

Promising Strategies for Improving Breastfeeding Rates in MIECHV Programs 12 0

Hello, everyone. This is Nancy Topping-Tailby from HV-ImpACT. And it's my pleasure to welcome you to our webinar this afternoon-- or this morning, depending on where you are-- on Promising Strategies for Improving Breastfeeding Rates in MIECHV Programs.

As a participation reminder, we want to hear you-- so we hope that everything will go smoothly with today's broadcast. Please mute your phone by pressing the star and then pound-- if it's noisy where you are-- and mute your computer speakers if you hear an echo. You have the chat function, which you all are used to. And we hope that you will-- as you always do-- enter lots of comments and questions for our presenters today.

We are recording, and will make the recording available as soon as it's ready. Please let us know if you're experiencing any technical support concerns and need to reach one of our support team by just letting us know with a note in the chat. If you look in the file pod-- which is right underneath the right-hand corner of your screen-- you'll see that we do have the slides available for you to download by just clicking them. And then you'll be directed to another screen, where you can download them to your computer and use them to take notes- if you like-- around the presentation today.

If you need to leave early, in the lower left-hand corner, you'll see that we have a link that you can copy and paste to our evaluation survey. We hope that you're able to stay with us for the full 90 minutes. But if not, the link will come up at the end. But if not, here is a link that you can use to give us your feedback. Your opinions and comments are very important to us. And we use them to refine our presentations so that they meet your needs.

And at the top left-hand corner of your screen, we have a note for you to watch for our upcoming home visiting home runs newsletter on breastfeeding that will be released on August 22. And I'll tell you more about that at the end of the presentation.

So I wanted to start by just reviewing the objectives, and by telling you that our overarching objective for today's webinar is to address the breastfeeding benchmark-- the percent of infants among mothers who enrolled in home visiting prenatally who were breastfed any amount at six months of age. Our efforts are to support your efforts as awardees to meet or exceed this performance measure. And during today's webinar, specifically, we will be reviewing the national landscape for improving breastfeeding rates and strategies to promote consistent messaging about the importance of breastfeeding-- identifying successful practices and lessons learned from our home visiting coIIN for engaging external and professional supports-- for families to promote breastfeeding awareness intention, initiation, exclusivity, and duration-- and lastly, describing successful systems efforts to build home visitor capacity to support breastfeeding as the recommended approach to early feeding that optimizes health and well-being for mother and infant.

So it's my pleasure to introduce our speakers today. We have wonderful presenters for the next 90 minutes, who will share their perspective with you.

Our first speaker is Dr. Joan Younger Meek, who is Professor in Clinical Sciences at Florida State University College of Medicine, Associate Dean Graduate Medical Education. And she is the Chair of the AAP Section on Breastfeeding. Dr. Meek is also past Chair of the US Breastfeeding Committee, a past President of the Academy of Breastfeeding Medicine, and former Education Chair for the American Academy of Pediatrics Section on Breastfeeding. She has also served on the Board of Directors of the International Board of Lactation Consultant Examiners. Dr. Meek has developed a breastfeeding slide kit for physician training, as well as educational sessions on breastfeeding counseling skills.

Our next speaker is Elaine Fitzgerald Lewis. Elaine oversees HV-ImpACT's targeted TA efforts, and directs the TA specialists' work in delivering virtual and in-person TA. Elaine has nearly 20 years of experience managing initiatives from the international to the local level that focus specifically on infant and early childhood health. As Director of the Infant Mortality coIIN, she developed and executed a TA curriculum designed to build the capacity of multi-sector stakeholders to improve infant health nationwide. Elaine provided TA as a subject matter expert on breastfeeding to the home visiting coIIN. Her prior work also includes directing an early childhood system of care that provided TA to the infant mental health workforce in Connecticut, and implemented an evidence-based home visiting model. Elaine is passionate about building the capacity of providers and systems to improve the health and well-being of children.

And she will be followed by Sara Remington, who is the Implementation Manager for the Rhode Island Department of Health Family Visiting Team. She's been with that program since its inception in 2010. Sarah is responsible for the nine Healthy Family America sites statewide, and has participated in multiple phases of HV coIIN. And currently, she serves as a CQI coach for one of Rhode Island's Parents as Teachers sites, so you'll have a chance to hear about the wonderful work that many of the local implementing agencies in Rhode Island did as part of the home visiting breastfeeding coIIN.

So to start our learning for today, we're going to do our Jump Start the Brain. And we thought, as the tests have changed, maybe it might be easier if we pulled up one poll at a time. So we encourage everyone to answer. And Kate is going to pull up the polls now. And we'll just move through them quickly.

So the first one is-- if you would please share your answer, again, the answers are anonymous. So if you're not sure, just take a guess-- there are racial and ethnic differences in breastfeeding initiation and duration rates. I'll give you just a moment. And then we'll move to the next one.

OK great, some of you-- it keeps changing. Some of you may not have answered. But let's move along, in the interest of time-- thank you, Kate. So here is the second question-- choose a number between 1 and 5 to complete the sentence-- currently, what number of babies out of-- what number of five babies in the US received breast milk-- do you think?

