.[27]

- ✓ The hospital will store formula in a locked cabinet or medication dispensing system. When administered, the type, amount, method of administration, lot number, time, reason for supplementation, person who administered the formula and patient number will be recorded.[31]

- ✓ The hospital will not accept free formula, breast milk substitutes, bottles or nipples.[27-29]

Strategies:

- ☐ Establish a team to review evidence-based research on the acceptable medical reasons for supplementation of healthy term, breastfed infants, and develop and implement a policy with supplementation guidelines. The policy should include: [27-29,31,57]

    - no supplementation with water, glucose water or formula unless specifically ordered by a care provider;
    - use of expressed breast milk or banked donor milk as a preference over formula;
    - formal evaluation and direct observation of breastfeeding to determine cause of poor feeding or inadequate milk transfer before supplementation;
    - instruction to mothers to express milk each time their baby receives a supplemental feeding, or about every 2–3 hours to help prevent maternal breast engorgement that will further compromise the milk supply and could lead to other complications;
    - documentation of formula supplementation for non-medical reasons using a supplementation informed consent form; and
    - collection of formula usage data and dissemination among hospital staff and leadership.

- ☐ Educate mother on the size of the newborn's stomach and provide assistance in breastfeeding techniques to prevent inappropriate supplementation due to mother's lack of confidence and inadequate education on the normal physiology of breastfeeding.[57]

- ☐ Before any supplemental feedings are begun, conduct a formal breastfeeding assessment to determine if there are latching issues and the need for assistance with breastfeeding techniques and reassurance of the mother.[57]

- ☐ Lock up formula supplies and require staff to sign supplies out, indicating their name, the patient's name, and medical indication for use to help to restrict formula usage.[28]

Supportive Policy/Position Statements
AAFP: *"The AAFP encourages that hospital staff respect the decision of the mother who chooses to breastfeed exclusively by not offering formula, water or pacifiers to an infant unless there is a specific physician order."* (Position Paper, Appendix 4)[16] ***AAP:*** *"Supplements (water, glucose water, formula, and other fluids) should not be given to breastfeeding newborn infants unless ordered by a physician when a medical indication exists."* (Policy Statement)[14] ***ACOG:*** *"It is important to help mothers understand that substituting for or delaying breastfeedings may ultimately reduce milk supply because of the reduction in stimulation derived from infant suckling."* (Special Report)[56]

7. Practice rooming-in – allow mothers and infants to remain together 24 hours a day.

There is an interactive relationship between mother-infant rooming-in, and feeding on demand. Opportunities for increased skin-to-skin contact, bonding and recognition of early infant feeding cues happen when mothers and infants remain together during the hospital stay. Increased separation of the mother-infant dyad can result in shortened breastfeeding duration.[22,48,58]

Required Policy Components:

a. **The hospital must support rooming-in 24 hours a day and allow mothers to breastfeed their babies at any time day or night. (BMBR)**

b. **The hospital must establish and implement the option of rooming-in for each patient unless medically contraindicated or the hospital does not have sufficient facilities to accommodate all such requests. (NYCRR)**

c. **The hospital must not restrict fathers or other primary support person(s) from visitation to the mother during the recovery period, must promote family bonding by allowing regular visitation for the newborn's siblings in a manner consistent with safety and infection control, and must permit visitations by other family members and friends in a manner consistent with efficient hospital operation and standards of care. (NYCRR)**

Recommendations:

- ✓ When possible, hospital maternity staff, including physicians, will perform routine medical procedures in the room with mother and baby present, not in the nursery. The hospital will purchase portable scales, bath equipment, etc. which can be used at the mother's bedside to support this practice.[28]

- ✓ Hospital maternity staff will make sure that healthy mothers and infants have ample opportunities for skin-to-skin contact and early learning of infant's feeding cues, regardless of the feeding choice, by supporting rooming-in 24 hours a day as the standard of care.[28,29]

- ✓ The hospital will develop and implement policies regarding visitation that emphasize mother and infant bonding, and decrease interruptions to infant feeding and sleeping patterns, but do not unreasonably restrict visitation by the mother's partner and/or other primary support person(s).[19,31]

Strategies:

- ☐ Discuss rooming-in as a standard option in prenatal classes and staff training and encourage mother to have infant remain with her, day and night, throughout the entire hospital stay.[27,30,31]

- ☐ Provide information about the rationale and benefits of rooming-in to mothers, family members, and/or support person(s). If a mother requests that her infant be cared for in the nursery, the staff should explore the reasons for the request, educate and the informed decision should be documented in the medical record.[28,29]

- ☐ Offer staff opportunities to role play response to mothers who request that their baby be taken from their room.[28]

- ☐ Do not wake the mother and/or infant by removing the infant from the mother to obtain routine weights and vital signs. Whenever possible, these should be done in the mother-infant room and timed so both can be assessed together to reduce the number of interruptions to mother's and infant's sleep. If the infant must be removed from the mother's room, the infant should be returned as soon as circumstances allow.[31]

- ☐ Discuss visitors with the mother, her partner and other primary support person(s) to determine which visitors will be authorized and placed on the mother's visitors list. Visitors should not interfere with adequate bonding time between the mother and infant.[19,31]

- ☐ Remind parents that evidence suggests that mothers do not get less or lower quality sleep when infants room-in.[28,48]

- ☐ When feasible, encourage her partner or primary support person to stay in the hospital 24 hours to help mother with baby during hospital stay.[31]

