

*Vital Signs* Town Hall Teleconference  
Hospital Support for Breastfeeding: Experiences from  
State and Tribal Partners  
Q & A  
October 10, 2015  
1:00 pm CT

Dr. Judy Monroe: So thank you. Thanks to all of our presenters today for these excellent talks. So for everyone on the call, remember you can get in the queue to ask a question or make a comment by pressing star 1. Say your name when prompted. The operator will announce when it's your turn.

Please specify which presenter your question is for or if it's a question for all of our presenters today. I encourage you also to take advantage of this opportunity to share your own strategies, lessons learned, challenges, and success stories. You can pose questions to our presenters or each other. We do have quite a few states and I know what looks like a number of hospitals and other organizations on the call and so this really is a forum for you all to discuss, collaborate and question different methods, practices, and experiences around the topic.

So operator, let me check in with you. Do we have anyone in the queue?

Coordinator: Alright, thank you and we do have one in queue. Veronica Hendricks.

Veronica Hendricks: Hello?

Dr. Judy Monroe: Yes, go ahead.

Veronica Hendricks: So this question is for Dr. Karol with the Indian Health Service and in that presentation there was a mention of webinars that were shared among the group and I wondered if they were recorded and if they're able to share those webinars.

Dr. Susan Karol: Thank you Veronica and yes, I believe that they were recorded. I'll be checking with my team and if you look on the IHS website, there is some - there's a way to work

with our Telebehavioral Center of Excellence and that's where we keep our webinars listed and recorded for everybody's use.

Veronica Hendricks: Thank you.

Dr. Susan Karol: Yep.

Coordinator: Alright, thank you and once again if you do have a question, please press the star 1 and please record your name. One moment.

Dr. Judy Monroe: And while we're waiting for the next question on the call - this is Judy Monroe again - you know, I'd like to, Carina, follow up with you a little bit. I was really struck by some of the disparities when you were talking about the hospitals that have more Medi-CAL patients. Can you talk a little bit more? The California Department of Public Health have planned next steps for addressing some of those disparities that you identified in the quality breastfeeding support across the California hospitals?

Carina Saraiva: Sure so we're currently still analyzing hospital level MPINC and other breastfeeding outcome data by the various patient demographics that we can pull from the data set. For example we're looking at which hospitals serve a large proportion of Medi-CAL as we've shown there or WIC recipients or black women, Hispanic women.

In order to identify those in need of resources and technical assistance as well as identifying hospitals that have better outcomes among these at-risk population or groups in order to gather maybe some best practices that they could share or lessons learned from these higher performing hospitals.

Our hope is that this type of assessment can help us focus our strategies and resources and to monitor our progress in reducing some of these identified disparities in the coming years.

Dr. Judy Monroe: Great, thank you. Okay operator, I believe we have some folks in the queue.

Coordinator: Yes, our next question is from Lisl Phelps.

Lisl Phelps: Hi.

Dr. Judy Monroe: Yes, go ahead.

Lisl Phelps: Hello, can you hear me?

Dr. Judy Monroe: Yes.

Lisl Phelps: Okay, great. I'm working with a number of hospitals that are pursuing Baby-Friendly status in the state of Delaware and one of the barriers that they have seen recently is some of the trainings that they have provided for staff were previously free or no cost and now they don't exist anymore. I was wondering if anybody has any resources they're willing to share as far as training for both OB staff and perhaps, you know, like a smaller or less in-depth training for non-OB staff that they're willing to share that's low or no cost.

Dr. Susan Karol: So this is Dr. Karol again and if you go to [ihhs.gov](https://www.ihhs.gov) and look on our website, we do have the webinars and training there that might help with what you need. I have that to offer.

Lisl Phelps: Thank you so much.

Coordinator: Thank you. Our next question comes from Anne Merewood.

Anne Merewood: Hello there. Actually I was just going to mention - speaking to the last question that I heard. I do a lot of work with different states on Baby-Friendly and there is a three hour training online available through Northeastern University and if someone from the CDC would like to contact me after the call, I can send you a link.

It's a three hour physician training program and it's completely free and they get CME's for it and I have no stake in it except that we use it and so it's something that

you can link your doctors in. You know, the doctors need three hours of training. The nursing staff - you need 15 hours of training and the doctor one you can get for free so that's something - that's a good resource.

My question or comment was for Cria. Yes, I did have to sort of - when I was looking at your data Cria I just wanted to make the point in case some places are not totally familiar with this that the MPINC data are self-report. So we're kind of - we're kind of looking at a good case scenario where we say like half the hospitals meet half the ten steps or whatever. I mean certainly some of the states that I work with - I can tell you that most of the hospitals are not meeting half of them and probably in others they, you know, are meeting more than half of them.