So when we do the Jump Start the Brain at the end, we'll broadcast the results and also give you the-- tell you what the right answer is. OK, Kate, why don't we move to the next one. So this is a true or false question-- again, a mother's intention to breastfeed her baby prior to delivery has no effect on rates of breastfeeding initiation or duration. Do you think that is true or false?

OK, let's move on, Kate. And apologies to those of you that I'm cutting off, because it may take a moment to reflect on the questions. But you already started to answer, so-- true or false, all states have a breastfeeding coalition.

All righty, well thank you for those of you who responded, and those of you who were thinking about responding. And we'll revisit our Jump Start the Brain take two at the end. So it's now my pleasure to turn the webinar over to Dr. Meek. Go ahead, Dr. Meek.

Thank you, Nancy. And good afternoon to everyone. I am really pleased to be here this afternoon to be able to share with you. And I'm going to start out by providing an overview of our national landscape of breastfeeding.

And I wanted to start by reviewing the concept that we do actually have a national agenda for breastfeeding. The Surgeon General's Call to Action back in 2011 actually established the first multi-sectoral national agenda. And one of the goals of that agenda was to make breastfeeding easier for mothers, and to enable more breastfeeding mothers and families to meet their own breastfeeding goals.

We do know that the vast majority of women do start out breastfeeding, but they encounter a lot of barriers. And the call to action specifically did not say, we want to force more women to breastfeed, but we want to enable them to be able to meet their own breastfeeding goals, which I think--

[AUDIO OUT]

The Call to Action established 20 different action steps. And they were divided into a number of sections. And as you'll see on the slide, some of those impacted mothers and their families, communities at large, and particularly, community support after hospital discharge-- the health care system, which includes our maternity care facilities, as well as physician and provider offices-- employment can be a big barrier for women who are breastfeeding, when they return to work particularly-- the public health infrastructure to support breastfeeding. But the call to action also emphasized the need to monitor progress, record accurate data, and to support research in terms of how we can do better in terms of protecting, promoting, and supporting breastfeeding.

I did want to point out that the CDC published a five-year progress update in the Journal of Women's Health in August of 2011 at the-- or 2016, excuse me-- at the five-year anniversary of the Surgeon General's original call to action. And their conclusion was that-- and they did a nice outline of the different steps, and what progress has been made-- but they concluded that, while we have made a lot of progress, there is still a lot of work to do.

And particularly, one of the areas where we need to--

[AUDIO OUT]

--of health equity regarding breast--

Joan?

Yes?

Joan, I'm sorry for interrupting you. This is Nancy. But there are a numbers of people who are saying that they're having difficulty hearing--

Oh.

--you.

[INAUDIBLE] OK.

So given the number, I thought it was worth--

Oh, thank you.

--interrupting you. Do you think you could try and speak a little more loudly, and could you also repeat the information about the five-year? Yes, please-- thank you.

OK, I apologize. Can you hear me better now?

People, can you let us know if this is better? Yes, so-- [INAUDIBLE] is saying yes. Yes, lots-- somebody said slightly. So I think you just have to continue to try and project. But most people seem to be saying it's better. So if you could just recap those comments-- thank you.

Certainly-- I apologize. I'll speak a little bit more loudly now. So I was pointing out that the Surgeon General's Call to Action that was issued in 2011 actually established our first national agenda on breastfeeding. And you see the areas that were particularly identified in the Call to Action. And one of the key points of the Call to Action, was that it was really a goal that we make breastfeeding easier for those mothers who do choose to breastfeed, because we know that most mothers do actually start out breastfeeding.

And it called for us improving what we do to support mothers and their families, our communities, and particularly, the community post-discharge from the hospital and in the home environment-- the health care arena, including the maternity-care facilities, as well as provider's offices. The employment arena is an area where we need to make improvements-- and then the public health infrastructure to support breastfeeding, as well as the need for additional research, and making sure that we include to track our data, so that we can actually measure how well we're doing in terms of supporting mothers in making their progress. And then I did mention that the CDC published a five-year progress update in the Journal of Women's Health in August of

2016. And their conclusion was, that while there have been some progress made, we still have a lot of work to do.

So the American Academy of Pediatrics issued their most recent Policy Statement on Breastfeeding and the Use of Human Milk in 2012. And in that statement, they re-emphasize that we should be recommending breastfeeding exclusively for about the first six months of life-- so that really means nothing else besides breast milk-- continuing for at least the first year of life with the addition of complementary solids. And the recommendation is that the complementary solids should be added at about six months of age.

And I understand that there is some variation in terms of practice, and in terms of what pediatric care providers might be recommending, but the AAP does recommend that the complementary solids be introduced at about six months. And for healthy-term newborns, their need for additional protein, iron, and zinc that they can get from those complementary solids really coincides with that six month period. So we're trying at the Academy to make sure that all of our pediatric colleagues do enforce that same message of continuing breastfeeding for six months, and then introducing solids at about six months.

And then there's no upper limit for breastfeeding. Women should be encouraged to continue breastfeeding as long as both the mother and her baby desire to continue. There's no point at which the breast milk no longer has any value. There's no point at which it becomes nutritionally inadequate for the baby-- in addition to the other solids that the child would be consuming at that point.