Supportive Policy/Position Statements

ACOG: *"Rooming in allows the mother to begin recognizing her infant's hunger cues. Rooming in and promoting skin-to-skin contact have numerous advantages for both the infant and the mother."* (Special Report)[56]

CDC: *"In addition, mothers who 'room in' with their infants, rather than having the infant taken to a nursery at night, will have more chances to learn feeding cues and practice breastfeeding because of the infant's proximity."* (CDC Guide)[32]

U.S. Surgeon General: *"Separating mothers from their babies during their hospital stay has a negative impact on the initiation and duration of breastfeeding…"* (Call to Action)[1]

8. Encourage breastfeeding on demand.

No restrictions should be placed on the frequency or length of breastfeeds. Unrestricted frequency and duration of breastfeeding sessions can provide reassurance to help prevent concerns with insufficient milk supply, and decrease problems with engorgement. Mothers should be taught infant feeding cues. Feeding on demand is dependent on the practice of rooming-in.[22,61]

Required Policy Components:

a. **The hospital must allow infants to be fed on demand (baby-led breastfeeding). (NYCRR)**

b. **The hospital must allow mothers to breastfeed their babies at any time day or night. (BMBR)**

Recommendations:

- ✓ The frequency and duration of breastfeeding will be infant-led, based on infant's early feeding cues of readiness.[27]
- ✓ The hospital will develop and implement policies regarding visitation that do not unreasonably restrict fathers or other primary support person(s), emphasize mother and infant bonding, and decrease interruptions to infant feeding and sleeping patterns.[19,31]
- ✓ Hospital maternity staff will teach mothers feeding cues and encourage mothers to feed as soon as their infant(s) display early infant feeding cues. If a mother and infant are separated, hospital maternity staff will take the breastfeeding infant to the mother for feeding whenever the infant displays early infant feeding cues, including, but not limited to, sucking noises, sucking on fist or fingers, fussiness, or moving hands toward mouth.[28]
- ✓ Hospital maternity staff will encourage mothers to avoid scheduled feedings and emphasize the importance and normalcy of frequent night feeds.[31,48]
- ✓ Hospital maternity staff will document all feedings in the infant's medical record.[27]
- ✓ The hospital will provide training to maternity staff about typical infant feeding cues and offer role playing opportunities to practice responding to parent's questions.[28]

Strategies:

- ☐ Adjust hospital routines whenever possible in order to reduce the number of interruptions to mother's and infant's sleep.[31]

- ☐ Teach parents that breastfeeding infants, including cesarean-birth babies, should be put to breast a minimum of eight to 12 times each 24 hours; some infants will need to be fed more frequently.[27,48]

- ☐ Encourage frequent skin-to-skin time to increase feeding frequency.[57]

- ☐ Educate mothers on the "supply and demand" principle of milk production, emphasizing the importance of exclusive breastfeeding to establish and maintain the milk supply, and how to recognize normal infant feeding cues and respond to them.[28]

- ☐ Discuss normal newborn feeding behavior including cluster-feeds (several closely spaced feedings followed by a longer period of sleep).[31]

- ☐ If an infant does not wake to feed at least eight times in 24 hours, assess for hydration status and signs of sepsis or hypoglycemia. If the infant appears healthy, continue to monitor until the infant is feeding effectively and spontaneously waking for feeds.[31]

Supportive Policy/Position Statements

AAP: *"This requires that medical and nursing routines and practices adjust to the principle that breastfeeding should begin should begin within the first hour after birth (even for Cesarean deliveries) and that infants must be continuously accessible to the mother by rooming in arrangements that facilitate around-the-clock, on-demand feeding for the healthy infant."* (Policy Statement)[14]

AAP and ACOG: *"The mother should be encouraged to offer the breast whenever the infant shows early signs of hunger, such as increased alertness, increased physical activity, motility or rooting, and not to wait until the infant cries."* (Perinatal Care)[47]

Baby-Friendly Step 8: *"Health care professions should help all mothers (regardless of feeding choice): 1) understand that no restrictions should be placed on the frequency or length of feeding, 2) understand that newborns usually feed a minimum of eight times in 24 hours, 3) recognize cues that infants use to signal readiness to begin and end feeds, and 4) understand that physical contact and nourishment are both important."*[29]

9. Give no pacifiers or artificial nipples to breastfeeding infants.

Routine, early use of pacifiers has been associated with mothers' failure to fulfill their intention to exclusively breastfeed. Pacifier use may increase the risk of weaning within the first three months of age. Based on this concern, pacifier use is discouraged until breastfeeding is well-established at around one month of age.[60,62-65]

Required Policy Components:

a. **The hospital must respect a mother's to decision to have her baby not receive any pacifiers. (BMBR)**

b. **Pacifiers or artificial nipples may be supplied by the hospital to breastfeeding infants to decrease pain during procedures, for specific medical reasons, or upon the specific request of the mother. (NYCRR)**

c. **Before providing a pacifier or artificial nipple that has been requested by the mother, the hospital must educate the mother on the possible impacts to the establishment and success of breastfeeding and discuss alternative methods for soothing her infant, and document such education. (NYCRR)**

Recommendations:

- ✓ The hospital will integrate skin-to-skin contact, rooming-in, and early breastfeeding into relevant infant care policies/protocols to promote infant soothing.[28,31]
- ✓ The hospital will not accept free or low-cost pacifiers or routinely distribute pacifiers to pregnant women, mothers or their families.[22,29]
- ✓ The hospital will store issued pacifiers in locked cabinets or locked medication dispensing devices and track pacifier use.[31]
- ✓ The hospital will educate all mothers about pacifier use:[14,66]
    - Pacifier use should be delayed until breastfeeding has been firmly established, usually about one month of age.
    - From age one month to six months of age, the infant can be offered a pacifier at nap time and bedtime to help decrease the risk of sudden infant death syndrome (SIDS).
    - Pacifier use should be limited or stopped during the second six months of life to reduce the risk of otitis media.[63]