So one of the kind of interesting things about the MPINC data as I work in different parts of the country is it's self-report and sometimes it's more a measure of self-honesty than it is of real reflection so not always does an MPINC score completely reflect what's happening in the hospital.

And I think the main thing that I've seen as I've gone around really are definitions and I don't know that the hospitals are doing this even on purpose but you have to be very careful about defining terms. So things like skin-to-skin they may be charting, you know, everyone's doing skin to skin but they're not actually doing an hour of skin-to-skin uninterrupted and we've come across many hospitals where they're doing - rooming in, you know, half the time and therefore they're saying half rooming in and really they have to be doing complete rooming in.

And I think it's just important to know that as you're working towards this because when you start to look at your own data very carefully as you go into this process, it may look worse at the beginning. When you start to define the terms correctly, you may actually see that it looks like your rates of skin-to-skin and rooming in are going down but in fact, you know, it's just because you're defining your terms more carefully and I think that's a big thing that has to be sort of put out there when you look at these MPINC data and also at your compliance with the ten steps.

Cria Perrine: Yes, this is Cria. It's very true Anne, you know this data well. This is a - it is self-report. We specifically - for those on the call less familiar with the MPINC survey, we begin every new MPINC survey by calling the main line of the hospital, asking to be transferred to the mother-baby manager, explaining to the mother-baby manager we're doing a survey about routine infant feeding and maternity care practices and then asking the mother-baby manager to identify who the survey should be sent to and then the cover letter that accompanies the survey encourages hospitals to get input from key staff as needed and we've learned that many hospitals complete this as a group.

So while it is sent to an individual, it's usually completed by many people and yes it is true that some people may want to inflate their score then report better practices than they may have. We've also heard the opposite. We've also heard some labor and delivery staff or some lactation consultants want it very well known how poor some of their practices may be so that they can take to their leadership a report saying look, this is what's happening in this hospital compared to other hospitals in the state or of similar size and we need to step up to make practice - to improve our practices.

So I think it could be on either end where there may not be 100% accuracy of what's happening. I also don't think that there's any reason to think there may be under or over reporting across different years so we still have the ability to look at trends across the data which this is doing but yes, it is a limitation of the survey that it is reported by the hospital.

And just as one additional plug, MPINC 2015 is currently in the field so we hope hospitals are filling it out and continuing to keep our high participation rate.

Coordinator: Alright, thank you. Our next question comes from Kym Gee. And Kym Gee please unmute your phone.

Kym Gee: Hi, we're calling from Richmond, Virginia and we had a question about support - postpartum support - for employees that work in a hospital. When they're pumping their milk, they go to put it in the refrigerator for nutrition - food and nutrition - and

there's some conflict that they have to have a specific separate refrigerator and is there a document that we can share with management that the treatment of their milk is different than with a patient - that we have a separate refrigerator for patients for breast milk but for employees it can go in the regular refrigerator.

Dr. Judy Monroe: Great question. Does anyone have an answer for that?

Cria Perrine: This is Cria. I don't off the top of my head but I will definitely follow up. I believe my email was on the slides or its cperrine@cdc.gov. If you want to send me an email we can follow up.

Dr. Judy Monroe: Yes, that's a great practical question.

Coordinator: Great and the next question comes from Rose Cohen.

Rose Cohen: I actually just wanted to chime in that Maryland WIC also has the modules online and I can - I'd be happy to send - to give an email address or to email them. I can forward that link to everybody. Thank you.

Dr. Judy Monroe: Good, thank you. It sounds like there'll be several resources here available following the call and I'll make sure those get posted.

Coordinator: Thank you and the next question's from Veronica Hendrix.

Veronica Hendrix: Mine was a resource as well - [txhealthsteps.com](http://txhealthsteps.com) is a free online module for physicians and we utilize it here in our state to provide to ancillary departments like pharmacy, lab and other providers that are not getting frontline information and support but just need a background in breastfeeding.

Dr. Judy Monroe: Thank you very much.

Coordinator: Okay, our next question comes from Sandra Maravilla.

Sandra Maravilla: Hello. I'm calling from a hospital in California in Los Angeles and I wanted to address the question of or the issue about inflated scores with breastfeeding. And while I am so proud of this breastfeeding effort, I'm really proud to say that my hospital is a baby-friendly facility.