It really is important that we establish human milk standard for infant feeding. And sometimes, if you look at the way infant feeding is portrayed in the media, you may not get that message. So some of our moms aren't necessarily seeing that reinforced particularly well. Even in women's magazines, there are a lot of advertisements for alternative feedings, but not as much information about breastfeeding.

We also feel, within the Academy, that the decision to breastfeed really should be a public health issue, and not just a lifestyle choice. We want to make sure that women do know that there are significant health outcomes related to breastfeeding-- and particularly longer duration of breastfeeding-- so that they can make an informed decision about how to feed. Certainly, formula feeding is an acceptable alternative for those mothers who aren't breastfeeding.

And we basically teach women that any breastfeeding is better than no breastfeeding at all. The longer the mother breastfeeds, the better the health outcomes will be for her and for her baby. And then the longer the duration of exclusive breastfeeding, the better correlation with long term benefits for both mothers and babies.

I do understand that with the coIIN initiative, you are looking at any breastfeeding rates. And as I said, any breastfeeding is better than no breastfeeding at all. So we do need to work on both duration, as well as trying to impact the exclusivity rates.

In terms of the health outcomes-- as I mentioned, there are significant benefits. And I expect most of the folks on this call are pretty well aware of these. But some of the benefits, as you can see on the slide, there is a poster that was distributed by the American Academy of Pediatrics saying that breastfeeding is babies' first immunization.

And it does support optimal immune outcomes, and helps to prevent the baby from infections from early on, as well as perhaps impacting the immune development of the child over time. When the baby's in utero-- inside mom-- the mother provides immune protection. But breastfeeding and breast milk really helps to bridge that gap before the child develops their own immune response.

In addition, we know that breast-fed babies have fewer ear infections, fewer diarrheal diseases, decreased respiratory infection, less risk of sudden infant death syndrome, and decreased risk of certain childhood cancers. It may also protect against development of obesity and Type 1 diabetes. The mother who breastfeeds also experiences the decreased risk of breast cancer, ovarian cancer, decreased risk of hypertension and MIs-- myocardial infarctions, or heart attacks. And mothers who breastfeed also have decreased risk of postpartum depression.

And finally, we know that breastfeeding promotes optimal attachment between mothers and infants. Now there's being described the fourth trimester of pregnancy, which is extra-uterine. And during that time, it's really important for babies to continue to have lots of skin-to-skin interaction with the mother, and then frequent breastfeeding as the child adapts from being in-utero to living outside of the uterus.

And finally, we know that breastfeeding is easier. It saves money. And it's more environmentally friendly. So there are lots of reasons why we of course would like for mothers and babies to breastfeed.

On this slide you see the Healthy People 2020 objectives. And you'll see that there were a number of objectives related to breastfeeding. I highlighted on the slide our current rates. And these were the rates that were released in this month-- August of 2017.

But they reflect the birth cohort from 2014. So there's a three-year delay in terms of analyzing and reporting the data. But our most recent data do show that our ever-breastfeeding rate actually exceeds the Healthy People target. We're currently at 82.5%, which is pretty much a national high for the last century or so.

And the exclusive-breastfeeding rate through three months actually slightly exceeded the target-- you can see-- at 46.6% percent. So that was also very good. Finally, the number of live births that occur in facilities that adopt the ten steps and provide recommended care exceeded that target. And we'll come back to that piece.

But it's really important for us to continue to monitor where we are doing relative to Healthy People 2020. And of course, Healthy People 2030 is being developed. So hopefully, we'll have even more aggressive targets during that period of time.

You can there's also an indicator on reducing the proportion of breastfed newborns who receive formula within the first two days of life. And we've really made great progress. We're almost meeting the target there. But that number was 1 in 3 not very long ago. So there's-- because of the work that's being done in the hospital system, we've seen a significant decrease in the supplementation of breastfed babies with formula in those first two days-- and really, only giving that formula to babies where there's a true medical indication.

This slide also reflects the most recent data that were released by the CDC. And it really tracks any breastfeeding rates over time. And you'll see the first recording is in 2002-- when the CDC started doing their annual surveys-- up through the 2014 birth cohort.

And as you see, there's been a steady rise in both the any-breastfeeding rates, or initiation rates, which is the top line and in blue. The six month duration is in the green line in the middle. And then finally, the pink-color one is at the bottom. So all of those have really shown nice positive trends over time.

This slide points out some of the geographic differences. This is updated through the 2013 birth cohort, I will mention. But you'll notice on the left-hand side of the slide is the initiation rate. And as I told you, we're a little over 80% in terms of national initiation.

It shows the individual state results, in terms of their initiation rates. So the darkly colored states-- the dark, deep red states-- exceeded the Healthy People 2020 initiation goals, whereas the light-pink ones-- or more salmon-colored-- did not meet the initiation rates. And then on the right-hand side of the map, you'll see the Healthy People 2020 goals relative to the six-month duration. And this is any breastfeeding at six months.

So you can see it gets a little bit sparser in terms of the number of states that met the six-month duration. But the gaps here are pretty striking. And it's-- as you can see from looking at the left-hand side, the highest rates are seen in the Northeast for the most part, and then the Western half of the US-- with the lowest rates being seen in the Southeastern area.