Strategies:

- ☐ Develop a protocol with clear limitations for pacifier use such as only using pacifiers during painful procedures and if the infant has a medical condition such as prematurity.[27,31]
- ☐ Ensure newborns learn to breastfeed by not introducing pacifiers.[28]
- ☐ Inform parents of the risk of interference (from pacifier use) with the establishment of breastfeeding.[31]
- ☐ Encourage mothers to hold and breastfeed infants during, or immediately following, routine painful procedures such as heel sticks and IM injections.[27]
- ☐ If pacifier is used during painful a procedure such as circumcisions, discard immediately after procedure is completed so the infant is not returned to the mother with a pacifier.[27]
- ☐ Encourage skin-to-skin contact and/or breastfeeding to soothe and pacify infant.[31]
- ☐ Teach calming techniques to parents/caregivers so they can apply these techniques at home.[31]

Supportive Policy/Position Statements
AAFP: *"The AAFP encourages that hospital staff respect the decision of the mother who chooses to breastfeed exclusively by not offering formula, water or pacifiers to an infant unless there is a specific physician order."* (Position Paper, Appendix 4)[16]
AAP: *"Given the documentation that early use of pacifiers may be associated with less successful breastfeeding, pacifier use in the neonatal period should be limited to specific medical situations. These include uses for pain relief, as a calming agent."* (Policy Statement)[14]
ACOG: *"Because the introduction of a pacifier or bottle has the potential to disrupt the development of effective breastfeeding behavior, their use should be minimized until breastfeeding is well-established."* (Special Report)[56]

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

Lactation support following hospital discharge is crucial to ensure success with breastfeeding at home. This is especially important in the early postpartum period when mothers often stop breastfeeding due to a misperception about insufficient milk, or because of painful nipples or other latch problems. Short- and long-term breastfeeding duration is increased when mothers received facilitative-type help and support from lactation consultants either by phone calls (initiated by the mother or the consultant) or in-person via home, hospital, or office visits. Peer support, which can offer a shared experience combined with realistic information and practical help, increases breastfeeding initiation and duration. Peer support can be offered in-person or by phone, prenatally or postpartum. Women who receive support and encouragement to breastfeed from their health care providers breastfeed longer. Written discharge materials are not effective in increasing duration. Returning to work is often the reason many report discontinuing breastfeeding. To be successful in continuing breastfeeding after returning to work or school takes planning and preparation. A woman will need to work with her employer or school to determine where and when she can pump and store her breast milk. Fortunately, federal and NYS laws provide women the right to time to pump breastmilk. NYS laws provide the right to breastfeed at the mother's workplace up to three years after the birth of her child.[36,65,67-69]

Required Policy Components:

a. **Prior to discharge, the hospital must determine that sources of nutrition for the infant and mother will be available and sufficient and if this is not confirmed, the attending practitioner and an appropriate social services agency must be notified. (NYCRR)**

b. **The hospital must determine that maternity patients have been instructed on and can perform basic self-care and infant care techniques prior to discharge or make arrangements for post discharge instruction. Topics to be covered shall include but not be limited to: (NYCRR and BMBR)**

- **normal postpartum events and common signs of complications;**
- **breast examination and care;**
- **care of the perineum and urinary bladder;**
- **amount of activity and exercise allowed;**
- **dietary requirements of breastfeeding;**
- **sanitary procedures for collecting and storing human milk;**
- **emotional responses (postpartum depression) and resumption of coitus;**
- **infant care including taking temperature, feeding, bathing, diapering, infant growth and development;**
- **parent-infant relationships;**
- **sources of advice and information available following discharge; and**
- **procedures to follow when a complication or emergency occurs after discharge.**

c. Prior to discharge, the hospital must document the completion of the newborn physical examination, and verification of passage of stool and urine, normal sucking and swallowing abilities and that newborn is stable. (NYCRR)

d. The hospital must offer each maternity patient a program of instruction and counseling in family planning and, if requested by the patient, a list, compiled by the NYS Department of Health and made available to the hospital, of providers offering the services requested. (NYCRR)

e. The hospital must provide mothers with commercial-free information about breastfeeding resources in their community, including information on the availability of breastfeeding consultants, support groups and breast pumps following discharge. (BMBR)

f. The hospital must inform mothers of community services, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and make referrals to such community services as appropriate. (NYCRR)

g. The hospital must provide mothers with information to help them choose a medical provider for their baby and understand the importance of scheduling follow-up medical arrangements, consistent with current perinatal guidelines and recommendations, for mother and newborn care. (NYCRR and BMBR)

h. The hospital must inform mothers about their right to breastfeed in any location, public or private, where they are authorized to be. This includes their place of employment or child day care center in an environment that does not discourage breastfeeding or the provision of breast milk. (BMBR)

i. The hospital must inform mothers about their right to take a reasonable number of unpaid breaks or use paid break time or meal time each day so mothers can express breast milk at work for up to three years following childbirth under NY Labor Law § 206-c. (BMBR)

Recommendations:

- ✓ The hospital will provide written information to and require that all breastfeeding mothers are able to do the following prior to discharge:[27]

  - position the baby correctly at the breast with no pain during the feeding;
  - latch the baby to breast properly;
  - state when the baby is swallowing milk;
  - state that the baby should be nursed a minimum of eight to 12 times a day until satiety, with some infants needing to be fed more frequently;
  - state age-appropriate elimination patterns (at least six urinations per day and three to four stools per day by the fourth day of life);
  - list indications for calling a healthcare professional; and

- manually express milk from their breasts.

