3RD EDITION

CONTAINING HEALTH CARE COSTS HELP IN PLAIN SIGHT

International Board Certified Lactation Consultants: Allied Health Care Providers Contribute to the Solution

Affordable Health Care Begins with Breastfeeding

The training of International Board Certified Lactation Consultants (IBCLCs) focuses exclusively on the care and support of lactation, resulting in allied health professionals uniquely qualified to address the health care needs of the breastfeeding family.

Reimbursement of the IBCLC yields a significant return on investment. Why pay more for disease when prevention costs less?

United States Lactation Consultant Association

202-738-1125
Washington, D.C.
info@uslca.org
www.uslca.org

3RD EDITION

CONTAINING HEALTH CARE COSTS HELP IN PLAIN SIGHT

International Board Certified Lactation Consultants: Allied Health Care Providers Contribute to the Solution

Judith L. Gutowski, BA, IBCLC, RLC
Chair, Licensure and Reimbursement Committee
United States Lactation Consultant Association

Marsha Walker, RN, IBCLC, RLC
Director, Public Policy, Licensure and Reimbursement
United States Lactation Consultant Association
Board of Directors

Ellen Chetwynd, RN, BSN, MPH, IBCLC, RLC
Licensure and Reimbursement Committee
United States Lactation Consultant Association
Carolina Global Breastfeeding Institute
UNC Gillings School of Global Public Health

United States Lactation Consultant Association
202-738-1125
Washington, D.C.
info@uslc.org
www.uslca.org

Recommended Citation:
Gutowski JL, Walker M, Chetwynd E.: “Containing Health Care Costs Help in Plain Sight. International Board Certified Lactation Consultants: Allied Healthcare Providers Contribute to the Solution. 3rd Edition” Washington, D.C. United States Lactation Consultant Association, July 2014.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Escalating medical costs have resulted in an emphasis on disease prevention by healthcare professionals, government agencies, and health insurers. By providing immune protection and proper nutrition, breastfeeding remains a cost-effective intervention for disease prevention with an accompanying reduction in healthcare spending. Informed women are initiating breastfeeding at an increasing rate, from 26% in 1970 to 77% in 2013. However, many women struggle to maintain breastfeeding for as long as it is recommended and fail to achieve the intensity and duration of breastfeeding that they planned. This is often due to poor access to effective breastfeeding support within the medical system, false and misleading infant formula marketing, and societal barriers including: lack of paid maternity leave, unsupportive places of employment, and cultural discomfort with breastfeeding. Consequently, healthcare dollars are spent on treating diseases and conditions that could have been effectively prevented by breastfeeding. To appropriately address this preventive healthcare gap and the excessive costs that result, consumers, healthcare providers, insurers and employers need to be able to identify and access competent lactation consultants to provide services and protect quality of care.

The United States Lactation Consultant Association recommends:

- Recognition of the *International Board Certified Lactation Consultant (IBCLC)* certification as the preferred provider of lactation care and services for private and Medicaid insurance plans.
- State licensure of IBCLCs.
- Identify and quantify IBCLC-provided lactation services as distinct from other healthcare services in the medical system, through specified billing codes or other means.
- Credentialing of IBCLCs by insurers in order to standardize proven qualifications, identify sound practice strategies, and maintain appropriate oversight.
- Third party reimbursement of skilled breastfeeding support provided by the IBCLC.

The training and skills of IBCLCs focus exclusively on the care and support of lactation, resulting in allied health professionals uniquely qualified to address the healthcare needs of the breastfeeding family.

Photo Courtesy of Pennsylvania Department of Health

Reimbursement of the IBCLC yields a significant return on investment. Why pay more for disease when prevention costs less?

HEALTH CARE COSTS ARE RISING

Rapidly rising healthcare costs have placed strain on the systems used to finance them, including both public and private insurance programs. Healthcare costs in the United States surpassed all other countries with $8508 USD spent per capita in 2011, accounting for 17.7% of the gross domestic product (GDP) in the country (Figure 1).[1] Legislators, government agencies, insurers, employers and healthcare consumers are struggling to find ways to curb this growth. Chronic diseases including heart disease, stroke, cancer, diabetes, osteoarthritis, rheumatoid arthritis and obesity are reduced for breastfed infants and women who breastfeed.[2,3] Chronic diseases are expensive to treat, consume 75% of national health expenditures, and are among the leading causes of death and disability.[4] In the U.S. today, 78 million adults and 12.5 million children and adolescents are obese.[5] Recent reports affirmed that obesity related medical costs make up almost 10 percent of all medical spending and may amount to $147 billion per year.[6]

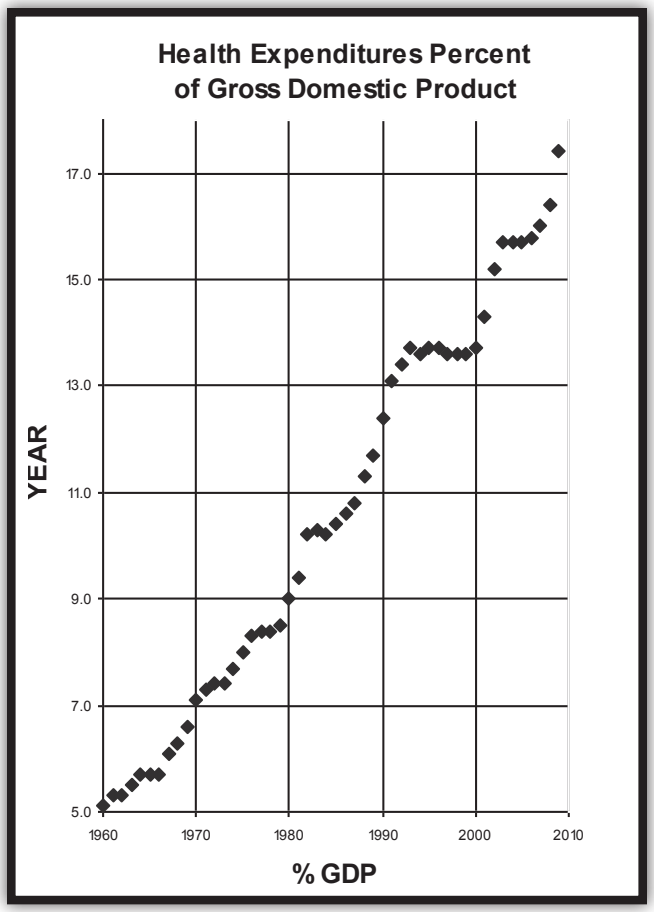

FIGURE 1

Figure 1 Health expenditures as a percentage of the gross domestic product

Health promotion and disease prevention are effective tools to reduce the incidence of costly acute and chronic illnesses and conditions. Health care agencies have made recommendations to stop smoking, to increase exercise, and to improve nutrition as the basis of health messages. In addition, they have recently recognized that infant and child nutrition has a strong influence on lifelong health. Major health organizations and government health agencies acknowledge the need to promote exclusive breastfeeding for the first six months of life and for the first year or more with complimentary foods as an optimal start for overall health and nutrition (Table 1).

Table 1: Breastfeeding Recommendations of Professional Organizations

Agency or Organization[7]	***Duration***	***Exclusivity***
National Business Group on Health[8]	At least a year	6 months
American Academy of Pediatrics[9]	At least 1 year and beyond as long as mutually desired by mother & child	6 months
American College of Obstetricians and Gynecologists[10]	Longer than 6 months and as long as possible	6 months
American Association of Family Physicians[11]	Continue breastfeeding with appropriate complimentary foods for at least one year	6 months
American College of Nurse-Midwives[12]	Ideally continue throughout the first year of life	6 months
American Dietetic Association[13]	With complementary foods from 6 months until at least 12 months.	6 months
International Lactation Consultant Association[14]	2 years or more is normal. Women should breastfeed as long as they wish	6 months
American Public Health Association[15]	At least 1-2 years and beyond	6 months

BREASTFEEDING AS HEALTH PROMOTION AND DISEASE PREVENTION

Breastfeeding reduces health risks across the lifetime for children and their mothers and can improve the quality of life for the entire community. Human milk is an important building block in human development. It provides perfect nutrition, and is of fundamental importance to the development of a healthy immune system and gastrointestinal tract.[16] Babies who are not breastfed, or who are only breastfed for a brief period of time, are exposed to higher disease risks as infants, children, and adults. Because breastfeeding reduces the incidence and severity of acute and chronic diseases[17], it is a cost saving intervention for insurers and self-insured employers (Table 2).

Table 2: Reduced Risk of Childhood Illnesses Associated with Breastfeeding Among Full-term Infants[18]

Disease	***% Reduction***
Acute Otitis Media	100%
Atopic Dermatitis	47%
Gastrointestinal Infection	178%
Lower Respiratory Infection, Hospitalization Rate	257%
Asthma, with family history	67%
Asthma, no family history	35%
Childhood Obesity	32%
Type II Diabetes	64%
Acute Lymphocytic Leukemia	13%
Acute Myelogenous Leukemia	18%
Sudden Infant Death Syndrome	56%
Necrotizing Enterocolitis in Pre-term Infants	138%

A mother who breastfeeds improves her health profile with increased total length of breastfeeding over her lifetime. This protection is related to the hormonal influences on the body during lactation.[19] Women who do not breastfeed after pregnancy demonstrate an increased risk for developing ovarian and breast cancers, diabetes, metabolic disease, and heart disease (Table 3). Breastfeeding creates significant emotional and relational advantages for mothers and infants including facilitation of attachment and reduction in depression and anxiety disorders.[20] Promoting, protecting and supporting breastfeeding medically and culturally have the potential to make a profound impact on healthcare spending and on the health status of the United States population.

Table 3: Maternal Risk Reduction from Breastfeeding	
Disease	***Risk Reduction***
Diabetes[21]	12%
Metabolic Syndrome[22]	8.4%
Ovarian Cancer[23]	21%
Breast Cancer[24]	4.3%
Coronary Artery Disease[25]	23%
Aortic Calcifications[26]	22%
Coronary Calcifications[27]	15%

THE ECONOMIC COST OF NOT BREASTFEEDING

The cost of formula feeding to society is profound. Direct costs include purchasing breast milk substitutes and infant feeding bottles and nipples, expenditures on fuel, paper, plastic, and metal to manufacture these products, and expenses to handle the waste from the use of these products. Unpublished proprietary data that the Nielsen Company prepared for ERS [Economic Research Service] indicate that total infant formula sales in 2005 totaled 3.4 billion dollars in the United States.[28]

- In the federal budget, the Women, Infants and Children's (WIC) program spent approximately $850 million on infant formula in fiscal year 2009.[29]
- Between 57 and 68 percent of all infant formula sold in the United States in 2004-2006 was purchased through WIC.[30]

Costs of ***not*** breastfeeding include the cost of healthcare for preventable illnesses and diseases. Decreased risk of pediatric diseases identified by the Agency for Healthcare Research and Quality (Table 2) have been quantified by Bartick and Reinhold who found that if 90% of US families complied with the medical recommendations to breastfeed exclusively for 6 months, with continued breastfeeding for one year, $13 billion could be saved and approximately 911 infant deaths could be prevented annually.[31] Using data from this analysis showed that the cost-benefit would be $5909 per child per year based on 2007 US dollars in savings on the infant illnesses cited in Table 2.[32] Further analysis from Bartick, Steube, Schwarz, Luongo, Reinhold and Foster (2013) for 1.88 million women showed the cost-benefit yield was $18.265 billion or $9715 per woman based on 2011 dollars for conditions shown in Table 3.[33] These dollar savings are incurred due to an estimated 4981 excess cases of breast cancer, 58,847cases of hypertension and 13,946 cases of myocardial infarction.[34]

Additional health related cost burdens for suboptimal breastfeeding include the following:

- The $270 billion annual cost of overweight and obesity to the U.S. economy (2009).[35]
- Medical costs for obese individuals are $1429 higher per year than for normal weight individuals.[36]

BARRIERS TO INITIATING AND SUSTAINING BREASTFEEDING

Mothers are choosing to breastfeed because promotion has worked. However, clinical lactation care in many hospitals and after discharge is insufficient, yet necessary to overcome barriers to continue to nurse. It is vital to make the distinction between breastfeeding *promotion* activities leading to initiation of breastfeeding and *clinical care* for management of breastfeeding problems as immensely different activities. Much of the present breastfeeding support is promotion or is geared toward only the days in the hospital requiring mothers to manage on their own for the rest of the 360 days of the first year.