And some of the reasons that are postulated for this have to do with the lack of social and cultural support that we see in the Southeastern and some of the Midwest areas-- unsupportive work environments-- lower numbers of hospitals that are designated as baby-friendly occur in the areas of the map that have the lighter pink color. And we do have higher rates of African-American women in the Southeast area.

Interventions that have been shown to help modify these initiation and continuation rates include things such as peer counseling, providing group prenatal education and enhanced breastfeeding support, and especially when these initiatives are led by people of color-- that seems to have a significant impact in terms of the greater breastfeeding rates. So there's been a major initiative over the last several of years recognizing that we were not meeting the needs of the African-American population as well-- to really provide some targeted intervention.

And we'll talk a little bit more about that. But we do have areas to improve-- as we'll see-- on both of the sides of the map. But definitely, the Eastern part of the country-- and particularly the Southeast-- has the most work to do.

So we have another poll. On a scale of 1 to 10, how effective do you believe your state breastfeeding initiatives are for promoting and supporting women to meet their breastfeeding goals-- with one being not effective at all, and 10 being highly effective. So we'll ask you to register your response.

All right, can we go ahead and display the results? I know some of you are probably still thinking about it. OK, can we view those now?

Folks can see them, Joan. They can see the results.

Oh perfect, all right, thank you. I'm sorry. So you can see, they're really, pretty spread out. We have very few 1s. But they're spread pretty well between 2 and 8. So sounds like most of the folks on the call feel like we could do a lot better in terms of our state breastfeeding initiatives. So thank you for weighing in there. We'll go ahead and move on.

So this slide, again, shows the most recent CDC data reflecting the birth cohort from 2014. And again you'll see on the upper blue line are the any-breastfeeding rates, and the lower red-colored line are the exclusive-breastfeeding rates. And we would hope-- of course, you notice that over time, the breastfeeding rates do decline.

And certainly, we have the highest rates right after birth. And there is a pretty steep decrease-- particularly around the two-week mark-- it's a back-to-work time for mothers-- for those mothers that are employed. But there's sort of a steady decline. We'd like to see that line be a little more straight.

And then you'll also notice that there is a discrepancy between the any-breastfeeding and exclusive-breastfeeding. And particularly early on, we'd like to tighten that gap a little bit, and have more of those moms do exclusive breastfeeding-- at least early on. But there is work to do in terms of decreasing that variability and trying to recommend exclusive breastfeeding, particularly early on in the child's life.

Again, I recognize that your goal-- in terms of this project-- is to get any breastfeeding. And that's certainly extremely important for our moms and babies. Did want to point out that there are definitely-- even within a geographic area-- there are definitely variations in terms of what we see with breastfeeding, what we see with mortality in general. And this points out some of the social determinants of health-- race, ethnicity, gender, sexual identity age, disability, socioeconomic status-- can all contribute to an individual's ability to achieve good health.

And these data from the Virginia Commonwealth University actually show an area in Miami-- which is in my home state. And the numbers that you'll see there displayed are the difference in expected-- the difference in life expectancy. And you can see, in a very fairly compact

geographic area, that there are significant differences-- up to 15 years difference-- in terms of life expectancy.

And in fact, in one article that was written, even one mile of difference can make 10 years difference or so in terms of life expectancy. And breastfeeding certainly is only a piece of this, but we know that breastfeeding is a very cost-effective measure. And that it can decrease infant mortality, and may impact the long term health of an individual. So when we're looking at health disparities-- certainly keeping in mind breastfeeding, and the promotion of breastfeeding, and how we can actually promote to individuals-- and particularly people of color-- is very important.

The national immunization survey-- again, this was collected by our folks from the Centers for Disease Control and Prevention. The national data-- as I mentioned-- show an overall initiation rate of 82.5%. You'll see the breakdown in terms of race and ethnicity that's collected. The Hispanic population actually had the highest initiation rates. And these are national averages.

About 84.8% of Hispanic women do start out breastfeeding. The non-Hispanic White rates are very similar-- 85.7-- actually, I think I read that backwards. But the non-Hispanic White is 85.7%-- so slightly greater than Hispanics. But then we see drop-offs from that-- non-Hispanic Asian-- 80.7%-- the non-Hispanic Pacific Islander and Native Americans-- around 79%. And then the lowest overall initiation rates have been recorded in the non-Hispanic Black population.

And of course you'll see similar rates when you look at the breastfeeding at six months. There are definitely disparities there, with non-Hispanic Blacks-- 41.5%-- compared to the non-Hispanic White of 60%. So again, it just points out that we do have a lot of work to do in terms of addressing the disparities, and making sure that all babies-- regardless of race, ethnicity, or geography-- have the same opportunity to be breastfed.

The Office on Women's Health actually several years ago put out some really nice materials. They called this initiative It's Only Natural. And it was predominately focused on African-American population. They did a lot of focus groups in terms of targeting the messages in this campaign.

They have video clips that are available online with African-American providers, as well as African-American women, their spouses, fathers of babies, and others-- really showing some role modeling, as well as providing some good information. So if you haven't looked at these materials, and you do work with an African-American-- a predominantly African-American population-- just a nice resource that's available to us, as is the next item, which is the Office on Women's Health your guide to Breastfeeding. These can be downloaded by those folks who have computers.