✓ Prior to discharge, hospital maternity staff will give parents anticipatory guidance on:[49,66]

- prevention and management of engorgement;
- interpretation of feeding cues;
- signs of jaundice;
- weight loss;
- safe co-sleeping practices;
- maternal medication, cigarette, and alcohol use;
- individual feeding patterns; and
- delay of pacifier use until breastfeeding is firmly-established at about one month. From age one to six months of age, parents should consider offering a pacifier at nap time and bedtime to help decrease the risk of sudden infant death syndrome (SIDS). Pacifier use should be limited or stopped after six months of age to reduce the risk of otitis media.

✓ The hospital will schedule a follow-up visit for all infants which includes a formal, observed evaluation of breastfeeding performance (position, latch and milk transfer), a weight check, physical examination, assessment of jaundice, dehydration, elimination patterns and breastfeeding issues, by a pediatrician or knowledgeable health professional within a timeframe consistent with current perinatal guidelines.[27,31,48]

✓ The hospital will schedule a follow-up visit or contact parents within 24 hours when the infant is still not latching or feeding well when discharged home.[27]

✓ The hospital will facilitate peer support groups (mother-to-mother) and/or groups staffed by lactation consultants, provide one-on-one lactation consultation at hospital-affiliated outpatient clinics or make home visiting referrals to support the continuation of breastfeeding.[29,31]

✓ The hospital will inform mothers who plan to return to work or school about the NY Labor Law § 206-c, *Nursing Mothers in the Workplace Act*. Resources and tools are available to assist women in planning to return to work and in making arrangements with their employer. See www.breastfeedingpartners.org for more information.[49,69]

Strategies:

☐ Conduct and document assessment of breastfeeding effectiveness at least once during the last 8 hours before discharge.[49]

☐ Provide education to key family members or support persons, when possible, so that they can provide support to the breastfeeding mother at home.[29]

☐ Arrange for evaluation of all infants by a pediatrician or other knowledgeable health professional, within 48 to 72 hours after discharge or at 3-5 days of age to provide encouragement to parents and avoid early non-medically indicated supplementation with infant formula.[14,31]

☐ Prior to discharge, if lactation problems are anticipated due to maternal and infant risk factors, create a plan of action for close follow-up. Mothers with risk factors for lactation problems, such as primiparity, obesity, multiples, older maternal age, or perceived inadequate milk supply, or

infants with risk factors such as gestational age <37 weeks (low birth weight/premature), poor latch or suck, or oral anatomical abnormalities should receive early evaluation post-hospital discharge.[14,31,54]

- ☐ Establish in-house breastfeeding support groups/outpatient lactation clinics and telephone help lines.[29]

- ☐ Provide designated lactation staff to call all new parents after discharge, preferably during the first week after discharge.[29,31]

- ☐ Provide breastfeeding mothers with names and telephone numbers of lactation consultants and/or community resources (including local breastfeeding support groups, La Leche League leaders and WIC breastfeeding coordinators and peer counselors) for breastfeeding assistance, ideally 24-hours a day.[27,28,30,49]

- ☐ Develop a plan for annually verifying the existence of breastfeeding support services and the accuracy of the contact information.[28]

- ☐ Partner with community breastfeeding organizations and advocates to assess un-served or underserved populations and strengthen collaborations with breastfeeding coalitions and community support services.[28]

- ☐ Refer all potential income-eligible women to WIC for lactation and nutrition support:[28,49]
  - http://www.breastfeedingpartners.org/
  - http://www.health.state.ny.us/prevention/nutrition/wic/

- ☐ Work with public and private health insurers to provide coverage of breastfeeding support, lactation counseling services and the provision of breast pumps in hospital-affiliated clinics and practices.[70]

Supportive Policy/Position Statements

AAP: *"Communicating with families that breastfeeding is a medical priority that is enthusiastically recommended by their personal pediatrician will build support for mothers in the early weeks postpartum."* (Policy Statement)[14]

ACOG: *"Obstetrician-gynecologists should ensure that women have the correct information to make an informed decision and, together with pediatricians, they should ensure that each woman has the help and support necessary to continue to breastfeed successfully."* (Special Report)[56]

ACOG: *"The offices of obstetrician-gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace and be a resource for breastfeeding assistance through the first year of life and for these women to continue to breastfeed beyond the first year."* (Committee Opinion)[41]

CDC: *"The role of the health care professional is to give consistent and evidence-based advice and support to help mothers' breastfeed effectively and continue breastfeeding"* (CDC Guide)[32]

Baby-Friendly Step 10: *"Discharge planning for the breastfeeding mothers and infants should include information on the importance of exclusive breastfeeding for about 6 months and available and culturally-specific breastfeeding support services without ties to commercial interests."*[29]

U.S. Surgeon General: *"Hospitals and birth centers have a unique opportunity to ensure that mothers are connected to support systems in the community after they are discharged."* (Call to Action)[1]