However I wanted to see how the Department of Public Health can help the honesty of self-reporting because one thing I want to bring up is that a lot of this is based on self-reports and however a recent trend that has been happening in a lot of other hospitals that we've noticed is that even with the newborn screening tests where it's being asked what the infant's nutrition is to date, a lot of the hospitals move to screening the baby or completing that survey at 24 hours to insure that their breastfeeding rate is higher because more than likely a baby has had one or two feeds as opposed to until the baby is discharged.

So and in regards to physician education, I know when we were also obtaining our designation and we work in a nearby location where there's about five other hospitals near us so the doctors do go to the different facilities. That facility wasn't requiring them to have their education although they had already obtained the Baby-Friendly designation.

So maybe my question is more in regards to how the Department of Public Health or the CDC can help reinforce baby-friendly move and make it a requirement for these efforts to be more solidified that there is proof that the physician had the education in order to practice there or that the newborn screening isn't done at 24 hours but rather is waited until the baby is discharged to get a greater assessment of what the exclusive breastfeeding rate is at that facility.

Carina Saraiva: Hi, this is Carina with the Department of Public Health. I can speak to the newborn screening data. That has been an ongoing concern of the quality of the data and we've recently done exploration of this data and the instructions from the newborn screening is that it's collected at the time that the heel stick genetic screen is done and we did assess the variability and when that happens. Unfortunately it's not at discharge. That's not what the indicator is and it's not what the data collection is.

We're looking at the birth certificate as an optional additional indicator but in looking at the data from the newborn screening, it's true that the majority of it falls within the 24 to 48 hours but that's due to the fact that it is the heel stick test and that's when the test is supposed to be conducted and we compared it to other data sources such as mom self-report and MEHA in terms of when supplementation happened to see if it's pretty accurate in terms of in hospital supplementation and we found that it's actually pretty accurate with some other self-reported at least at the state level.

We did analyze the timing at the hospital level and we didn't - I mean we saw variability only because of policies or practices of when they conduct the heel stick. It's just the nature of the data system we're using unfortunately.

Cria Perrine: And this is Cria Perrine. I think one other measure that is important and is going to become even more so is the joint commission measure of exclusive breastfeeding at hospital discharge. So that does specify that it's exclusive breastfeeding throughout the entire hospital stay and the joint commission which is the group that accredits may US hospitals added that to the perinatal quality core measure set in 2011.

In 2014 it became required to be reported by all hospitals with 1100 or more births per year but as of January 2016 it's going to be a required reportable measure among all hospitals with 300 or more births per year which encompasses more than 80% of US hospitals. So really within the next year or two the majority of US hospitals are going to be responsible for that indicator of exclusive breastfeeding throughout the entire birth hospitalization.

Coordinator: And the next question comes from Holly Pamand.

Woman: A lot of people are asking questions and they haven't gotten...

Coordinator: Holly?

Holly Pamand: Hello.

Coordinator: You may go ahead.

Holly Pamand: Oh hi, I have two things. One, I just wanted to say that the moms who pump - employees who pump - can keep their milk in the - in a cooler with an ice pack that's good for 24 hours. So that was just a suggestion. That's what our nurses do here. And second I wanted to see if anybody had any ideas of how to increase their exclusive rates. We've implemented all ten steps and for the past year so we're kind of stalled at, you know, between the 40 and 50% exclusive. We can't seem to get over that.

Dr. Judy Monroe: Good question. Recommendations for her?

Dr. Susan Karol: This is Dr. Karol. I will just say that a big part of the push from the Indian Health Service was to really engage leadership. I think that was one of the bigger pieces that made us successful and I'll let you go from there but leadership really needs to buy in.

Cria Perrine: This is Cria Perrine. Do you have a sense if your exclusive rates are low because your initiation rates are low or among breastfeeding moms that you're still not achieving that exclusivity?

Holly Pamand: Yes, it's we - our initiation rates are always in the 80's but our exclusivity rate - they always seem to want a bottle or two more while they're here no matter how much education we give.

Cria Perrine: So it's moms requesting versus...

Holly Pamand: Yes.

Cria Perrine: It feels like maybe it needs to come more into that step three of education and more information about how even a small amount of supplementation in that very early period can be detrimental.

I think there's often a misperception of oh, one or two bottles doesn't matter and later on it may not but in that very early period where you're establishing feeding it really likely does and so maybe just more education around that issue.

Holly Pamand: Okay, thank you.

Coordinator: Alright and the next question is from Trish MacEnroe.