In-patient care research conducted by Clegg at a 10 hospital health system, determined that "Of tasks done by lactation consultants [IBCLCs], 71% could ***not*** be deferred to the bedside nurse or non-clinician support person." This was the case even when the staff nurses were well trained in basic breastfeeding support.[37]

A study from the Centers for Disease Control found that, "Most mothers who want to exclusively breastfeed intend to do so for 3 months, but the majority are not meeting their intended duration."[38] Additionally, the study found that more than half of the mothers in their analysis had stopped exclusively breastfeeding by 2 months even when their infants were delivered in "Baby Friendly" Hospitals.[39]

The Infant Feeding Practices Study II queried mothers' reasons for weaning.[40] The authors identified concerns related to the feeding process such as latching, breast and nipple pain, and actual low milk supply or perceived low milk supply, as the most frequently cited in the decision to stop breastfeeding among mothers within the first month, while inconvenience and need for separation and pumping became more frequent reasons for those who weaned between 1 and 2 months."[41] The results also showed that the most common two reasons for weaning over the entire first year of life were that mothers believed "Breast milk alone did not satisfy my baby" - 49.5% and "I didn't have enough milk" - 45.5%.[42]

A study in 2011 by Wagner, Chantry, Dewey and Nommsen-Rivers found that "only 8% of mothers reported no [breastfeeding] problems" and "only 49% of mothers report full resolution [of problems] by day 7."[43] These investigators determined breastfeeding problems to be nearly universal for first-time mothers. The most common problems coincided with those found in the Infant Feeding Practices II Study and were strongly associated with stopping breastfeeding. The study found only 13% of mothers were exclusively breastfeeding for 6 months."[44] In fact, the article says that "the majority of participants continued to report breastfeeding concerns throughout the study" which went on through 60 days postpartum.[45] Other research in the journal Pediatrics found that, "Approximately 60% of mothers who stopped breastfeeding did so earlier than desired."[46] The article concluded that major reasons why mothers stop breastfeeding before they desire include concerns about maternal or child health (infant nutrition, maternal illness or the need for medicine, and infant illness) and processes associated with breastfeeding (lactation and milk-pumping problems). The authors noted that "continued professional support during the course of nursing is needed to address these challenges and help mothers meet their desired duration."[47]

HEALTHCARE SUPPORT OF BREASTFEEDING IS IMPORTANT

Human milk is free and nutritionally adapted to the needs of infants and children worldwide, regardless of the quality of a mother's diet or her socioeconomic status.[48] A woman does not need to be wealthy to provide her baby with her own milk and the majority of women are able to do so. In doing so she provides superb nutritional, immunologic, developmental, psychological, social, economic, and environmental advantages.[49] One study determined that up to 5% of women may be physically unable to produce adequate milk for their infants.[50] This impartial availability of breastmilk is why breastfeeding has been called the great equalizer. Breastmilk provides the best start in life regardless of race, education, geography or other demographic factors. It is also a healthcare equalizer, because of the uniform ability to reduce acute and chronic illness in mothers and babies, therefore diminishing the need for future healthcare services.

Women are significantly more likely to achieve their breastfeeding goals if they are supported prenatally, in the maternity care facility and after discharge, particularly within the first two weeks. At this time, a new mother can be hormonally labile, recovering from surgery and/or birth, suffering from fatigue, and learning how to fit a baby into her life. When breastfeeding problems exist, women confront them every two or three hours around the clock. Difficult breastfeeding is grueling, and when support is not initiated immediately, the breastfeeding relationship can be lost within a matter of days or even hours affecting the mother, child, and family's future for the rest of their lives. Women who want to breastfeed and are unsuccessful in achieving their goals can be reminded of their loss each time they give their baby formula, experience an infant illness, or see other women breastfeed. Breastfeeding can be lost in a matter of hours or days when things are not going right, yet IBCLC services are not available to many mothers during the critical early days.

The most common problems treated by IBCLCs are suppressed lactation, latching difficulties, pain, slow weight gain, oversupply, and jaundice.[51] IBCLC support could impact all of the identified barriers with evidence-based clinical interventions and consistently available follow-up.

An IBCLC is qualified to provide this necessary and ongoing care of the breastfeeding dyad. Additionally, Chantry's address to the Academy of Breastfeeding Medicine stated "less than half of these mothers reported receiving support from anybody in the primary care setting – despite the early hospital follow-up visit."[52] According to Nommsen-Rivers, the solution to resolving early breastfeeding difficulties is that "Priority should be given to enacting strategies for lowering the overall occurrence of breastfeeding problems and, in particular, targeting support for mothers with infant feeding or milk quantity concerns *within the first week after leaving the hospital*. [Emphasis added]"[53]

IBCLCs are the experts on the health professional team in breastfeeding management and also provide relational support that women need to build confidence and breastfeeding self-efficacy.[54] Mothers need access to IBCLC services that are: 1) easy to find, 2) affordable, 3) conveniently located and 4) available quickly. Even though some hospitals provide out-patient care, access can be cost-prohibitive due to lack of insurance coverage for the services or geographically prohibitive for families once they have travelled home after discharge with the newborn.

UNITED STATES BREASTFEEDING POLICIES

Breastfeeding duration rates in the United States are low (Figure 2).[55] The Surgeon General's Call to Action to Support Breastfeeding stated that "Many mothers in the United States want to breastfeed, and most try. And yet within only three months after giving birth, more than two-thirds of breastfeeding mothers have already begun using formula. By six months postpartum, more than half of mothers have given up on breastfeeding, and mothers rarely breastfeed one-year olds or toddlers."[56] Furthermore, unacceptable racial/ethnic and socioeconomic disparities in breastfeeding persist."[57]

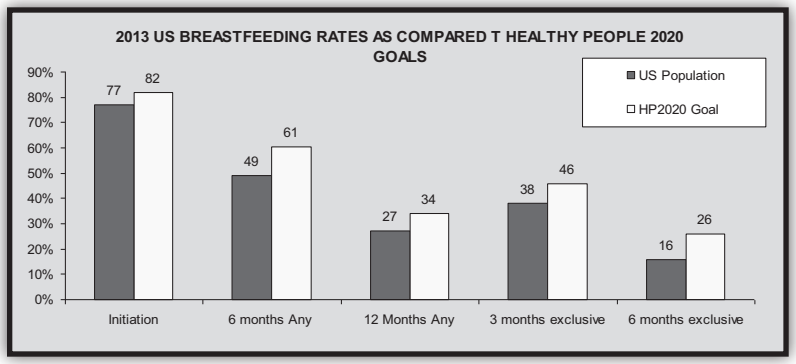

FIGURE 2

In an effort to improve health and reduce the costs of preventable disease, many healthcare and government agencies are creating programs and policies that promote and support breastfeeding.

Public Health Policies:

- The Surgeon General issued a Call to Action to Support Breastfeeding stating, "The time has come to set forth the important roles and responsibilities of clinicians, employers, communities, researchers, and government leaders and to urge us all to take on a commitment to enable mothers to meet their personal goals for breastfeeding." The Call to Action details how individuals and groups can provide breastfeeding support.[58]

- The Institute of Medicine's *Consensus Report Clinical Preventive Services for Women: Closing the Gaps* recommended third party coverage of "Comprehensive lactation support and counseling and costs of renting breastfeeding equipment."[59]

- The United States Preventive Services Task Force (USPSTF) "Coverage of Preventive Health Services" recommendations for breastfeeding include: pre and postnatal breastfeeding education, formal breastfeeding evaluations undertaken by trained caregivers in the hospital and out-patient care settings, followed by interventions to correct problems as needed.[60]

- US Department of Health & Human Services National Prevention Strategy recommends support policies and programs in order to increase the initiation and duration of breastfeeding including

workplace breastfeeding support and access to lactation services.[61]

- The Centers for Disease Control and Prevention publishes the Breastfeeding Report Card to provide state data so that health professionals, legislators, employers, business owners, community advocates and family members can work together to identify states' needs, develop solutions, and work together within their community to better protect, promote, and support breastfeeding. This report includes the ratio of IBCLCs per delivery in each state as a metric determining the degree of lactation support available to families.[62]

- The US Department of Agriculture WIC food packages were adjusted in 2009 to provide greater incentives for continued breastfeeding.[63]

- The American Public Health Association issued "An Update to A Call to Action to Support Breastfeeding: A Fundamental Public Health Issue" urging public and private payers to cover lactation consultations provided by IBCLCs with third party reimbursement.[64]

- The White House Task Force on Childhood Obesity Report to the President recommended that hospitals, healthcare providers and insurance companies should educate new mothers about breastfeeding and provide support for breastfeeding.[65]

Workplace Policies:

- The US Department of Health and Human Services, Health Resources and Services Administration, created the "Business Case for Breastfeeding," a program whose goal is to provide the materials needed to make workplaces more breastfeeding friendly.[66]

- Section 4207 of the Affordable Care Act included: "Reasonable Break Time for Mothers" stating, "Employers are required to provide unpaid, reasonable break time for an employee to express breast milk for her nursing child and provide a private place, other than a bathroom, which may be used by an employee to express breast milk."[67]

Healthcare Policies:

- The Joint Commission has added "Exclusive breastmilk feeding during the newborn's entire hospitalization" to the Perinatal Care Core Measures Set. Exclusive breastfeeding was identified as most relevant to patient safety and quality of care.[68]

- The National Initiative for Children's Healthcare Quality is leading a nationwide effort to help hospitals become Baby Friendly.[69]

- United States Preventive Services Task Force (USPSTF) recommendations have been adopted by Bright Futures, an initiative of the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA). Bright Futures recommendations are supported and coordinated by

the American Academy of Pediatrics.[70,71]

- The National Business Group on Health recommends that employer plan benefits include 5 lactation consultant visits per pregnancy with IBCLCs as approved providers of these services.[72]

BREASTFEEDING HAS A "B" RATING WITHIN THE USPTF RECOMMENDATIONS MAKING THIS COVERAGE MANDATORY FOR PRIVATE INSURERS WITH NO COST SHARING REQUIREMENTS.

Photo Courtesy of Pennsylvania Department of Health

Despite these supportive official documents and mandates given to increase breastfeeding incidence and duration, the healthcare system has lagged behind in the provision of breastfeeding support services. The "Kaiser Family Foundation State Medicaid Coverage of Prenatal Services: Summary of State Survey Findings" notes that, despite the recognition of the importance of breastfeeding in improving health, coverage of breastfeeding support services for low-income women is far from universal.[73] Their report from November 2009 stated that Medicaid covered breastfeeding education services in only 25 states; and even fewer, 15 states, covered individual lactation consultations.