The International Code of Marketing of Breast-milk Substitutes

11. Infant Formula Marketing Including Formula Discharge Packs

The International Code of Marketing of Breast-milk Substitutes was adopted in 1981 to promote, protect and support breastfeeding by ensuring appropriate feeding practices and the proper use of breastmilk substitutes and infant feeding bottles, when necessary. Infant formula marketing can undermine a mother's decision to breastfeed, and is associated with lower rates of exclusive breastfeeding and shorter duration of breastfeeding. Distribution of formula by hospitals implies hospital, health care provider and staff endorsement of infant formula use, an expectation of failure, and confusion about the importance of breastfeeding.[23,30,71-73]

Required Policy Components:

a. **The hospital or hospital-affiliated clinics must not distribute marketing materials, samples or gift packs that include breast milk substitutes, bottles, nipples, pacifiers, or coupons for any such items to pregnant women, mothers or their families. (NYCRR)**

b. **The hospital or hospital-affiliated clinics must <u>not</u> use educational materials which refer to proprietary product(s) or bear product logo(s), unless specific to the mother's or infant's needs or condition, or distribute any materials that contain messages that promote or advertise infant food or drinks other than breast milk. (NYCRR)**

Recommendations:

- ✓ The hospital will keep all infant formula cans/containers and pre-prepared bottles of formula out of patient or public view unless in use.[29,30]
- ✓ If a hospital provides materials at discharge to mothers, they will ensure they are commercial-free, are non-proprietary, and do not bear product logos.[28]
- ✓ The hospital will not allow marketing representatives to directly or indirectly contact maternity care staff, providers, patients or their families in the hospital.[29]
- ✓ The hospital will ensure that business relationships and vendor policies with infant formula and breastfeeding supply companies are congruent with policies for other vendors.[31]
- ✓ The hospital or any hospital-affiliated clinic or primary care practice will not display pictures, posters or other materials provided by manufacturers or distributors of breast-milk substitutes, bottles, teats and pacifiers that promote the use of these products or contain any wording which may idealize the use of breast-milk substitutes.[23,30,39]

- ✓ All hospital staff, including support staff, will not use note pads, post-its, pens, or any other incentives obtained from commercial formula companies or other companies that violate the International Code of Marketing of Breast-milk Substitutes.[23]

Strategies:

- ☐ Discontinue the distribution of industry-sponsored discharge gift packs to pregnant women, mothers and their families at primary care practices.[23]
- ☐ Do not allow hospital staff to receive gifts or personal samples from manufacturers or distributors of breast milk substitutes, bottles, nipples or pacifiers.[23,29]
- ☐ Create a breastfeeding-friendly environment by displaying pictures or photographs of women breastfeeding their infants in patient areas.[23,39]
- ☐ Do not accept supplies of breast milk substitutes at no cost or below fair market value[29]
- ☐ Collect formula usage data over time, and put a bid out to vendors to determine the fair market price for formula.[28]

Supportive Policy/Position Statements
AAFP: *"The AAFP discourages distribution of formula or coupons for free or discounted formula in hospital discharge or physician office packets given to mothers who choose to breastfeed exclusively."* (Position Paper, Appendix 4)[16]
AAP: *"The Academy advises pediatricians not to provide formula company gift bags, coupons, and industry-authored handouts to the parents of newborns and infants in office and clinic settings."* (2011 Resolution)[74]
ACOG: *"Distribution of formula marketing packs implies that formula is a recommended feeding method. Such marketing should not occur in inpatient or outpatient health care settings."* (Committee Opinion)[41]
AMA: *"Manufacturers are acutely aware of the conflict [of interest] between patient vulnerability and profit incentives."*[75]
ABM Protocol #7: *"The hospital will not accept or provide discharge packs that contain infant formula, coupons for formula, logos of formula companies, and/or literature supplied or sponsored by formula companies or their affiliates."* (ABM #7)[27]
WHO Code: *"No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this Code."*[23]

Summary

Breastfeeding is once again becoming the norm in NY, the U.S., and the world. Breastfeeding saves lives, improves health and cuts costs. It is a public health imperative, not a lifestyle choice. Improving breastfeeding rates is not the sole responsibility of individual women, rather governments, policy makers, hospitals, healthcare providers, communities and families all share the responsibility for improving breastfeeding support.[5] Hospitals and maternity care providers play a critical role implementing evidence-based maternity care policies and practices in support of breastfeeding, assuring that every newborn has a healthy start in life.

Hospitals that adopt the NYS Model Hospital Breastfeeding Policy can ensure compliance with NY laws, rules and regulations that promote, protect and support breastfeeding. The Model Policy and Implementation Guide are informed by the *Ten Steps to Successful Breastfeeding*[22] and the *International Code of Marketing of Breast-milk Substitutes*.[23] By implementing the required policy components, recommendations, and strategies, and providing evidence-based infant and maternity care practices, hospitals will be protecting, promoting and supporting breastfeeding consistent with the global Baby-Friendly® Hospital Initiative.

References

1. U.S. Department of Health and Human Services. The Surgeon's Call to Action to Support Breastfeeding, Washington, DC: US Department of Health and Human Services, Office of the Surgeon General; 2011.

2. Stuebe AM. The risks of not breastfeeding for mothers and infants. Rev Obstet Gynecol 2009;2(4):222-231.

3. Bartick MC, Stuebe AM, Schwarz EB, Luongo C, Reinhold, AR, Foster EM. Cost analysis of maternal disease associated with suboptimal breastfeeding. Obstet Gynecol 2013;0(0):1-9.

4. Bartick MC, Reinhold AR. The burden of suboptimal breastfeeding in the United States: A pediatric cost analysis. Pediatrics 2010;125(5):e1048-e1056.