Trish MacEnroe: Hello. This is Trish MacEnroe from Baby-Friendly USA so first of all thank you for this wonderful town hall. You're doing a fabulous job. And I just wanted to respond to the question around maintaining standards in Baby-Friendly designated hospitals after the designation.

So Baby-Friendly USA has implemented an annual QI process which certain steps are evaluated each year but more specifically to the question of physician training following designation, beginning in the year 2017 all re-designations of Bab-Friendly designated hospitals will be conferred through an onsite assessment and will be looking at those training records again during that process.

So there is some mechanisms that we're putting in place in addition to the other wonderful efforts that are going on around the country but we're putting in some mechanisms so that we'll also be monitoring those processes so hopefully that will help with compliance as well.

Dr. Judy Monroe: That's great. Thank you.

Coordinator: The next question is from Amy Resnik.

Amy Resnik: Hi, can you hear me?

Dr. Judy Monroe: Yes, loud and clear. Go ahead.

Amy Resnik: Okay, great. I was just wanting to respond to one of the previous commenters about how to get the rates up that, you know, they've already implemented all ten steps. I'm on the WIC program and what we're finding when we're working with our participants is you can't do it in your own box because once they get out of your environment, they're influenced by everybody else.

So the way that we are trying to increase our rates even more when we get stuck at a plateau is to network and work within the community whether it's the employers, you know, the community resources, the WIC program, the physician because as much as you're telling them in the hospital, they're influenced by people before you come into the hospital and then after they leave the hospital. And unless everybody's doing the same thing and saying the same thing, you're not going to succeed.

So that's - that's what we're doing here to get our rates up higher is really working together with all venues.

Dr. Susan Karol: This is Dr. Karol. I have to totally agree and really most of our communities stood behind us. We did work with WIC very closely and have to say yes, make sure the community's behind what you're working on. That will help.

Coordinator: Alright, our next question comes from Arissa Palmer.

Arissa Palmer: Hi, I was going to add to the discussion about, you know, how to improve the exclusivity rates. In Los Angeles one thing that we've really done is the regional hospital breastfeeding consortium meeting and really working together as a community with all of the hospitals that are working towards Baby-Friendly designation as well as WIC sites who are supported and really working together to ask these questions - how have you improved your rates and what are you doing to actually move towards Baby-Friendly designation and really helping and partnering with each other to really improve our rates overall.

And I would recommend for other areas that are maybe struggling with it to kind of really work together with all of the folks in their community like the last caller said

WIC, other hospitals that are working on this, community partners who can really work together to help improve it.

Dr. Judy Monroe: Thank you. Any comments from anyone? That's great. Operator, do we have any more questions?

Coordinator: There are no other questions at this time.

Dr. Judy Monroe: Okay. So well thanks everyone for your questions and comments and all the resources. I think it's really terrific. I heard - certainly on the call I heard some real key points but just to reiterate, I think the leadership engagement really is important and if leadership's not engaged and not visible and, you know, vocal on this topic, that's - that's something that you may want to try to spur on.

I liked hearing about the accountability – Baby-Friendly USA coming in - because there does need to be, you know, structure for accountability and then, you know, hearing about everyone getting on board in the community. I mean all of these elements come together in creating a culture that really supports breastfeeding and really needs to be adopted along the way because if grandma doesn't believe in it, that cannot be so good or if your best friend or your work doesn't support it and so forth.

So I really appreciate all of the comments and discussion today. So before we close, I'd ask you all to take just a moment and look at the next to the last slide which is slide 37.

This is the prevention status reports or the PSR's which highlight for all 50 states and the District of Columbia the status of certain policies and practices designed to address ten public health problems including nutrition and physical activity.

The PSR's pull together information about state policies and practices in a simple easy to use format the decision makers can use to examine their state's status and identify areas for improvement.

Visit the link at the bottom of the slide to see how all of the PSR's by state or topic that you might look for and you can use - you can look for the link on the October Vital Signs town hall teleconference web page to go directly to the 2013 nutrition, physical activity and obesity PSR and we will be having a new PSR come out in the next couple of months updating for 2015.

And finally please let us know how we can improve these teleconferences so you can email your suggestions to [oftltsfeedback@cdc.gov](mailto:oftltsfeedback@cdc.gov). That's O-F-T-L-T-S feedback - all one word - at [cdc.gov](http://cdc.gov).

We hope all of you will be able to join us for next month's town hall on Tuesday November 10th and at that time we will focus on food safety. Thanks again to all of our presenters and everyone who attended the call and I hope you enjoy the fall weather.

Coordinator: Thank you. This completes today's conference. You may disconnect at this time.

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