WHY IBCLCS SHOULD PROVIDE BREASTFEEDING SUPPORT

Research shows that the role of the healthcare provider is critical to breastfeeding success.[74,75,76,77,78,79] Despite the US Breastfeeding Committee's Core Competencies in Breastfeeding Care for All Health Professionals,[80] healthcare providers have difficulty providing effective lactation care. Training is often absent or minimal in their academic medical program preparation and may not have been available or pursued through continuing education.[81,82] Deficiencies in breastfeeding management are seen in pediatricians,[83] pediatric residents,[84] obstetricians,[85] family practitioners,[86] clinic nurses and public health nurses,[87] pediatric nurse practitioners,[88] hospital staff nurses,[89] neonatal intensive care nurses,[90] and WIC personnel.[91] Furthermore, effective lactation support is time intensive with an average consultation lasting one hour.[92] These extended visits are often difficult for providers to accommodate as their time is already at a premium.[93,94] Most providers specialize in the care of the mother *or* the infant, rather than caring for them as a unit. This adds to the time and complexity of providing lactation support and continuity of care.

Professional lactation consultation services are needed for pregnant and breastfeeding Medicaid recipients. Women with Medicaid insurance initiated breastfeeding 69% of the time and only 48% continue breastfeeding at four weeks postpartum.[95] This is in comparison to women who are not Medicaid recipients, those who have no insurance, private insurance or other insurance, who initiate breastfeeding 83-88% of the time and continue to breastfeed at four weeks 63-71% of the time.[96] Services required include: clinical management of breastfeeding, preventive healthcare, patient education, nutrition counseling, and therapeutic treatment. Medicaid insured women, and infants and children may also qualify through the pregnancy care benefit, Early Periodic Screening, Diagnosis and Treatment program (EPSDT), Early Intervention programs.

Women without Medicaid benefits may be able to access IBCLC services via private insurance plans which are required by the Affordable Care Act to provide lactation services as preventive healthcare. Individual, small group and insurance exchanges may or may not cover lactation counseling. Plans are required to include categories of services specified by the Essential Health Benefit, but the law does not name the specific services that must be covered or the amount, duration, and scope of covered services. Therefore, they may determine not to include lactation services or equipment. Coverage will vary. Private non-grandfathered plans and issuers must cover lactation counseling services without cost sharing consistent with these guidelines in the first plan year that began on or after August 1, 2012. In-network coverage is required; out-of-network coverage is not required. Employer or insurer must notify the plan members of eligibility for this benefit.[97]

FIGURE 3 FACETS OF A LACTATION CONSULTATION

As shown in the diagram in Figure 3, breastfeeding involves two patients, thus adding to the complexity of consultations and care. In addition, while a lactation consultation has static components, lactation consultants must be sensitive to the current needs of the mother such as her emotional state and the infant's hunger. It is best to adapt the timing of the visit in the order that facilitates caring for the needs of these two patients at the time.

Clinical lactation evaluation and management by a qualified lactation consultant, can involve an office visit of 60-120 minutes to include the following components:

Figure 3. An Individualized Lactation Consultation Process includes:

I. Review chief complaint, the reason patient has been referred.

II. Subjective History

a. Maternal History

i. Perinatal History: all pregnancies, medical conditions past and present, including medications to address risk factors (thyroid disease, diabetes, obesity, PCOS, infertility, hypertension, PIH)

ii. Lactation History: past and present, including risk factors for insufficient supply (breast surgery, nipple anomaly, breast hypoplasia, accessory mammary tissue, lactation failure)

iii. Pregnancy History

b. Infant History

i. Birth History including gestation and delivery interventions and complications for the infant

ii. Risk factors for inadequate intake (Down's, heart defect, preterm, near-term, jaundice, neurological, head, neck or oral anomalies)

iii. Feeding History: mother's perceived breastfeeding effectiveness, infant output, feeding schedule.

c. Social History: Review of mother's goals and expectations and support systems.

III. History of Present Illness
- a. Observations of past 24-48 hours feeding details, output and behavior
- b. Maternal reported pain

IV. Objective Physical Assessments:
- a. Infant physical/oral assessment
  - i. General physical appearance, weight, weight gain appearance
  - ii. Digital suck assessment
  - iii. Assessment of body positioning, infant tone, etc.
- b. Maternal breast and nipple assessment
  - i. Visual inspection and palpation
  - ii. Functional assessment after breastfeeding or pumping
- c. Observation of latching and feeding
  - i. Latch assessment
  - ii. Milk transfer, test weights
  - iii. Infant satiety
  - iv. Breast changes after feeding
- d. Milk supply
  - i. Pump after feeding (if supply or infant effectiveness in question)
  - ii. Assess milk calories with creamatocrit (optional)

V. Additional areas that may be addressed include:
- a. Diet and nutrition
- b. Maternal medications
- c. Lifestyle adjustment
- d. Emotional and relational health
- e. Employment adjustments

VI. Lactation Assessment
- a. Infant: Gestalt diagnosis of feeding ability and milk transfer ability
- b. Maternal: Gestalt diagnosis of milk supply, milk production ability

VII. Plan
- a. Instruct mother in latch techniques, positioning, exercises to improve infant tone
- b. Instruct mother in feeding management
  - i. Feedings per 24 hours, one or both breasts, length of feeds, cluster feeds, etc
  - ii. Instruct mother in supplementation if required, collaborate with PCP as needed
  - iii. Instruct mother in breast expression if required
  - iv. Instruct mother in any special equipment required (pillows, nipple shields, breast pump, lactation aids, supplemental feeders, etc.)
  - v. Instruct mother regarding galactagogues, collaborate with PCP as needed
  - vi. Instruct mother regarding nipple treatment, collaborate with PCP as needed
  - vii. Instruct mother on recording of feedings and output, maternal diet
- c. Anticipatory guidance
  - i. Fussiness
  - ii. Cluster feeds
  - iii. Growth spurts

iv. Contraception
v. Older infant issues, i.e. biting, starting solids, weaning

d. Give mother written instructions

VIII. Follow-up

IX. Schedule follow-up per phone, visit or return to MD.

X. Documentation

a. Electronic Medical Record
i. Complete Outpatient Assessment forms
ii. Enter appropriate charges

b. Order breast pump or necessary supplies for mother

c. Physician Reporting
i. Complete Infant Report for pediatrician or PCP
ii. Complete Maternal Report for obstetrician or PCP
iii. Fax reports

Utilization of IBCLCs for breastfeeding support is a cost effective solution. They provide safe and effective care with resulting improvements in breastfeeding initiation, duration, and exclusivity—all of which result in reduced healthcare claims. Integration of lactation consultants into community settings will advance duration rates, as demonstrated by Witt's study which showed improved duration with the addition of standardized IBCLC support in a pediatric practice.[98] Qualitative evidence from two randomized control trials demonstrated that support from IBCLCs provided to mothers pre-and postnatal, as a standard of care, increased breastfeeding intensity and duration at 6 months with a total of 3 hours of contact.[99] Research has shown that IBCLCs have a positive effect on breastfeeding success in various settings. (Table 4) Their clinical competencies encompass a broad range of lactation care and services.[100]

Table 4: Effectiveness of IBCLCs

Setting	***Effect of IBCLCs on initiation & duration of breastfeeding***
WIC	More mothers initiate breastfeeding[101]
Community Clinic	Access for lactation consultants facilitates mothers achieving their breastfeeding goals[102]
Primary Care	Promote a longer duration of breastfeeding[103] LCs help overcome barriers and sustain breastfeeding[104] LC integrated into routine care increase breastfeeding intensity at 3 months[105]
NICU	Breastfeeding rates 50% compared to 36% without an IBCLC[106] NICU dedicated lactation consultant increases babies receiving human milk[107]
Hospitals	2.28 times increase in the odds of breastfeeding at discharge[108]
Medicaid mothers with IBCLC contact in hospitals	4.13 times increase in the odds of breastfeeding at discharge[109]

"For primary care, breastfeeding support constitutes the quintessential health maintenance and disease prevention intervention….Traditionally, medical practitioners may have eschewed breastfeeding support interventions because they tend to be labor intensive, which as a general rule are poorly reimbursed. If breastfeeding-related metrics can be included in performance standards upon which Medicare bonuses are based, there could quite conceivably be a very substantial financial incentive for physicians to become far more actively involved in breastfeeding support in their respective practices….The nature of primary care could be radically altered in a short period of time, and in a very favorable manner. Our task now is to keep the importance of breastfeeding support front and center in the thinking of our policy makers….We need to educate the leaders of our professional health societies and the Centers for Medicare and Medicaid Services (CMS) that breastfeeding must not be overlooked if we truly wish to reduce the cost of medical care and safeguard the health of American citizens in the years ahead."

Jerry Calnen, MD, is a pediatrician and is the Immediate Past President of the Academy of Breastfeeding Medicine.[110]

TRAINING AND QUALIFICATIONS OF INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANTS (IBCLCS)

The International Board Certified Lactation Consultant (IBCLC) is a member of the maternal-child healthcare team with specialized skills in breastfeeding care and management. Lactation Consultants (IBCLCs) have been working in the healthcare field since 1985 in the United States and around the world. The certification can be added to an existing healthcare profession, or function as a stand-alone certification.

The IBCLC works in hospital maternity and pediatric care units to provide clinical lactation services and lactation education to staff. In the outpatient setting, lactation consultants work independently, in medical practices or public health settings. Lactation consultants can be employed by corporations to provide work place lactation services or can work for government or other healthcare

Photo Courtesy of Pennsylvania Department of Health

agencies. Their expertise is used to develop and implement policies to support, protect, and promote breastfeeding. Some IBCLCs carry out breastfeeding-related research.

Depending on their educational and professional background, IBCLCs are required to accrue 300-1000 hours of supervised lactation-specific clinical experience and 90 hours of didactic education in human lactation as well as training in another healthcare field, or 14 college level classes in health sciences. Following this education and training, they must pass a criterion referenced exam which provides a standard for IBCLC certification. The exam is administered by the International Board of Lactation Consultant Examiners (IBLCE). IBLCE is an independently accredited organization that determines prerequisites to sit for the exam and assures its validity through the use of psychometric guidelines. Requirements to sit for the exam include:[111]

Educational Background

- 90 hours of lactation-specific education within the 5 years immediately prior to exam application
- 8 college level health professional courses
  - Biology
  - Human Anatomy
  - Human Physiology
  - Infant and Child Growth and Development
  - Introduction to Clinical Research
  - Nutrition
  - Psychology or Counseling Skills or Communication Skills
  - Sociology or Cultural Sensitivity or Cultural Anthropology
- 6 health related continuing education courses
  - Basic Life Support
  - Medical Documentation
  - Medical Terminology
  - Occupational Safety and Security for Health Professionals
  - Professional Ethics for Health Professionals
  - Universal Safety Precautions and Infection Control
- 300-1000 clinical practice hours
- Pass a criterion-reference exam

Photo Courtesy of Pennsylvania Department of Health

Re-certification by the IBLCE is required every five years. IBCLCs must re-certify by continuing education every five years with 75 continuing education recognition points or re-examination. All IBCLCs must re-certify by re-examination every tenth year. Lactation courses are available through a variety of programs meeting the established standards for the Lactation Education Accreditation and Approval Review Committee (LEAARC). Additional courses are obtainable if awarded Continuing Education Recognition Points (CERPs) as approved by the IBLCE.

Experience
IBCLCs are the only lactation service provider with a pre-requisite of clinical experience to qualify for examination by the IBLCE, currently 300-1000 hours of clinical practice, as defined by IBLCE Pathways.