5. UNICEF United Kingdom. Protecting Health and Saving Lives: A Call to Action for Breastfeeding in the UK. 2016. Available at: http://www.unicef.org.uk/BabyFriendly/News-and-Research/News/call-to-action/. Accessed May 2, 2016.

6. DiGirolamo AM, Grummer-Strawn LM, Fein SB. Effect of maternity-care practices on breastfeeding. Pediatrics 2008;Suppl 2:S43-9.

7. Philipp BL, Merewood A, Miller LW, Chawla N, Murphy-Smith MM, Gomes JS, Cimo S, Cook JT. Baby-friendly hospital initiative improves breastfeeding initiation rates in a US hospital setting. Pediatrics 2001;108(3):677-81.

8. DiGirolamo AM, Grummer-Strawn LM, Fein S. Maternity care practices: implications for breastfeeding. Birth 2001;28(2):94-100.

9. Guaraldi F, Salvatori G. Effect of breast and formula feeding on gut microbiota shaping in newborns. Frontiers in Cellular and Infection Microbiology 2012;2(94):1-4.

10. Johnson CL, Versalovic J. The human microbiome and its potential importance to pediatrics. Pediatrics 2012;129(5):1-23.

11. Walker M. Formula supplementation of the breastfed infant: Assault on the gut microbiome. Clinical Lactation 2014 5(4):128-133.

12. Godfrey JR, Lawrence RA. Toward optimal health: the maternal benefits of breastfeeding. J Women's Health 2010;19(9):1597-1602.

13. Schwartz E, Ray R, Stuebe A, et al. Duration of lactation and risk factors for maternal cardiovascular disease. Obstet Gynecol 2009;113:974–982.

14. American Academy of Pediatrics (AAP). Breastfeeding and the Use of Human Milk: Section on Breastfeeding. Pediatrics *2012;*129(3). Available at: http://pediatrics.aappublications.org/content/129/3/e827.full.html

15. American Congress of Obstetricians and Gynecologists (ACOG). Optimizing support for breastfeeding as part of obstetric practice. Committee Opinion No. 658. (Replaces Committee Opinion No. 361, 2007) Obstet Gynecol 2016;127:e86-92.

16. American Academy of Family Physicians (AAFP). Breastfeeding, Family Physicians Supporting (Position Paper). 2008. Available at: http://www.aafp.org/about/policies/all/breastfeeding-support.html http://www.aafp.org/about/policies/all/formula-hospital.html. Accessed February 25, 2016.

17. Lawrence RM. Circumstances when breastfeeding is contraindicated. Pediatr Clin N Am 2013;60:295-318.

18. Greene S, Ion A, Elston D, Kwaramba G, Smith S, Carvalhal A, Loutfy M. "Why aren't you breastfeeding?": How mothers living with HIV talk about infant feeding in a "breast is best" world. Health Care Women Int 2015;36(8):883-901.

19. NY Codes Rules and Regulations, Title 10, § 405.21 Perinatal Services. Available at: http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm. Accessed January 4, 2016.

20. NY Public Health Law, Article 25, Title 1, § 2505-a (2009) - *Breastfeeding Mothers' Bill of Rights*. Available at: http://www.health.ny.gov/publications/2028/ and http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: Accessed January 4, 2016.

21. NY Public Health Law, Article 28, § 2803-j (2008) - Information for Maternity Patients. Available at: https://www.health.ny.gov/publications/2901.pdf and http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO:

22. World Health Organization (WHO), Division of Child Health and Development. Evidence for the Ten Steps to Successful Breastfeeding. Geneva, Switzerland: World Health Organization; 1998. Report No. WHO/CHD/98.9. Available at: http://whqlibdoc.who.int/publications/2004/9241591544_eng.pdf.

23. World Health Organization. International Code of Marketing of Breast-milk Substitutes. 1981. ISBN 92 4 154160 1. Available at: http://www.who.int/nutrition/publications/code_english.pdf. Accessed December 31, 2015.

24. NY Public Health Law, Article 28, § 2803 - Hospital Care for Maternity Patients. Available at: http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: Accessed May 4, 2016.

25. NY Public Health Law, Article 41, Title 3, § 4130 - Registration of Births. Available at: http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO: Accessed May 4, 2016.

26. Semenic S, Childerhose JE, Lauziere J, Groleau D. Barriers, facilitators, and recommendations related to implementing the Baby-Friendly Initiative (BFI): An integrative review. J Hum Lact 2012;28:317-334.

27. Academy of Breastfeeding Medicine. ABM Clinical Protocol #7: Model breastfeeding policy (Revision 2010). *Breastfeed Med.* 2010;5(4):173-177. Available at: http://www.bfmed.org/Media/Files/Protocols/English%20Protocol%207%20Model%20Hospital%20Policy.pdf. Accessed January 15, 2016.

28. Overcoming Barriers to Implementing *The Ten Steps to Successful Breastfeeding:* Final Report, Baby-Friendly USA, Inc. Available at: https://www.oumedicine.com/docs/ad-obgyn-workfiles/bfhi-overcomingbarriers.pdf?sfvrsn=2. Accessed January 4, 2016.

29. Baby-Friendly USA, Inc. The Baby-Friendly Initiative, Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. 2016 Edition, Updated 06/30/16. Available at: https://www.babyfriendlyusa.org/get-started/the-guidelines-evaluation-criteria. Accessed July 18, 2016.