They were just revised. And they have them in different languages, as well. And you can order print copies, as well. Although I heard just last week that they were running low on their print copies.

And they're making a few adjustments. And are going to reprint those. But the downloadable PDFs are available all the time. So it's another great resource that you can order to use--

[AUDIO OUT]

--for them.

So the Baby-Friendly Hospital Initiative-- I actually started a number of years ago-- it is administered in the United States by Baby-Friendly USA, which designates hospitals as having adopted all of the ten steps to successful breastfeeding. And this was recommended as a worldwide initiative by the World Health Organization and UNICEF. And it really puts in place systems that support women in breastfeeding. Again, it breaks down some of the barriers and prevents every mother from having to fight her own battle in the hospital-- in terms of getting the support that she needs, if the system itself has adopted these ten steps, and has really, systematically made sure that they are following them on a regular basis.

The exciting news is that we've had a significant increase in the number of designated hospitals over the last several years. In 2007, we only had 2.9% of US births occurring in Baby-Friendly designated facilities. And as of July 2017, 21.71% are occurring at Baby-Friendly designated facilities-- and that well exceeds the Healthy People 2020 goal. And we now actually have Baby-Friendly designated hospitals in all 50 states, the District of Columbia, and Puerto Rico.

So that's really exciting-- the spread of Baby-Friendly. And it's really been supported by the CDC funding for the Best-Fed Beginnings Project, as well as Empower Breastfeeding. And Empower specifically concentrated on that Southeastern region of the US. So it's really helping some of the facilities in the states that have the lowest breastfeeding rates to address the hospital maternity care practices.

I did want to point out the mPINC survey-- the maternity Practices and Infant Nutrition and Care. This is also conducted by the CDC, and typically, has been every two years. There will be a break this year. So it will resume in 2018, because they're revising the survey.

But there are state-level data. These are available at the CDC website. So you can download the aggregate information from the state. And you can actually track the progress going back to the first year in 2007, up through the 2015 survey.

It highlights which of the ten steps the state--

[AUDIO OUT]

--whole, are doing well-- in terms of making progress, and implementing the steps-- and then also identifies the areas for improve--

[AUDIO OUT]

So individual hospitals will get their own reports, if they participate in the survey. And then the state as a whole will get the information back. So for those people that are working with the state breastfeeding coalition, it's really important to be aware of these, and to be actively using them, in terms of developing strategic plans for the state breastfeeding coalition-- or even looking at the more local breastfeeding coalitions. So the next mPINC survey will actually be administered in 2018. So it'll be probably about another year after that before we get the next data from that survey.

I also wanted to point out the significant increase in the number of HMBANA Donor Milk Banks-- the Human Milk Banking Association of America-- that provides standards for donor human milk-- the processing, the screening of mothers, and then the distribution of that milk. And we went from having six donor milk banks not too long ago, to having multiple banks available. And it's really increased the supply of donor milk that's available quite dramatically.

And states before-- that had to go multiple states over to get donor milk-- now often have their own milk bank. So that's been a very important development. And this milk is predominantly used in the NICUs with the premature and critically-ill babies-- sometimes with babies with significant cardiac disease, heart disease. But the increase in supply has been really important.

And that 2012 statement from the American Academy of Pediatrics did recommend that all babies that were born weighing less than 1500 grams should be fed human milk. So that really helped to stimulate some of this growth. But it's been an exciting trend. Still don't have enough-- but much more than we did before.

Another factor that has helped to provide support for breastfeeding women was the Patient Protection and Affordable Care Act. And one of the sections of that Affordable Care Act provided for break time for nursing mothers, so that employers must provide a reasonable break time, in a private non-bathroom place, for breastfeeding mothers to express their breast milk during the workday for the first year of the child's life. And that does apply to all employers.

And those who employ less than 50 workers can request an exemption-- a hardship exemption-- but they have to demonstrate why it would be a hardship for them to comply. So there is not an automatic exemption for employers with less than 50 employees. I just wanted to emphasize that.

And then the other portion of the Affordable Care Act that was really important was that the Women's Preventative Services required all health plans to cover-- at no cost share to women-- breastfeeding support, breastfeeding supplies, including a breast pump and counseling. So that was very important in terms of changing the landscape as well. We do have laws to protect women for nursing in public-- whether they're in a public or private location.

We know that there are still periodic-- virtually every day, there's some report of a woman who experiences difficulty with breastfeeding in public. But there are laws in most areas. And many of the states actually have laws that specifically exempt breastfeeding from public indecency laws, that might otherwise be on the books.

The coalitions have been really instrumental, in terms of bringing folks from all different sectors together. There are state coalitions. And I certainly hope that many of you on the call are involved with your state coalition. There are local coalitions.

But it's really important to get all of these, sort of, diverse folks-- all of who play a role. They're all stakeholders in making sure that we support breastfeeding. But some of the folks that hopefully are involved in your coalition is somebody from the Department of Health, and somebody who addresses Medicaid guidelines in your state from the Department of Health-- the WIC breastfeeding director-- and again, there's a state director. But there are also local directors-- somebody that's working with Perinatal Quality Collaborative that may be addressing some of the in-hospital work.