The certification status of an individual can be obtained via the online verification tool at the IBCLE website: http://iblce.org/resources/iblce-registry/ which is available to anyone with the practitioner's name or IBCLC number.

Other training programs and certifications do exist. Most provide knowledge of basic lactation support for the normal course of breastfeeding. Generally these are 15 to 45 hour courses with no prerequisites and limited or no continuing education requirements as shown in Table 5.

Table 5

TITLE	TRAINING TIME	SKILLS
International Board Certified Lactation Consultant	Usually around 5 years, of preparation	• 90 hours lactation specific education, • 8 college level health professional courses, • 6 health related continuing education courses, • 300-1000 clinical practice hours • Pass a criterion-reference exam The International Board Certified Lactation Consultant possesses the necessary skills, knowledge, and attitudes to provide quality breastfeeding assistance to babies and mothers. IBCLCs specialize in the clinical management of breastfeeding which includes: preventive healthcare, patient education, nutrition counseling, and therapeutic treatment.
Certified Lactation Specialist Breastfeeding Specialist	45 hours	Designed for the aspiring lactation consultant or nurses, physicians, midwives, dieticians, breastfeeding assistants or others desirous of improving their knowledge base and skills in working with the breastfeeding dyad. This certification is a stepping stone to the IBCLC credential.[112]
Lactation Educator Counselor	45 hours	This university based program trains participants to be Lactation Educator Counselors. Lactation Educator Counselors are typically entry level practitioners and deal primarily with the normal process of lactation. This course is the required prerequisite to the Lactation Consultant course.[113]
Breastfeeding Counselor	10-14 months, Provide 30 hours of support	2-3 day workshop, self evaluation, one written paper & case studies, read and review 5 books, submit one survey on breastfeeding support available in your community, open book online tests (multiple choice) to cover physiology & anatomy.[114]
Breastfeeding Educator	1010 hours	Qualified to teach, support, and educate the public on breastfeeding and related issues and policies. Workbook activities, required reading materials, attend 8 breastfeeding meetings, research paper, submit a class presentation, work for clients in their community.[115]
Community Breastfeeding Educator	20 hours	"Does not issue Lactation Consultant status. For community workers in maternal child health, focuses on providing services to pregnant women to encourage the initiation and continuation of breastfeeding."[116]
Certified Lactation Counselor	45 hours	"This comprehensive, evidence-based, breastfeeding management course includes practical skills, theoretical foundations and competency verification."[117]

Baby Friendly Curriculum	Approximately 20 hours	Used by facilities to strengthen the knowledge and skills of their staff towards successful implementation of the Ten Steps to Successful Breastfeeding [118]
WIC Peer Counselor	30-50 hours, Varies by state, some states have quarterly training	Must have successfully breastfed their infant. Provide information to help mothers make an educated choice about how they will feed their babies, share tips for helping mothers get off to a good start with breastfeeding, answer common questions, and encouragement for challenges. Will also refer mothers who have challenging questions and concerns.[119]
Certified Lactation Educator	20 hours total, some have 8 hours clinical	Qualified to teach, support, and educate the public on breastfeeding and related issues. Complete course training, attend support group meetings, observe consultation or videos, review research studies and other requirements, including a test.[120]
La Leche League Peer Counselor (volunteer)	18-20 hours	Have successfully breastfed their infants for 6 months. Program developed to provide support systems within targeted communities that will provide ongoing access to breastfeeding information and support.[121]
La Leche League Leader (volunteer)	Approximately 1 year of self-study training	An experienced breastfeeding mother, familiar with research and current findings dealing with breastfeeding, who offers practical information and encouragement to nursing mothers through monthly meetings and one-to-one help.[122]

The Surgeon General's Call to Action to Support Breastfeeding in Action Step 11 specifies the need to make IBCLC services available by policy changes.[123] The Surgeon General has published implementation strategies for Doctors, Nurses and Healthcare Leaders. These documents summarize Action Step 11 as follows:

"Guarantee equitable access to services provided by International Board Certified Lactation Consultants.

- Include support for lactation as an essential medical service for pregnant women, breastfeeding mothers, and children.
- Ensure that reimbursement of IBCLCs is not dependent on their having other professional certification or licensure.
- Work to increase the number of racial and ethnic minority IBCLCs to better mirror the U.S. population."[124]

CURRENT STRATEGIES AND DEFICIENCIES OF LACTATION SUPPORT SERVICES

Lack of licensure for IBCLCs is a significant barrier to reimbursement that prevents women from accessing care. This is due in part to federal requirements regarding state licensure of Medicaid providers in section 1905 of the Social Security Act. The relevant federal regulations can be found at the Centers for Medicare and Medicaid Services government printing office website (42 C.F.R. 440.60 and 42 C.F.R. 440.90). The provision regarding "other diagnostic, screening, preventive, and rehabilitative services" was added to section 1905 in 2010 by the Patient Protection and Affordable Care Act.[125] In 2013, CMS issued an "Update on Preventive Services Initiatives" informing states of a new option for offering preventive services in state Medicaid plans that is applicable to inclusion of IBCLC services. The letter says, "In particular, the statute at section 1905(a)(13) indicates that services must be "recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law…" By contrast, our former regulation at 42 CFR 440.130(c) indicated that, "Preventive services meant services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice…" and the letter further states, "preventive services may be provided, at state option, by practitioners other than physicians or licensed practitioners" effective January 1, 2014. This can be accomplished by including the preventive service providers in the State Plans.[126]

So far, no state has taken advantage of this opportunity to include IBCLCs as preventive service providers. This rule would apply to Medicaid Fee-for-service plans. Conversely, Medicaid managed care organizations have had and continue to have the option to add IBCLC services to their plan benefits.

Lactation management by IBCLCs is not consistently reimbursed by public or private third party payers. The credentials used influence the success of reimbursement claims. Many IBCLCs are not familiar with reimbursement or do not submit to insurance."[127]

Photo Courtesy of Pennsylvania Department of Health

Work-around strategies for reimbursement of professional IBCLCs vary with the type of facility or place of service, such as inpatient or outpatient hospital settings, community based clinics (private or non-profit), or as private, self-employed IBCLCs. There are differences in the type of reimbursement strategy used depending on which work setting of the IBCLC. Non-profit and self-employed IBCLCs often use direct billing successfully, hospitals bill with infrastructure processes most of which are not reimbursed, and for those who bill under a secondary licensed credentail a moderate reimbursement rate is achieved.[128]

Employers, such as hospitals and WIC agencies, provide in-patient and/or out-patient lactation support. Commonly the work of the IBCLC is rolled into the total cost of care without a separately identifiable cost center. In these situations there is no billing for the service and no reimbursement. This inappropriately spreads the cost of care to every patient in the hospital as a general operating expense. Additionally, when budgets are scrutinized this cost is seen as superfluous and lactation care is eliminated which can lead to inadequate or no lactation consultant staffing due to budgetary constraints.

Lactation services are sometimes billed as nurse visits in medical settings. These visits can be reimbursed, but do not accurately identify the provider as an IBCLC or the service rendered. This results in departmental revenue losses because the low level of reimbursement for nursing visits is based on a typical brief nursing encounter rather than the time for intensive lactation consults. These lactation programs have been discontinued or poorly staffed due to negative financial outcomes.

Due to the multiple health benefits associated with breastfeeding, "Centers for Medicare and Medicaid Services (CMS) encouraged States to go beyond the requirement of solely coordinating and referring enrollees to the Special Supplemental Food Program for Women, Infants, and Children (WIC) and include lactation services as separately reimbursed pregnancy-related services." They published an issue brief offering billing strategies for lactation, unfortunately IBCLC services were not specifically mentioned in these strategies.[129]

Due to the pre-existing CMS requirement of licensure for state Medicaid providers, two states previously implemented IBCLC services in Medicaid benefits when provided by an IBCLC possessing a second credential that is licensed. Oklahoma began including IBCLCs who were also licensed as dieticians or nurses as Medicaid providers in 2007 for pregnant women up to 60 days postpartum.[130] New York included IBCLC services in Medicaid beginning April 2013 when provided by licensed physicians, physician assistants, nurse midwives, nurse practitioners, or nurses allowing coverage for up to three visits within 12 months postpartum.[131] Rhode Island Medicaid Managed Care plans offer lactation services with various strategies including some in the home or out-patient setting. The Neighborhood Health Plan of Rhode Island names IBCLCs as providers of this service while United HealthCare provides IBCLC services through a home health agency.[132,133] The District of Columbia Department of Health Care Finance implemented a policy recently for all Medicaid and managed care organizations which include coverage of lactation services furnished by physicians, nurse practitioners, nurse mid-wives or lactation consultants certified by the IBCLC as part of pregnancy-related care or Early Periodic Screening Diagnosis and Treatment programs. [134]

The California WIC Association offers lactation services in medical offices, community clinics and outpatient hospital clinics through contracts, memorandums of understanding or agreements. California Medi-Cal includes lactation benefits and a variety of other payment scenarios are used to allow women access to IBCLC services, including through the Comprehensive Perinatal Services Program and Federally Qualified Health Centers.[135]

An independent, outpatient IBCLC may bill using standard Healthcare Common Procedure Coding System numbers (HCPCS) and Diagnosis Codes (ICD-9).[136] However, none of these codes adequately describe the service, time involved and nature of a lactation visit. The clients typically self-pay at the time of the visit and must seek insurance reimbursement on their own to recover the cost of the service. Billing can be done under the IBCLC's National Provider Identifier (NPI) number either as a Nursing Service Provider, Registered Nurse, and Lactation Consultant (163WL0100X) or the Other Service Providers, Lactation Consultant Non-RN (174N00000X) National Provider Identifier. It is difficult to obtain any or appropriate reimbursement for those independently billing with the lactation consultant NPI taxonomy codes. IBCLCs working in the outpatient settings within the medical care system that possess credentials such as physician, midwife, nurse practitioner, therapist or dietician can bill commensurate with these credentials using the associated NPI taxonomy code and their services will be covered by insurance at the usual professional rates. Visits billed this way are not reflective of the IBCLC credential or service provided.

IBCLC services are also sometimes billed "incident to" another licensed and reimbursable healthcare professional under established patient visit codes and billing criteria. When the physician and IBCLC "share" the same patient on the same day their work is combined and billed under the physician at 100% of the fee schedule. The physician must provide a face-to-face portion of the evaluation and management service.[137] IBCLC / physician "shared visits" are a typically successful "work around" for the lack of reimbursement for lactation services, but necessitate complicated and sometimes limiting patient flow strategies.