30. World Health Organization/UNICEF. *Baby Friendly* Hospital Initiative: Revised, Updated and Expanded for Integrated Care. World Health Organization, UNICEF, 2009. Available at: http://apps.who.int/iris/bitstream/10665/43593/1/9789241594967_eng.pdf. Accessed January 4, 2016.

31. United States Breastfeeding Committee (USBC). Implementing The Joint Commission perinatal care core measure on exclusive breast milk feeding. 2nd Revised Edition. Washington, DC: United States Breastfeeding Committee; 2013. Available at: http://www.usbreastfeeding.org/TJC-Measure-EBMF. Accessed January 5, 2016.

32. Centers for Disease Control and Prevention (CDC). Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies. Atlanta: U.S. Department of Health and Human Services; 2013.

33. United States Lactation Consultant Association. International Board Certified Lactation Consultant Staffing Recommendations for the Inpatient Setting. 2010. Available at. http://www.selca.info/uploads/2/7/0/7/2707925/ibclc_staffing_recommendations_july_20101.pdf. Accessed January 4, 2016.

34. United States Breastfeeding Committee. Core Competencies in Breastfeeding Care and Services for all Health Professionals. Revised edition. Washington, DC, 2010. Available at: http://www.usbreastfeeding.org/core-competencies. Accessed January 4, 2016.

35. American Congress of Obstetricians and Gynecologists (ACOG). Breastfeeding in underserved women: Increasing initiation and continuation of breastfeeding. Committee Opinion No. 570. 2013;122(2) (Part 1):423-8.

36. Guise, J_M, Palda V, Westhoff, Chan BKS, Helfand M, Lieu TA. The effectiveness of primary care-based interventions to promote breastfeeding: Systematic evidence review and meta-analysis for the US Preventive Services Task Force. Ann Fam Med 2003;1(2):70-8.

37. U.S. Preventive Services Task Force. Primary interventions to promote breastfeeding: U.S. Preventive Services Task Force Recommendation Statement. Annuals of Internal Medicine 2008;149(8): 560-564,W-107. Available at: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breastfeeding-counseling. Accessed May 4, 2016.

38. U.S. Preventive Services Task Force: Breastfeeding: Primary Care Interventions. Draft Recommendation Statement. 2016. Available at: http://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement158/breastfeeding-primary-care-interventions. Accessed May 4, 2016.

39. Academy of Breastfeeding Medicine. ABM Clinical Protocol #14. Breastfeeding-friendly physician's office: Optimizing care for infants and children, Revised 2013. Breastfeed Med 2013;8(2):237-242. Available at: http://www.bfmed.org/Media/Files/Protocols/Protocol_14_revised_2013.pdf. Accessed January 5, 2016.

40. Academy of Breastfeeding Medicine. ABM Clinical Protocol #19. Breastfeeding promotion in the prenatal setting, Revision 2015. Breastfeed Med 2015;10(10):451-457. Available at: http://www.bfmed.org/Media/Files/Protocols/prenatal%20setting2015.pdf. Accessed January 5, 2016.

41. American Congress of Obstetricians and Gynecologists (ACOG). Optimizing support for breastfeeding as part of obstetric practice. Committee Opinion No. 658. (Replaces Committee Opinion No. 361, 2007) Obstet Gynecol 2016;127:e86-92.

42. Newton ER, Hale TW. Drugs in breast milk. Clin Obstet Gynecol 2015;58(4):868-884.

43. Moore ER, Anderson GC, Bergman NJ. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database Syst Rev 2011;(3):CD003519.

44. Hung, K.J. & Berg, O. Early skin-to-skin after cesarean to improve breastfeeding. MCN 2011;36(5):318-324.

45. Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Sowden AJ, Lister-Sharp D. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. Health Technol Assess 2000;4:1-171.

46. Gouchron, S., Gregori D., et al. Skin-to-skin contact after cesarean delivery: an experimental study. Nurs Res 2010;59(2):78-84.

47. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care, 7th Edition. ISBN 978-1-548110-734-0 (AAP) ISBN 978-1-934984-17-8 (ACOG).

48. Academy of Breastfeeding Medicine. ABM Clinical Protocol #5. Peripartum breastfeeding management for the healthy mother and infant at term (Revision 2013). *Breastfeed Med* 2013;8(6):469-473. Available at: http://www.bfmed.org/Media/Files/Protocols/Protocol_5_revised2013.pdf. Accessed January 5, 2016.

49. Hannula L, Kaunonen M, Tarkka M-T. A systematic review of professional support interventions for breastfeeding. J Clin Nursing 2008;17:1132-1143.

50. Nichols J, Schutte NS, Brown RF, Dennis C-L, Price I. The impact of a self-efficacy intervention on short-term breast-feeding outcomes. Health Educ Behav 2009;36:250-8.

51. Nyqvist KH, Haggkvist A, Hansen MN, Kylberg E, Frandsen, AL, Maastrup. Ezeonodo A, Hannula L, Koskinen K, Haiek LN. Expansion of the Ten Steps to Successful Breastfeeding into neonatal intensive care: Expert group recommendations for three guiding principles. J Hum Lact 2012;28(3):289-296.

52. Benoit B, Semenic S. Barriers and facilitators to implementing the Baby-Friendly Hospital Initiative in neonatal intensive care units. JOGNN 2014;43:614-624.

53. Renfrew MJ, Craig D, Dyson L, McCormick F, Rice S, King SE, Misso K, Stenhouse E, Williams AF. Breastfeeding promotion for infants in neonatal units: A systematic review and economic analysis. Health Technol Assess 2009;13(40):1-170.