The states all have state lactation consultant associations, so having somebody from that organization is helpful. The American Academy of Pediatrics designates at least one Chapter Breastfeeding Coordinator, who is a pediatrician, in each of the states. And some of the larger states like New York and California actually have more than one. But that's a good resource to work with your Breastfeeding Coalition-- particularly if you don't already have another health care provider working.

Community peer counselors are really helpful. And as I said, particularly in communities of color, they've been very helpful within the WIC program. They've been very instrumental in terms of increasing breastfeeding rates-- and then of course the MIECHV awardees that are doing the home visitation and helping to provide education and support to mothers.

So this is just a partial list. But again, I hope that many of you are engaged and are working with a number of these other folks, and can think about asking others to join you if you're not. So our next opportunity to chat-- we want you to name some of the partner organizations that you've worked with to support breastfeeding in your state or territory, and describe some of your successful strategies to share with the others on the call.

We'll give you just a couple of moments to look at that one.

And then Joan, I think we want to try and wrap up soon to allow time for questions and other presenters.

OK, all right--

Thank you.

I will move on.

I want folks to be able to chat. But maybe you can review their answers at the end, OK?

Sure-- so a couple topics-- just in closing here-- pacifiers have been a hot topic in some areas. The discrepancy between the recommendation that we establish breastfeeding well before introduction of pacifiers, versus the SIDS' recommendation that babies should be introduced to

pacifiers to decrease risk of SIDS-- and the way that those are reconciled is that it is recommended that breast-fed babies have breastfeeding well established before the pacifier is introduced, so it's less likely to interfere with breastfeeding at that point. So we still do recommend the pacifiers, but after breastfeeding as well established.

Marijuana, as you know, is legal in some areas. The Academy of Pediatrics is actually working on a policy statement to address marijuana. And the statement, while not published yet, and not official policy yet, is really looking at the fact that occasional use of marijuana is probably not likely to be a significant issue for the baby, whereas long-term, heavy use of marijuana might be contraindicated.

And so we do need to use judgment about that. And mothers should, ideally, consult with their health care providers, and be honest about their use, so that appropriate guidance can be given. But occasionally use-- particularly in those areas where it is legal-- is not likely to have a significant impact on the baby.

And I think Nancy said you all have talked about Neonatal Abstinence Syndrome on another webinar. But this is-- the treatment for mothers who are in a treatment program, and babies being monitored-- it's actually recommended that those babies do breastfeed. They actually do better. They're less likely to experience Neonatal Abstinence Syndrome, and have less severe symptoms. So that's certainly encouraged.

And then ankyloglossia has been a hot topic. I don't know how many on the call have experienced this. But there's definitely been a major initiative throughout the country to evaluate babies, and to recommend that they get tongues clipped-- which, in some cases, may be very important. But again, I would encourage folks to interact with their health care providers in their area, and make sure that a lactation consultant has done a good evaluation of the baby, in terms of whether that is necessary or not. We could spend a whole other hour on that piece, as well.

So as I mentioned, there are barriers to breastfeeding. And really, what we're working on doing-- from the national agenda-- is to try to decrease those barriers. And we need to work on our local levels as well. And this is part of what the work of the coalitions is about, is really trying to decrease some of the barriers, and make it easier. And whether we need legislative remedies in place, or the back-to-work policies-- certainly looking at our hospital policies-- but I think this is an area where we all should be examining this, and working with our coalitions, in terms of how we can make improvements there.

So just in summary, we do have a national agenda-- our Surgeon General's Call to Action. All states do have a breastfeeding coalition. We know that at least four out of five babies do receive breast milk or human milk.

Over 21% of US births occur in Baby-Friendly designated facilities. And we have significant increase in the use of donor milk in those facilities. And then finally, the Affordable Care Act does provide for nursing breaks and coverage for lactation services.

This I just will show you briefly. It's the infographic that came from the Lancet Series on breastfeeding that really summarized, globally, what was happening-- and how we really can save lives. We can save money. We can decrease risk of breast cancer.

But we need to protect and support mothers in order to allow them to be successful. And we can save \$300 billion a year. So it's important from an economic standpoint as well.

So why should we support breastfeeding? We want every baby to have the best health outcomes. And we need to support every mother in the community-- in the health care arena and in her home. And healthier families are in everyone's best interest. So I know I covered that very quickly. But do we have time for a few questions, Nancy?

We do. And there was such rich feedback about all the different organizations that folks are working with in their state, in terms of your question about who are their natural partners. So you may want to scroll through the chat.

I saw you know lots of people were calling out WIC, in particular-- which was one of the groups that was on your list. But there was a range of suggestions that varies from state to state-- La Leche, several people mentioned in particular. Lactation Peer Counselors-- so there's a lot of good data there that we can use for analysis about where some successes have been. So you might want to take a moment to look at that, Joan, and see if you have any thoughts.