Photo Courtesy of Pennsylvania Department of Health

COST EFFECTIVENESS OF REIMBURSEMENT FOR LACTATION CONSULTANTS

One study from the Commonwealth of Virginia analyzed the cost of standard provision of breastfeeding services and equipment to medical assistance clients and found that it was at least cost neutral. They determined that given the overwhelming scientific evidence regarding the benefits of breastfeeding, and the fact that the services provided are at least cost neutral and likely cost saving, the Medicaid State Plan should cover comprehensive breastfeeding services, including supplies and education for Medicaid recipients.[138]

A cost/benefit analysis from the Oregon Health Plans determined the financial impact of two lactation visits for their state Medicaid population. Findings concluded:

- If 15% of mothers used the services the program costs would range from budget neutral to a savings of $600,000 per year
- If 30% of mothers used the services cost would range from budget neutral to a savings of up to $2.8 million per year[139]

The New York State Department of Health, Office of Public Health estimated a savings of $532 per infant for lactation education and counseling services derived from reduced costs of illness.[140]

A sampling of fees for a one hour outpatient preventive counseling lactation consultation, coded 99404, ranges from $94-$123, depending on the geographic area served (median cost $108).[141] The National Business Group on Health recommends insurance coverage of up to five postpartum lactation consultant visits per pregnancy delivered by an IBCLC.[142] In the unlikely event that *every* US mother received five lactation consultations at the cost of $540,subtracted from the cost savings of $5909 per breastfed child (as identified by Bartick et al[143]) for 3,952,937 infants born in the US in 2012 the total savings would be $5369 per child.[144] This would be a high estimate of cost savings of $21,223,318,753 annually on only the few identified infant conditions cited in the study. A dissertation from Morris showed that the majority of mothers only use from one to three visits with a lactation consultant per delivery to overcome breastfeeding problems and improve breastfeeding duration.[145] There would be additional savings for improved maternal health as well; counting $9715 per woman, assuming no multiple deliveries, this would be a saving of $38,402,782,955.[146]

The presence of an IBCLC in a pediatric practice setting can not only increase breastfeeding initiation and duration but also be profitable to the practice. One busy middle-sized pediatric practice with 1 FTE IBCLC lactation consultant enjoyed a $19,000 per physician profit from this arrangement.[147]

Regarding in-patient care, Intermountain Healthcare determines that lactation-related readmissions from poor support to mothers in their 23 hospital health system produced and annual cost of $1.9 million.[148]

POLICY AND PROCEDURES NEEDED TO INCLUDE AND IMPROVE PREVENTIVE LACTATION CARE

The Surgeon General's Call to Action describes a many faceted approach to achieving public health breastfeeding goals for all women, while acknowledging persistent, unacceptable disparities in breastfeeding by race/ethnicity, socioeconomic characteristics, and geography."[149] Lack of access to care or lack of third party coverage for care often requires mothers to pay out of pocket for breastfeeding support services. This places vulnerable populations at the greatest risk for breastfeeding failure. This also contributes to low breastfeeding rates among lower socioeconomic status and African American mothers, leaving these populations with increased healthcare needs from infancy through the lifespan.[150]

There are currently 13,848 IBCLCs in the United States.[151] There were 3,952,937 births in the most recent CDC statistics (2013),[152] making for approximately 2.85 IBCLCs for every 1000 live births. The Surgeon General's Call to Action uses Mannel & Mannel's work to estimate that 8.6 IBCLCs are needed for each 1000 live births in the United States in order to maintain inpatient staffing levels, without taking into account the care needed to provide support in the community settings.[153] Many hospitals do not employ IBCLCs or enough IBCLCs to meet the recommended staffing guidelines.

Recommended in-patient IBCLC staffing ratios for hospitals have been determined through research concerning the IBCLC role and duties. In 2010, the United States Lactation Consultant Association issued the following staffing recommendations:

- 1.9 FTE per 1000 births for Level III hospitals
- 1.6 FTE per 1000 births for Level II hospitals
- 1.3 FTE per 1000 births for Level I hospitals[154]

These recommendations were based on the work of Mannel and Mannel who used data collected from chart reviews and time studies to estimate actual time spent over a two year period in a large tertiary care teaching hospital.[155] Their estimates included the acuity of the patient population, and factored in direct and indirect clinical activities.

Utilizing patient satisfaction scores, reimbursement patterns, cost of care, and lactation failure admissions, Francis-Clegg and Francis evaluated and standardized lactation services in a twenty-three hospital system in order to optimize IBCLC care and provide efficient staffing. They utilized two internal time studies at 10 hospitals to segment work into standard breastfeeding support tasks that could be deferred to non-clinical staff or bedside nurses. Using a matrix which ranked lactation support providers from IBCLCs (Level IV)

to bedside nurses who had received a standard three day training course (Level II), results of the time studies, billing records, and a review team of 10-12 IBCLCs, they found that 29% of inpatient breastfeeding support tasks could be deferred to well-trained non-IBCLC in-patient care providers, but 71%, or the majority, of lactation services needed to be delivered by IBCLCs.[156] Mannel has described an evidence-based model for evaluating and responding to maternal-infant lactation acuity, rather than the wider hospital level acuity, which will allow further refinement in utilizing in-patient IBCLCs appropriately.[157,158]

There are no calculations of acuity or staffing needs in the outpatient or community setting, nor is it customary to provide lactation support outside of the hospital setting, despite 92% of mothers reporting difficulties on day three after birth, and 83% still reporting difficulties on day seven after birth.[159]

Lactation services are currently provided as prenatal education, but are not equally accessible to all women or unequivocally recommended. Concerning post-discharge needs, The American Academy of Pediatrics (AAP) "Policy on Breastfeeding and the Use of Human Milk: Recommendations on Breastfeeding Management for Healthy Term Infants" does advise lactation evaluations as a standard-of-care.[160] Additionally, the Academy of Breastfeeding Medicine Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: ''The Going Home Protocol,'' Revised 2014, suggests early referral to a lactation consultant or breastfeeding medicine physician for infants with feeding problems.[161]

Previously mentioned lactation plan benefits cover services ranging from 2 visits to 6 visits with more available on physician referral. Bonuck et al. showed significant increases in breastfeeding with 3 one-hour visits.[162]

The "Final Rule" language in Diagnostic, Screening, Preventive, and Rehabilitative Services (Preventive Services) (§ 440.130) states, "(c) Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency."[163]

Given this language licensed practitioners would use the customary practices for referral to other service providers and document this in the patient chart. The IBCLC would follow- up with report to the referring licensed provider as required according to their Code of Professional Conduct (CPC)[164] and Documentation Guidelines.[165] The Code of Professional Conduct consists of eight principles, which every IBCLC must adhere to:

1. Provide services that protect, promote and support breastfeeding
2. Act with due diligence
3. Preserve the confidentiality of clients
4. Report accurately and completely to other members of the healthcare team
5. Exercise independent judgment and avoid conflicts of interest
6. Maintain personal integrity
7. Uphold the professional standards expected of an IBCLC
8. Comply with the IBLCE Disciplinary Procedures.

Reimbursement costs have not been analyzed in detail and payment rates vary with geography, practice setting and qualities of the visit. Using the preventive counseling code 99404, 60 minute visit as an example[166] payment varies across the US between $93 and $126.[167] The Oklahoma Medicaid rate for a follow up visit is $60 (Smith, R. Personal Communication 2013) and a private practice visit in Manhattan, NY may be $250-300.[168] New York Medicaid is reimbursing $45 for a lactation counseling visit.[169] The Oklahoma Health Care Authority used an average of 1.4 IBCLC visits per delivery during the state fiscal years 2010-2013 (Okalhoma Health Care Authority, Personal Communication, 6-2014). One could estimate on average 1-3 visits per delivery for 70-92% of breastfeeding women since all women do not require a lactation visit considering this range of payments.

The United States Lactation Consultant Association previously requested a HCPCS code be created specifically for lactation services: “Lactation evaluation and management performed by a certified and registered lactation consultant, each 15 minutes (Walker, M. Personal Communication, nd).” CMS has denied this request. However, given the new opportunities and likelihood of increased use of IBCLC services for lactation counseling this issue could be re-visited to create a process, or potentially a new code, that would permit tracking of lactation services for quantity and costs to further financial analysis. In the interim, states already providing IBCLC services have created their own codes which vary, these include New York[170] and Oklahoma (Oklahoma Health Care Authority, Personal Communication, 6-2014).

In order to effectively increase breastfeeding duration in the United States, the services of IBCLCs will need to be utilized in all of the settings where pregnancy and postpartum-related services are provided. Embracing coverage of lactation services as the ubiquitous standard-of-care is crucial in the US healthcare system model to ultimately improve the health of all insured individuals.

SUMMARY RECOMMENDATIONS

In summary, the United States Lactation Consultant Association recommends:

- Recognition of the IBCLC certification as the preferred provider of lactation care and services for private and Medicaid insurance plans
- State licensure of IBCLCs
- Identify and quantify IBCLC - provided lactation services as distinct from other healthcare services in the medical system, through specified billing codes or other means.
- Credentialing of IBCLCs by insurers to standardize proven qualifications, identify sound practice strategies, and maintain appropriate oversight
- Reimbursement of skilled breastfeeding support by the IBCLC.

For more information contact:

United States Lactation Consultant Association
WWW.USLCA.ORG

Washington, D.C.
Phone: 202-738-1125
Email: info@uslca.org

REFERENCES

[1] Organization for Economic Co-Operation and Development. (2013) OECD Health Data 2013 – How Does the United States Compare. Accessed February 27, 2014, http://www.oecd.org/unitedstates/Briefing-Note-USA-2013.pdf.

[2] Centers for Disease Control: National Center for Chronic Disease Prevention and Health Promotion (2009) Chronic Diseases: The Power to Prevent, The Call to Control. US Department of Health and Human Services, Centers for Disease Control Atlanta, GA Accessed May 21, 2012, http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf./chronic.pdf.

[3] Wall, Ginna (2010) Outcomes of Breastfeeding Versus Formula Feeding. La Leche League International. Schaumburg, IL. Accessed May 21, 2012, HYPERLINK "http://www.llli.org/docs/Outcomes_of_breastfeeding_June_2007.pdf" http://www.llli.org/docs/Outcomes_of_breastfeeding_June_2007.pdf..

[4] Centers for Disease Control: National Center for Chronic Disease Prevention and Health Promotion (2009) Chronic Diseases: The Power to Prevent, The Call to Control. US Department of Health and Human Services, Centers for Disease Control Atlanta, GA Accessed May 21, 2012, HYPERLINK "http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf" http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf./chronic.pdf.

[5] Ogden, CL, MD Carroll, BK Kit and KM Flegal. (2012) *Prevalence of Obesity in the United States*, 2009-2010. NCHS data brief, no 82. Hyattsville, MD: National Center for Health Statistics. 2012, Accessed February 27, 2014, http://www.cdc.gov/nchs/data/databriefs/db82.pdf.

[6] O'Grady M and J Capretta (2012) Assessing the Economics of Obesity and Obesity Interventions. Campaign to End Obesity. Washington DC. Accessed May 21, 2012, HYPERLINK "http://obesitycampaign.org/documents/StudyAssessingtheEconomicsofObesityandObesityIntervention.pdf" http://obesitycampaign.org/documents/StudyAssessingtheEconomicsofObesityandObesityIntervention.pdf.

[7] For a complete list of government agencies and organizations that support breastfeeding, see members of the United States Breastfeeding Committee: http://www.usbreastfeeding.org/AboutUs/Membership/tabid/64/Default.aspx.

[8] Campbell KP, editor.(2007) *Investing in Maternal and Child Health: An Employer's Toolkit*. Washington, DC:
Center for Prevention and Health Services, National Business Group on Health. Accessed May 29, 2012, http://www.businessgrouphealth.org/benefitstopics/et_maternal.cfm.

[9] LM Gartner et al.(2012) "Breastfeeding and the Use of Human Milk," Pediatrics 129:3;e827. Accessed May 29, 2012, http://pediatrics.aappublications.org/content/129/3/e827.full.html.

[10] ACOG Committee Opinion (2007) "Breastfeeding: Maternal and Infant Aspects," *Obstetrics and Gynecology* 361: 478-480. Accessed June 1, 2012, http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Breastfeeding_Maternal_and_Infant_Aspects

[11] AAFP Breastfeeding Advisory Committee (2008), "Breastfeeding, Family Physicians Supporting (Position Paper) American Academy of Family Physicians Accessed May 29, 2012, http://www.aafp.org/online/en/home/policy/policies/b/breastfeedingpositionpaper.html.