54. Academy of Breastfeeding Medicine. ABM Clinical Protocol #2: Guidelines for hospital discharge of the breastfeeding term newborn and mother: "The going home protocol," Revised 2014. Breastfeed Med 2014;9(1):3-8. Available at: http://www.bfmed.org/Media/Files/Protocols/protocol_2GoingHome_revised2014.pdf. Accessed January 5, 2016.

55. Mannel R, Mannel RS. Staffing for hospital lactation programs: Recommendations from a tertiary care teaching hospital. J Hum Lact 2006;22(4):409-417.

56. American Congress of Obstetricians and Gynecologists (ACOG). Special Report from ACOG – Breastfeeding: Maternal and Infant Aspects. ACOG Clinical Review January-February 2007;12(1) (Supplement). ISSN:1085-6862.

57. Academy of Breastfeeding Medicine. ABM Clinical Protocol #3: Hospital Guidelines for the Use of Supplementary Feedings in the Healthy Term Breastfed Neonate (Revision 2009). *Breast Med* Volume 4, Number 3, 2009. Available at: http://www.bfmed.org/Media/Files/Protocols/Protocol%203%20English%20Supplementation.pdf. Accessed January 5, 2016.

58. Nickel NC, Labbok MH, Hudgens MG, Daniels JL. The extent that noncompliance with the Ten Steps to successful breastfeeding influences breastfeeding duration. J Hum Lact 2013;29(1): 59-70.

59. Parry JE, Ip DKM, Chau PYK, Wu KM, Tarrant M. Predictors and consequences of in-hospital formula supplementation for healthy breastfeeding newborns. J Hum Lact 2013;29(4):527-536.

60. Declercq E, Labbok MH, Sakata C, O'Hara M. Hospital practices and women's likelihood of fulfilling their intention to exclusively breastfeed. AJPH 2009;99(5):929-935.

61. Fallon A, Van der Putten D, Dring C, Moylett EH, Fealy G, Devane D. Baby-led compared with scheduled (or mixed) breastfeeding for successful breastfeeding (Review). The Cochrane Collaboration. 2014;7:1-17.

62. Kramer MS, Barr RG, Dagenais S, Yang H, Jones P, Ciofani L, Jané F. Pacifier use, early weaning, and cry/fuss behavior: A randomized controlled trial. JAMA 2001;286(3):322-326.

63. Howard CR, Howard FM, Lanphear B, Eberly S, deBlieck EA, Oakes D, Lawrence RA. Randomized clinical trial of pacifier use and bottle-feeding or cupfeeding and their effect on breastfeeding. Pediatrics 2003;111(3):511-518.

64. Sexton S, Natale R. Risks and benefits of pacifiers. Am Fam Physician 2009;79(8):681-685.

65. Schmied, V, Beake S, Sheehan A, McCourt C, Dykes F. Women's perceptions and experiences of breastfeeding support: A metasynthesis. Birth 2001;38(1):49-60.

66. American Academy of Pediatrics. SIDS and other sleep-related infant deaths: expansion of recommendations for a safe infant sleeping environment. Policy Statement. Pediatrics 2011:135(4):e1105.

67. Lewallen LP, Dick MJ, Flowers J, Powell W, Zickefoose KT, Wall YG, Price ZM. Breastfeeding support and early cessation. JOGNN 2006;35(2):166-172.

68. Taveras EM, Capra AM, Bravemen PA, Jensvold NG, Escobar GJ, Lieu TA. Clinician support and psychosocial risk factors associated with breastfeeding discontinuation. Pediatrics 2003;112(1):108-115.

69. NY Labor Law § 206-c. NYS Nursing Mothers in the Workplace Act. Available at: http://www.labor.ny.gov/workerprotection/laborstandards/nursing-mothers.shtm. Accessed May 4, 2016.

70. United States Breastfeeding Committee, National Breastfeeding Center. *Model Policy: Payer Coverage of Breastfeeding Support and Counseling Services, Pumps and Supplies*. 2nd Revised ed. Washington, DC: United States Breastfeeding Committee and National Breastfeeding Center, 2014. http://www.usbreastfeeding.org/Portals/0/Publications/Model-Policy-Payer-Coverage-Breastfeeding-Support.pdf. Accessed May 4, 2016.

71. Rosenberg KD, Eastham CA, Kasenhagen LJ, Sandoval. Marketing infant formula through hospitals: The impact of commercial hospital discharge packs on breastfeeding. Am J Public Health 2008; 98(2):290-295.

72. Howard C, Howard F, Lawrence R, Andresen E, DeBlieck E, Weitzman M. Office prenatal formula advertising and its effect on breast-feeding patterns. Obstet & Gynecol 2008;95(2):296-303.

73. Parry K, Taylor E, Hall-Dardess P, Walker M, Labbok M. Understanding women's interpretation of infant formula advertising. Birth 2013;40(2):115-124.

74. American Academy of Pediatrics (AAP). Divesting from Formula Marketing in Pediatric Care. (12)-2012 Annual Leadership Forum. 2011; Resolution #67SC. Available at: https://www2.aap.org/breastfeeding/files/pdf/DivestingfromFormulaMarketinginPediatricCare.pdf. Accessed April 21, 2014.

75. Brennan TA, Rothman DJ, Blank L, Blumenthal D, Chimonas SC, Cohen JJ, Goldman J, Kassirer JP, Kimball H, Naughton J, Smelser N. Health industry practices that create conflicts of interest: A policy proposal for academic medical centers. JAMA 2006;295(4):429-431.