And you have time. But we have a number of questions that we posted, and some comments. So Angela Harris from Alabama commented that she thinks that nonsupport is probably the reason that-- in their state-- they have not been able to meet either of the Healthy People goals. Someone else called out they thought the lack of consistency of education about breastfeeding laws was a factor. Someone-- Cindy Richardson would like to clarify if breastfeeding includes pumping and bottle-feeding human milk.

Yes, so typically, when we use the definition, it's receiving human milk-- whether it's directly from mother-- which would be the preferred route-- but expressed milk in a bottle is certainly perfectly acceptable as an alternative to direct breastfeeding. So yes, we typically are including both of those.

Thank you, and Sandra wanted to know-- what pathway would you suggest home visitors take to become certified as a lactation consultant to assist with breast feeding initiatives.

Well, I think a first step might be to take a CLC type course, which are the one week courses. And I think that's a good start for someone-- particularly if they don't come from a health care background to begin with. Certainly we need more IBCLCs. See

We need IBCLCs in some of the geographic areas where we have the greatest need. And we need more IBCLCs who are people or women of color. So those are some of the demographics that we need. And I can certainly provide additional information one on one for anyone that's interested in the pathway to become an IBCLC. But I think starting out with one of the one week courses, if you're able to do that, is a good place to start.

Thank you, and Cathy Schneider wanted to know-- who can we contact in our state-- I'm not sure what state Cathy's in-- if mom is not getting support at work to pump.

So that's a federal regulation. So the Department of Labor is the one that is actually getting the complaints. And they actually have some guidance that can help individual employers that need some assistance in terms of how they provide that.

Someone who has a complaint-- an individual mother who has a complaint can lodge a complaint with the Department of Labor. And I would mention that the HERSA has the business case for breastfeeding that is available. And it provides really some nice innovative solutions in lots of different areas-- different types of employment-- where mothers can work with their employer to come up with some solutions. But if there's a complaint, it goes to the Department of Labor, because it is a federal law.

Thank you, and last question, then I'll just highlight some hot topics that we can perhaps come back to this time at the end. But I want to move a move on for the other presenters. But where is the best place to find medications that should not be taken while breastfeeding? Is a good, sort of, centralized list where--

Yes, that is a great question. There's an NIH National Library of Medicine website called lactmed-- L-A-C-T-M-E-D. If you just Google that, it'll take you right to it. And that's really the most up to date, available site to look at medications. And it comes in an app as well. So you can download an app. That's L-A-C-T-M-E-D-- very useful, and it's one of the great things that our federal government does to help us support breastfeeding.

OK, that sounds great. Well, I'll just highlight that folks were interested in calling out that incarcerated moms is a hot topic in New Mexico and in Colorado, where-- as we know-- marijuana is legal. And the use of marijuana or [INAUDIBLE] in cord blood leads to a CPS referral and possible prosecution.

Folks who are interested in talking about, say, sleep and bed sharing as it relates to breastfeeding. So lots of things for us to talk about, if we have time to continue the conversation at the end. But I want to thank you. And feel free to look at the chat and write back to anybody as we move on. So at this point, I'm going to turn it over to Elaine.

Hello everyone. Thank you, Nancy and Dr. Meek for that comprehensive overview of the national landscape on breastfeeding. I would like to now highlight successful practices and resources from the home visiting coIIN breastfeeding collaborative.

For those may be less familiar, home visiting coIIN was a time-limited learning collaborative using a break-through series quality improvement model. And this model improving rates of initiation and duration of exclusive breastfeeding was one of four program outcomes that participating local home visiting agencies were seeking to attract using collaborative learning, rapid testing for improvement, and sharing best practices, while building quality improvement capacity.

Expert faculty were recruited to develop a framework known as the Key Driver Diagram that you can see here. And the Key Driver Diagram includes evidence-based changes that participants could draw from to support them with their aims and priorities.

Participants gain the knowledge and quality improvement methods from faculty-- and most importantly, from one another-- by actively participating in three learning sessions. In between these learning sessions, there would be what we called action periods, where teams would have what they learn within their LIAs, and with the families that they serve.

So the Breastfeeding Home Visiting coIIN Collaborative included 11 LIAs across six MIECHV- - home visiting grantees including Florida, Michigan, Ohio, Rhode Island, Virginia, and Wisconsin. So I know many of you who have been involved with home visiting coIINs-- please chat in to the chat box your experiences and your reflections. We'd love to hear from you.

And key aspects that framed our work together included engaging parents to share their opinions and concerns about breastfeeding across all critical time points-- building capacity of home visitors to address breastfeeding barriers-- insure families are intentionally linked to appropriate breastfeeding support systems that met individual needs-- and ensuring internal policies are standardized to support breastfeeding practices among all families served by the program. As many of you know, the quality improvement-- there are three main questions we seek to answer. The first being-- what exactly are we trying to accomplish? That brings us to our smart aim that you can see here-- that 30% of infants are exclusively breastfed at three months, and 15% at six months.

The Driver Diagram is our theory, based on evidence, on how participating LIA can move toward testing change that wouldn't be a sustainable improvement. There is a lot of information on this slide including the farthest right column of high leverage changes and interventions that have been tested and then found effective in moving LIAs towards their smart aim. And because of our limited time today, I'll just provide a high-level overview.