[12] Division of Women's Health Policy and Leadership (1992, 2004) Breastfeeding (Position Statement) American College of Nurse Midwives. Silver Spring, MD. Accessed June 2, 2012, http://www.midwife.org/siteFiles/position/Breastfeeding_05.pdf.

[13] American Dietetic Association (2009) Promoting and Supporting Breastfeeding. *J Am Diet Assoc*.;109:1926-1942. Accessed June 2, 2012, http://www.eatright.org/About/Content.aspx?id=8377.

[14] International Lactation Consultant Association (1991, 2000) Position Paper on Infant Feeding, International Lactation Consultant Association, Accessed May 29, 2012, http://www.ilca.org/files/resources/ilca_publications/InfantFeedingPP.pdf.

[15] American Public Health Association (2007) A Call to Action on Breastfeeding: A Fundamental Public Health Issue. American Public Health Association Accessed May 29, 2012, http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1360

[16] Stuebe, AM (2009) "The Risks of Not Breastfeeding for Mothers and Infants," *Obstetrics and Gynecology* 2, no. 4: 222-231. Accessed June 2, 2012, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2812877/pdf./RIOG002004_0222.pdf.

[17] Ip S et al. (2009): "A Summary of the Agency for Healthcare Research and Quality's Evidence Report on Breastfeeding in Developed Countries," *Breastfeeding Medicine* 4, no. s1 s17-s30.

[18] U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Accessed June 2, 2012, http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf.

[19] Stuebe, AM (2009) "The Risks of Not Breastfeeding for Mothers and Infants," *Obstetrics and Gynecology* 2, no. 4: 222-231. Accessed June 2, 2012, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2812877/pdf./RIOG002004_0222.pdf.

[20] Kendall - Tackett K. (2014) It's Not Just Milk - It's Relationship: Recent Findings in Neuroscience Show Breastfeeding's Effect Throughout the Lifespan. Clinical Lactation 5 (2) 37-40. Online ISSN: 2158-0537

[21] Ram KT et al. (2008): "Duration of Lactation is Associated with Lower Prevalence of the Metabolic Syndrome in Midlife–SWAN, the Study of Women's Health Across the Nation," *Am J Obstet Gynecol* 198, no. 3 268e1-268e6.

[22] Ibid.

[23] Ip et al., "A summary of the agency for healthcare research and quality's evidence report on breastfeeding in developed countries."

[24] Ibid.

[25] Stuebe AM et al. (2009) "Duration of lactation and incidence of myocardial infarction in middle-to-late adulthood," *Am J Obstet Gynecol* 200, no. 2: 138e1-138e8.

[26] Schwarz EB et al. (2010) "Lactation and maternal measures of subclinical cardiovascular disease," *Obstetrics and Gynecology* 115, no. 1: 41-48.

[27] Ibid.

[28] Oliveira, Victor, Elizabeth Frazão, David Smallwood (2010) Rising Infant Formula Costs to the WIC Program: Recent Trends in Rebates and Wholesale Prices, ERR-93, U.S. Department of Agriculture, Economic Research Service, February. Accessed June 2, 2012, http://www.ers.usda.gov/publications/err93/.

[29] Neuberger Zoë (2010), WIC Food Package Should Be Based On Science: Foods with New Functional Ingredients Should Be Provided Only If They Deliver Health or Nutritional Benefits. Center on Budget and Policy Priorities, Washington DC. Accessed June 19, 2012, http://www.cbpp.org/cms/index.cfm?fa=view&id=3201.

[30] Oliveira, Victor, Elizabeth Frazão, David Smallwood (2010) Rising Infant Formula Costs to the WIC Program: Recent Trends in Rebates and Wholesale Prices, ERR-93, U.S. Department of Agriculture, Economic Research Service, February. Accessed June 2, 2012, http://www.ers.usda.gov/publications/err93/.

[31] Bartick M and A Reinhold (2010) "The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis," *Pediatrics* 125, no. 5: e1048-e1056. Accessed June 2, 2012, http://pediatrics.aappublications.org/content/125/5/e1048.

[32] Bartick MC and A. Reinhold. (2010) The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis. Pediatrics 125:e1048-e1056. Accessed February 25, 2014, http://pediatrics.aappublications.org/content/125/5/e1048.long.

[33] Bartick MC, Steube AM, Schwarz EB, Luongo C, Reinhold AG, Foster EM. (2013) Cost Analysis of Maternal Disease Associated With Suboptimal Breastfeeding. *Obstet Gynecol* 2013;0:1-9. Accessed February 25, 2014, HYPERLINK "http://www.tufts.edu/med/apua/policy/policy---antibiotics-and-nutrition_3_754959592.pdf" http://www.tufts.edu/med/apua/policy/policy---antibiotics-and-nutrition_3_754959592.pdf.

[34] Ibid.

[35] Behan, Donald F et al. (2010) Obesity and its Relation to Mortality and Morbidity Costs. Society of Actuaries, December. Accessed June 2, 2012, http://www.soa.org/News-and-Publications/Newsroom/Press-Releases/New-Society-of-Actuaries-Study-Estimates-$300-Billion-Economic-Cost-Due-to-Overweight-and-Obesity.aspx.

[36] Finkelstein EA, Justin G. Trogdon, Joel W. Cohen and William Dietz. (2009) Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates. *Health Affairs*, 28, no.5 (2009):w822-w831Accessed February 27, 2014, http://content.healthaffairs.org/content/28/5/w822.full.html.

[37] Francis-Clegg S, Francis DT. Improving the "bottom-line": financial justification for the hospital-based lactation consultant role. *Clinical Lactation*. 2011; 2(1):19-25.

[38] Wagner, EA. CJ. Chantry, KG. Dewey, and LA. Nommsen-Rivers. (2013) Breastfeeding Concerns at 3 and 7 Days Postpartum and Feeding Status at 2 Months. *Pediatrics*, September 2013 DOI: 10.1542/peds.2013-0724

[39] Ibid.

[40] Li, R, Fein, S, Chen, J, & Grummer-Strawn, LM. (2008). During the First Year: why mothers stop breastfeeding: mothers. *Pediatrics*, 122(Supplement 2), Accessed http://pediatrics.aappublications.org/cgi/reprint/122/Supplement_2/S69.pdf.

[41] Ibid.

[42] Ibid.

[43] Wagner, EA. CJ. Chantry, KG. Dewey, and LA. Nommsen-Rivers. (2013) Breastfeeding Concerns at 3 and 7 Days Postpartum and Feeding Status at 2 Months. *Pediatrics*, September 2013 DOI: 10.1542/peds.2013-0724.

[44] Ibid.

[45] Ibid.

[46] Erika C. Odom, Ruowei Li, Kelley S. Scanlon, Cria G. Perrine and Laurence Grummer-Strawn (2013) Reasons for Earlier Than Desired Cessation of Breastfeeding. *Pediatrics*; published online February 18, 2013; DOI: 10.1542/peds.2012-1295. Available at http://pediatrics.aappublications.org/content/early/2013/02/13/peds.2012-1295.

[47] Ibid.

[48] Hamosh, M, (1996) Breastfeeding: Unraveling the Mysteries of Mother's Milk, Georgetown University Medical Center, Medscape General Medicine 1(1) accessed at http://www.medscape.com/viewarticle/718175

[49] Wall, G. (2013, Nov) *Outcomes of Breastfeeding*. Evergreen Perinatal Education. Retrieved February 25, 2014 from HYPERLINK "http://evergreenperinataleducation.com/upload/OutcomesofBreastfeeding_Nov2013.pdf" http://evergreenperinataleducation.com/upload/OutcomesofBreastfeeding_Nov2013.pdf

[50] Neifert MR (2001) Prevention of breastfeeding tragedies. Pediatr Clin North Am 48(2): 273-97.

[51] Witt AM, et al (2012) Integrating Routine Lactation Consultant Support into a Pediatric Practice. Breastfeeding Medicine Vol 7, Num 1, DOI: 10.1089/bfm.2011.0003, 38-42.

[52] Chantry, CJ. (2011) Supporting the 75%: Overcoming Barriers After Breastfeeding Initiation. Breastfeeding Medicine, Vol 6, Num 5, DOI: 10.1089/bfm.2011.0089, 337-339.

[53] Cincinnati Children's Hospital Medical Center (2013, September 23). Breastfeeding fraught with early challenges for many first-time mothers. *ScienceDaily*. Retrieved October 29, 2013, from HYPERLINK "http://www.sciencedaily.com/releases/2013/09/130923093035.htm" http://www.sciencedaily.com/releases/2013/09/130923093035.htm

[54] Skouteris H, C Nagle, M Fowler, B Kent, P Sahota, and H Morris. (2014) Interventions designed to promote exclusive breastfeeding in high-income countries: A systematic review. Breastfeeding Medicine Feb 5, [Epub ahead of print], 9(3). Retrieved March 17, 2014 at http://online.liebertpub.com/doi/pdf/10.1089/bfm.2013.0081

[55] Centers for Disease Control and Prevention National Immunization Survey, Division of Nutrition, Physical Activity, and Obesity. Provisional Data, 2010 births, http://www.cdc.gov/breastfeeding/pdf./2013BreastfeedingReportCard.pdf.

[56] U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Accessed June 2, 2012, http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf.

[57] Scanlon, KS et al. (2010) Racial and Ethnic Differences in Breastfeeding Initiation and Duration, by State --- National Immunization Survey, United States, 2004-2008. Centers for Disease Control Mortality and Morbidity Weekly Report March 26, 59:11. Accessed June 2, 2012, http://www.cdc.gov/mmwr/pdf./wk/mm5911.pdf.

[58] U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Accessed June 2, 2012, http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf.

[59] Committee on Preventive Services for Women, Institute of Medicine (2011) Clinical Preventive Services for Women Closing the Gaps. Institute of Medicine of the National Academies, Washington DC, July. Accessed June 2, 2012, http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx

[60] *Primary Care Interventions to Promote Breastfeeding*, Topic Page. October 2008. U.S. Preventive Services Task Force. Accessed June 3, 2012, http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrfd.htm.

[61] National Prevention Council (2011) *National Prevention Strategy*, Washington, DC:
U.S. Department of Health and Human Services, Office of the Surgeon General. Accessed June 2, 2012, http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.

[62] Centers for Disease Control and Prevention, (2013). Breastfeeding Report Card – United States. Accessed March 5, 2014 , http://www.cdc.gov/breastfeeding/pdf./2013breastfeedingreportcard.pdf.

[63] USDA National Agricultural Library: WICworks, "Breastfeeding Support, a Review," 2010, Accessed June 2, 2012, http://www.nal.usda.gov/wicworks/Sharing_Center/CO/BF_SupportReview.pdf.

[64] American Public Health Association. (2013) An Update to A Call to Action to Support Breastfeeding: A Fundamental Public Health Issue, Nov 5. Policy number 20132. Accessed http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1448.

[65] White House Task Force on Childhood Obesity. (2010) Solving the Problem of Childhood Obesity within a Generation. Washington DC, May. Accessed June 2, 2012, http://www.letsmove.gov/sites/letsmove.gov/files/TaskForce_on_Childhood_Obesity_May2010_FullReport.pdf.

[66] Office of Women's Health,, (2009) http://mchb.hrsa.gov/pregnancyandbeyond/breastfeeding/ The Business Case For Breastfeeding - Steps For Creating A Breastfeeding Friendly Worksite, Accessed March 24, 2014, http://mchb.hrsa.gov/pregnancyandbeyond/breastfeeding/

[67] C Rangel, Health Care Bill - H.R.3590: Patient Protection and Affordable Care Act, 2010, Section 4207 Reasonable Break Time for Nursing Mothers. Accessed June 3, 2012, http://housedocs.house.gov/energycommerce/ppacacon.pdf.

[68] Joint Commission National Quality Care Measures, "Specifications Manual for Joint Commission National Quality Core Measures (2010A2)," 2010, Accessed June 2, 2012, http://manual.jointcommission.org/releases/TJC2010A/.

[69] National Initiative for Children's Healthcare Quality (2011) Best Fed Beginnings: Improving Breastfeeding Support in US Hospitals. Accessed June 3, 2012, http://www.nichq.org/our_projects/cdcbreastfeeding.html.

[70] Bright Futures and American Academy of Pediatrics, "Recommendations for Preventative Pediatric Health Care: Bright Futures Periodicity Schedule," brightfutures.aap.org, 2008, http://brightfutures.aap.org/pdf.s/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf.

[71] American Academy of Pediatrics, Section on Breastfeeding. "Breastfeeding and the Use of Human Milk." Pediatrics 115, no. 2 (2005): 496-506.

[72] Campbell KP, editor. *Investing in Maternal and Child Health: An Employer's Toolkit*. Washington, DC: Center for Prevention and Health Services, National Business Group on Health; 2007.

[73] Ranji U and A Salganicoff., A Stewart, M Cox, L Doamekpor (2009) Kaiser Family Foundation State Medicaid Coverage of Prenatal Services: Summary of State Survey Findings. The Henry J Kaiser Family Foundation and The George Washington University School of Public Health and Health Services. Accessed June 19, 2012, http://www.kff.org/womenshealth/upload/8014.pdf.

[74] ND Calonge et al., "Primary Care Interventions to Promote Breastfeeding: U.S. Preventive Services Task Force Recommendation Statement," *Annals of Internal Medicine* 149, no. 8 (2008): 560-564.

[75] Castrucci et al., "A Comparison of Breastfeeding Rates in an Urban Birth Cohort, "*Journal of Public Health Management* 12, no. 6 (2006): 578-585.

[76] Castrucci et al., "Availability of lactation counseling services influences breastfeeding among infants admitted to neonatal intensive care units," *Am J Public Health* 21, no. 5 (2007): 410-415.

[77] MJ Heinig, "The Cost of Breastfeeding Support: A Primer," *J Hum Lact* 17, no. 2 (2001): 101-102.

[78] MIC de Oliveira, LAB Camacho, and AE Tedstone, "Extending Breastfeeding Duration Through Primary Care: A Systematic Review of Prenatal and Postnatal Interventions," *J Hum Lact* 17, no. 4 (2001): 326-343.

[79] US Department of Health and Human Services, *Healthy People 2020: Maternal, Infant, and Child Health* (Washington, DC: US Department of Health and Human Services, 2010),Accessed June 3, 2012, http://healthypeople.gov/2020/topicsobjectives2020/pdf.s/MaternalChildHealth.pdf.

[80] United States Breastfeeding Committee, Core Competencies in Breastfeeding Care for All Health Professionals (Washington DC, 2009).

[81] GL Freed et al., "National assessment of physicians' breast-feeding knowledge, attitudes, training, and experience. Breastfeeding education of obstetrics-gynecology residents and practitioners," *Journal of the American Medical Association* 273 (1995a): 472-476.

[82] Perry, A. Evidence based recommendations addressing Action 9 of the Surgeon General's *Call to Action to Support Breatfeeding:* A systematic review. (2014) Frontier Nursing University (Doctoral Dissertation)

[83] LB Feldman-Winter et al., "Pediatricians and the promotion and support of breastfeeding," *Arch Pediatr Adolesc Med* 162, no. 12 (2008): 1142-1149.

[84] Yardaena BO et al. (2011) Breastfeeding Education and Support Services Offered to Pediatric Residents in the US. *Academic Pediatrics* Vol 11: Issue 1 Jan-Feb, 75-79.

[85] ML Power et al., "The effort to increase breast-feeding. Do obstetricians, in the forefront, need help?," *J Reprod Med* 48, no. 2 (2003): 72-78.

[86] GL Freed et al., "Breast-feeding education and practice in family medicine," *J Fam Pract* 40, no. 3 (1995c): 297-298.

[87] KA Szucs, DJ Miracle, and MB Rosenman, "Breastfeeding knowledge, attitudes, and practices among providers in a medical home," *Breastfeeding Medicine* 4, no. 1 (2009): 31-42.

[88] P Hellings and C Howe, "Breastfeeding knowledge and practice of pediatric nurse practitioners," *Journal of Pediatric Health Care* 18, no. 1 (2004): 8-14.

[89] AM Nelson, "Maternal-newborn nurses' experiences of inconsistent professional breastfeeding support," *J Adv Nurs 60*, no. 1 (2007): 29-38.

[90] R Cricco-Lizza, "Formative Infant Feeding Experience and Education of NICU Nurses," *The American Journal of Maternal/Child Nursing* 34, no. 4 (2009): 236-242.

[91] AJ Khoury et al., "Improving breastfeeding knowledge, attitudes, and practices of WIC staff," *Public Health Reports* 117 (2002): 453-462.

[92] KA Bonuck et al., "Randomized, Controlled Trial of a Prenatal and Postnatal Lactation Consultant Intervention on Duration and Intensity of Breastfeeding up to 12 Months," *Pediatrics* 116, no. 6 (2005): 1413-1426.

[93] GC Kane et al., "The anticipated physician shortage: meeting the nation's need for physician services," *The American Journal of Medicine* 122, no. 12 (2009): 1156-1162.

[94] Witt AM, et al. (2012) Integrating Routine Lactation Consultant Support into a Pediatric Practice. *Breastfeeding Medicine* Vol 7, Num 1, DOI: 10.1089/bfm.2011.0003, 38-42.

[95] Centers for Disease Control and Prevention (2008), Pregnancy Risk Assessment Monitoring System (PRAMS Report of CDC's Winnable Battles: Collecting Data in Order to Improve the Health of Mothers and Infants: Breastfeeding. Accessed February 22, 2014, http://www.cdc.gov/prams/PRAMSReport.html.

[96] Ibid.

[97] US Department of Health And Human Services (2010) Affordable Care Act. Accessed, February 27,2014 at http://www.hhs.gov/healthcare/rights/law/.

[98] Witt AM, et al., Integrating routine lactation consultant support into a pediatric practice. *Breastfeeding Medicine*. 2012, 7(1): 38-42.

[99] Bonuck, K, A Stuebe, J Barnett, MH Labbock, J Fletcher, and PS Bernstein. (2013) A primary care intervention increases breastfeeding duration and intensity: Results of two randomized clinical trials. *American Journal of Public Health*, December e pub ahead of print. Accessed January 7, 2014, HYPERLINK "http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301360?url_ver=Z39.88 2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed" http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301360?url_ver=Z39.88 2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed.

[100] Professional Practice - International Lactation Consultant Association," *International Lactation Consultant Association*, 2010. Accessed June 3, 2012, http://www.ilca.org/i4a/pages/index.cfm?pageid=3354.

[101] S Yun et al., "Evaluation of the Missouri WIC (Special Supplement Nutrition Program for Women, Infants and Children) breast-feeding peer counseling programme.," *Public Health* Nutr 13, no. 2 (2009): 229-237.

[102] Pastore, M, & Nelson, A. (1997). A Breastfeeding drop-in center survey evaluation. *Journal of Human Lactation*, 13(291), Accessed May 2, 2010 from http://jhl.sagepub.com/cgi/content/abstract/13/4/291 DOI: 10.1177/089033449701300414.

[103] SE Thurman and PJ Allen, "Integrating lactation consultants into primary health care services: are lactation consultants affecting breastfeeding success?," *Pediatric Nursing* 34, no. 5 (2008): 419-425.

[104] Andaya E, K Bonuck, J Barnett, and J Lischewski-Goel. (2012) Perceptions of Primary Care-Based Breastfeeding Promotion Interventions: Qualitative Analysis of Randomized Controlled Trial Participant Interviews. *Breastfeeding Medicine* 7(6). Accessed March 2, 2014 HYPERLINK "http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3523239/pdf/bfm.2011.0151.pdf" http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3523239/pdf./bfm.2011.0151.pdf.

[105] Bonuck, K, A Stuebe, J Barnett, MH Labbock, J Fletcher, and PS Bernstein. (2013) A primary care intervention increases breastfeeding duration and intensity: Results of two randomized clinical trials. *American Journal of Public Health*, December epub ahead of print. Accessed January 7, 2014, HYPERLINK "http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301360?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed"http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301360?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed.

[106] BC Castrucci et al., "Availability of lactation counseling services influences breastfeeding among infants admitted to neonatal intensive care units," *Am J Public Health* 21, no. 5 (2007): 410-415.

[107] Dweck N, MAugustine, D Pandya, R Valdes-Greene, P Visintainer and HL Brumberg. (2008) NICU Lactation Consultant increases percentage of outborn versus inborn babies receiving human milk. *J Perinatol* Feb: 28(2) 136-40. Accessed March 2, 2014, http://www.nature.com/jp/journal/v28/n2/pdf./7211888a.pdf.

[108] BC Castrucci et al., "A Comparison of Breastfeeding Rates in an Urban Birth Cohort," *Journal of Public Health Management* 12, no. 6 (2006): 578-585.

[109] Ibid.

[110] Calnen, J. Breastfeeding Medicine Blog: Breastfeeding Promotion and the Accountable Care Organization, http://bfmed.wordpress.com/2010/05/19/breastfeeding-promotion-and-the-accountable-care-organization/.

[111] International Board of Lactation Consultant Examiners. (2013, Aug 15) IBLCE Candidate Information Guide. International Board of Lactation Consultant Examiners, Falls Church, VA. Accessed January 25, 2014, http://iblce.org/wp-content/uploads/2013/12/candidate-information-guide.pdf.

[112] Lactation Education Consultants. Accessed March 2012, http://www.lactationeducationconsultants.com/course_clsc.shtml.

[113] Lactation Education at UC San Diego. Accessed March 2, 2014, http://breastfeeding-education.com/home/clec-2/.

[114] Childbirth International. Accessed March 2, 2014, http://www.childbirthinternational.com/information/pack.htm.

[115] Birth Arts International. Accessed March 2, 2014, http://www.birtharts.com/beced.htm.

[116] Healthy Children CC. Accessed March 2, 2014, http://www.healthychildren.cc/maternalinfant.htm/

[117] Healthy Children CC. Accessed March 2, 2014, http://www.healthychildren.cc/clc2.htm.

[118] Baby Friendly USA. Accessed March 2, 2014, http://www.babyfriendlyusa.org/get-started.

[119] United States Department of Agriculture. Accessed March 2, 2014, http://www.nal.usda.gov/WICworks/Learning_Center/support_peer_materials.html.

[120] Childbirth and Postpartum Professional Association. Accessed March 2, 2014, http://www.cappa.net/get-certified.php?lactation-educator.

[121] La Leche League International. Accessed March 2, 2014, http://www.llli.org/llleaderweb/lv/lvaugsep99p92.html.

[122] La Leche League International. Accessed March 2, 2014, http://www.lalecheleague.org/lad/talll/faq.html.#howlong.

[123] U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Accessed June 2, 2012, http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf.

[124] U.S. Department of Health and Human Services. Office of the Surgeon General. Doctors in Action. Nurses in Action and Health Care Leaders in Action. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Accessed June 2, 2012, http://www.cdc.gov/breastfeeding/promotion/calltoaction.htm

[125] US Government Printing Office, 732 North Capitol Street, NW, Washington, DC Accessed June 7, 2012, http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf./CFR-2011-title42-vol4-sec440-60.pdf and
http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf./CFR-2011-title42-vol4-sec440-90.pdf.

[126] The final rule can be found here: http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf. The letter from CMS is available here: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf.

[127] Chetwynd E, A Meyer, A Stuebe, R Costello and M Labbock.(2013) Recognition of International Board Certified Lactation Consultants by Health Insurance Providers in the United States: Results of a National Survey of Lactation Consultants. *Journal of Human Lactation*, Nov 29(4) 517-526. Accessed March 2, 2014, http://jhl.sagepub.com/content/29/4/517.

[128] Ibid.

[129] Centers for Medicaid and Medicare Services, Centers for Medicaid and CHIP Coverage. "Medicaid Coverage of Lactation Services" Issue Brief 1-10-12 . Accessed June 7, 2012, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf.

[130] Oklahoma Healthcare Authority. (2007, Dec 1) Policies and Rules: Part 20 Lactation Consultants. Library Policies 317:30-5-230, 231,232, 233, 234, 235, Accessed April 28, 2014, https://www.okhca.org/xPolicyPart.aspx?id=561&chapter=30&subchapter=5&part=20&title=LACTATION%20CONSULTANTS

[131] New York State Medicaid Update. (2013) Policy and Billing Guidance: Fee-for-Service Medicaid: Breastfeeding Support Payment for Specially Trained Lactation Counselors. New York State Department of Health. Accessed February 27, 2014, https://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-03.htm#fee.

[132] Rhode Island Department of Health (2012) Breastfeeding Benefit Coverage Guidelines: Neighborhood Health Plan of Rhode Island 4/27. Accessed March 18, 2014, http://www.health.ri.gov/breastfeeding/about/insurancecoverage/NHPRI.pdf.

[133] Rhode Island Department of Health (2011) Breastfeeding Benefit Coverage Guidelines: United Healthcare (UHC)-Medicaid 5/8. Accessed March18, 2014,http://www.health.ri.gov/breastfeeding/about/insurancecoverage/UHCInsuranceCoverage.pdf.

[134] Government of District of Columbia: Department of Health Care Fianance. (2014 Apr 11) Policy Regarding Medicaid Coverage to Promote Breast Feeding. Transmittal No.: 14-21

[135] California WIC Association. (2012) Ramping Up for Reform: Quality Breastfeeding Support in Preventive Care. A Practitioner's Guide to Leveraging WIC and Community Partnerships. Accessed February 27, 2014, http://www.calwic.org/storage/documents/bf/2012/Ramping_up_for_Reform-WIC_Breastfeedling_Toolkit_2012.pdf.

[136] MH Dann et al., "Providing Lactation Care: Seeking Quality, Efficiency Reimbursement," in United States Lactation Consultant Association (Las Vegas, Nevada, 2008), http://www.kff.org/womenshealth/8014.cfm.

[137] Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2002) Medicare Carriers Manual Part 3-Claims Process. Transmittal 1767, August 28. Section 2050.1 to 2050.1 Accessed June 7, 2012, http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1764B3.pdf.

[138] K Cole James, "Report of the Department of Medical Assistance on the feasibility of revising the state plan for medical assistance services to include lactation and supplies for Medicaid recipients" (Commonwealth of Virginia, Department of Health and Human Resources, 1995), http://leg2.state.va.us/dls/h&sdocs.nsf/fc86c2b17a1cf388852570f9006f1299/7980cdba33e6b415852561580071ac7d/$FILE/HD28_1995.pdf.

[139] Oregon Health Plan (2010) Covering Lactation Services Lowers Health Risks and Costs. Accessed February 27, 2014, http://www.oregon.gov/oha/OHPB/committees/pehpc/2010/100927-cov-lact-srv.pdf.

[140] Gregg D, D Urban and M Kinnicutt. (2013) Webinar: New York Coverage of Lactation Counseling Services and Breastpumps. NewYork State Department of Health. Accessed February 27, 2014, http://calwic.org/storage/documents/webinars/NY_Lactation_Services_and_Pump_Coverage_07.17.13.pdf.

[141] American Medical Association (2014) Code Manager: Cpt code/Relative Value Search. Accessed March 18, 2014, https://ocm.ama-assn.org/OCM/CPTRelativeValueSearch.do.

[142] Campbell KP, editor. (2007) Investing in Maternal and Child Health: An Employer's Toolkit. Washington, DC:
Center for Prevention and Health Services, National Business Group on Health. Accessed May 29, 2012, http://www.businessgrouphealth.org/benefitstopics/et_maternal.cfm.

[143] Bartick M and A Reinhold (2010) "The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis," *Pediatrics* 125, no. 5: e1048-e1056. Accessed June 2, 2012, http://pediatrics.aappublications.org/content/125/5/e1048.

[144] Centers for Disease Control: National Vital Statistics (2013) Reports, Births: Preliminary Data for 2012. Sept 6, 63(3). Accessed March 18, 2014, http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_03.pdf.

[145] Morris, C.A. (2013). *The effect of a lactation consultant in the pediatric primary care setting* (Doctoral dissertation). Retrieved from ProQuest. 3610203.

[146] MC, Steube AM, Schwarz EB, Luongo C, Reinhold AG, Foster EM. (2013) Cost Analysis of Maternal Disease Associated With Suboptimal Breastfeeding. *Obstet Gynecol* 2013;0:1–9. Accessed February 25, 2014, HYPERLINK "http://www.tufts.edu/med/apua/policy/policy---antibiotics-and-nutrition_3_754959592.pdf" http://www.tufts.edu/med/apua/policy/policy-antibiotics-and-nutrition_3_754959592.pdf.

[147] Dahlquist N, Rosqvist JL. Lactation support in a busy pediatric practice: who pays the price? [Abstract 8]. *Breastfeed Med* 2007, 2:180.

[148] Francis-Clegg S, DT Francis, Intermountain Healthcare Lactation Standardization Project 2007. (2011) Improving the "Bottom-Line": Financial Justification for the Hospital-Based Lactation Consultant Role. Clinical Lactatin 2(1) 19-25.

[149] U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Accessed June 2, 2012, http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf.

[150] Scanlon, KS et al.(2010) Racial and Ethnic Differences in Breastfeeding Initiation and Duration, by State - National Immunization Survey, United States, 2004-2008. Centers for Disease Control Mortality and Morbidity Weekly Report March 26, 59:11. Accessed June 2, 2012, http://www.cdc.gov/mmwr/pdf./wk/mm5911.pdf.

[151] International Board of Lactation Consultant Examiners. (2013) *Current Statistics on Worldwide IBCLCs* . International Board of Lactation Consultant Examiners: Falls Church, VA. Accessed February 22, 2014, http://iblce.org/about-iblce/current-statistics-on-worldwide-ibclcs/.

[152] Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2012. National Vital Statistics Reports; Vol 62: 3 Hyattsville, MD, National Center for Health Statistics, 2013. Accessed February 27, 2014, http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_03.pdf.

[153] U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. Accessed June 2, 2012, http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf.

[154] Witt AM, et al. (2012) Integrating Routine Lactation Consultant Support into a Pediatric Practice. *Breastfeeding Medicine* Vol. 7, Num 1, DOI: 10.1089/bfm.2011.0003, 38-42.

[155] Mannel R, Mannel R. Staffing for hospital lactation programs: recommendations from a tertiary care teaching hospital. *J Hum Lact* 2006; 22:409-417.

[156] Francis-Clegg S, Francis DT. Improving the "bottom-line": financial justification for the hospital-based lactation consultant role. *Clinical Lactation*. 2011; 2(1):19-24.

[157] Mannel, R. Defining lactation acuity to improve patient safety and outcomes. *J Hum Lact* 2011; 27(2): 163-170.

[158] Mannel, R. Lactation rounds: a system to improve hospital productivity. *J Hum Lact* 2008; 24(4): 367-8.

[159] Chantry, CJ. Supporting the 75%: overcoming barriers after breastfeeding initiation. *Breastfeeding Medicine*. 2011; 6(5): 337-9.

[160] American Academy of Pediatrics. (2012, Feb) Breastfeeding and the use of human milk. *Pediatrics*, 129:e827–e841. Accessed February 27, 2012, http://pediatrics.aappublications.org/content/early/2012/02/22/peds.2011-3552.

[161] Academy of Breastfeeding Medicine Protocol Committee. (2014) ABM Clinical Protocol #2: Guidelines for Hospital Discharge of the Breastfeeding Term Newborn and Mother: "The Going Home Protocol," Revised 2014. *Breastfeeding Medicine*, © Mary Ann Liebert, Inc. Volume 9, Number 1.Accessed February 27, 2014, HYPERLINK "http://online.liebertpub.com/doi/pdf/10.1089/bfm.2014.9996" http://online.liebertpub.com/doi/pdf./10.1089/bfm.2014.9996.

[162] Bonuck, K, A Stuebe, J Barnett, MH Labbock, J Fletcher, and PS Bernstein. (2013) A primary care intervention increases breastfeeding duration and intensity: Results of two randomized clinical trials. *American Journal of Public Health*, December epub ahead of print. Accessed January 7, 2014, HYPERLINK "http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301360?url_ver=Z39.88 2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed" http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301360?url_ver=Z39.88.2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed.

[163] National Archives and Records Administration. (2013) *Federal Register: Part II Department of Health and Human Services: Centers for Medicare and Medicaid Services* 42 CFR Parts 431, 435, 436, et al. Office of the Secretary 45 CFR Parts 155 and 156, Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility
and Enrollment; Final Rule Vol 78:135 July 15. Accessed February 27, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf./2013-16271.pdf.

[164] International Board of Lactation Consultant Examiners. (2011, Nov) *Code of Professional Conduct for IBCLCs*. International Board of Lactation Consultant Examiners: Falls Church, VA. Accessed January 23, 2014, http://iblce.org/wp-content/uploads/2013/08/code-of-professional-conduct.pdf.

[165] International Board of Lactation Consultant Examiners. (2012, Feb) *IBLCE Documentation Guidelines*. International Board of Lactation Consultant Examiners: Falls Church, VA. Accessed February 22, 2014, http://iblce.org/wp-content/uploads/2013/08/documentation-guidelines.pdf.

[166] Aetna Insurance (2012) Lactation Counseling – Medical Policy Coverage.

[167] American Medical Association (2014) cpt ®Code/Relative Value Search. Accessed April 21, 2014 at https://ocm.ama-assn.org/OCM/CPTRelativeValueSearch.do.

[168] Johnson, Avery. (2013, April 8) Lactation consultants Receive Big Push from Health-Care Act. Wall Street Journal. Accessed April 28, 2014, http://online.wsj.com/news/articles/SB10001424127887324662404578333822840857226

[169] Gregg, Debbie. (n.d.) Expanding Coverage of Breastfeeding Education/Lactation Counseling and Breast Pumps by NYS Medicaid. New York State Department of Health. Accessed April 28, 2014, http://www.amchp.org/programsandtopics/womens-health/Focus%20Areas/MaternalMortality/Documents/Gregg%20AMCHP%20NYS%20Medicaid%20Coverage%20of%20Lactation%20Counseling%20Services%20and%20Breast%20Pumps%2012%2016%2013%20final.pdf

[170] Ibid.

United States Lactation Consultant Association
202-738-1125
Washington, D.C.
info@uslca.org
www.uslca.org