We're really excited to have Sara join us today to share their work in Rhode Island as part of the breastfeeding collaborative as well. And that's really where, afterwards, you can really dive into our questions. Know that all the material through the collaborative is available to you. And I'll hear more on that shortly.

So I'd like to highlight the system components that we identified to close the gap in breastfeeding outcomes. These system components-- otherwise known as the five primary drivers listed on the previous slide-- they include active family involvement in infant feeding practices-- strong community linkages to breastfeeding support systems-- confident and skilled work forces to support breastfeeding-- standardized and reliable policies and practices for breastfeeding-- and comprehensive data tracking systems. In the simplest terms, we wanted to effect the process of breastfeeding by first ensuring support was available and appropriate to women who wanted to breastfeed-- that women had accurate information to make an informed decision that would confirm their intention to breastfeed-- and that women with an intention to breastfeed are successful, meeting their goals to initiate and continue breastfeeding.

Now the second question in quality improvement is always how will we know that a change is an improvement. This gets us to our measures. To measure progress towards the collaborative's smart aim, the home visiting coIIN developed common measures that LIAs report and analyze monthly.

These measures were aligned to the process of breastfeeding, as you see here. And so a few of those measures that LIAs reported on each month included the percentage of women with need for breastfeeding support identified this month who received peer or professional breastfeeding support-- the percentage of women who report intention to breastfeed-- the percentage of women who initiate breastfeeding-- among all enrolled women, percentage of women exclusively breastfeeding at three months. And these are just a few of those measures.

The home visiting coIIN playbook includes a charter, the Key Driver Diagram, change packages, and the measurement strategy. The charter is a written statement of the aim, and serves as a tool to engage stakeholders. The charter details what you all are trying to accomplish, and expectations for engagement of stakeholders as committed, ready partners to achieve a shared goal or vision.

And we've already discussed the Key Driver Diagram. The change packages included in the breastfeeding playbook are specific change ideas for each of the primary drivers with successful examples of PDSAs that LIAs engaged in, along with access to tools and resources developed as a result of the PDSAs. This is a tremendously robust and exceptional tool. And in quality improvement, we believe stealing shamelessly supports all to grow and rapidly spread learning-- so definitely check it out.

And the measurement strategy includes all the measures that I briefly touched upon-- plus others-- that the participating LIAs reported on monthly. I was excited to see that Dr. Mary Catherine Arbour is also on the call, who is the Improvement Advisor for home visiting coIIN-- so Mary Catherine, please feel free to jump in at any point. And please be available as well at the end for any questions that may come up. I know I already see one in the chatbox about collecting data on extended breastfeeding.

But here, what I wanted to highlight on this slide, where four key measures and their corresponding run charts that illustrates the impact of the home visiting breastfeeding collaborative. Greatest progress was made in supporting home visitors to gain knowledge and confidence to promote recommended infant feeding practices, with over 90% of home visitors trained in infant feeding and lactation. We observed that over 80% of mothers reported an intention to breastfeed. This is extremely critical, because-- as we know from research-- women that have an intention to breastfeed are much more likely to initiate.

And one of the measures that I, personally, find such excitement over is the bottom run chart that shows a steady increase in the percentage of women with an infant feeding plan written prior delivery. My work with the Boston Healthy Start Initiative focused on supporting women who indicate an intention to breastfeed, meet their infant feeding goal through the development of an infant feeding plan-- a plan that, when developed early and iteratively, serves as a critical tool to facilitate discussion, engage formal and informal support, empower women to advocate for

themselves, and documents clearly what their intentions are including supporting the ten steps to breastfeeding-- like holding their baby skin-to-skin, and roomings in-- and what their plans are around initiation, and exclusivity, and duration. And those are just to name a few.

This work is actually based on your guide to Breastfeeding that Dr. Meek actually referenced earlier, so it's really-- it's a tool that's out there, that supports existing resources that are free to all of you. As all good planners know, the more you plan-- and create a detailed one-- the more likely it is to be achieved. So I'm really excited by that final-- that run chart there on the bottom.

The Breastfeeding Collaborative actually also began to see a shift in exclusive breastfeeding at three month from 3% to 15%. That is a remarkable change in the right direction. Another great strength of the home visiting coIIN was setting expectations that LIAs will share their data-- their wins, failures, and struggles-- with each other. This creates a community where all teach, all learn-- and to me-- is one of the critical underpinnings of quality improvement learning collaborative.

This slide illustrates examples of highly successful changes for each driver. You'll be hearing more details in a few of these from Sara. But I want to just briefly highlight a couple here.

So a successful change, for example, under primary driver one-- to support LIAs to have more reliable and effective policies and practices for breastfeeding-- was a breastfeeding questionnaire administered during critical time points that was developed and tested. Under primary driver two-- an effective test of change to build confident and skilled work force-- included developing and testing a policy to train home visitors in infant feeding and lactation within three months of hire, and tracking that.

For primary driver three-- strong community linkages to breastfeeding support systems, including coordination with joint visits with WIC-- and I briefly shared, in the previous slide, the use of the Boston Infant Feeding Toolkit as a successful change for primary driver four-- active family involvement in infant feeding practices. Finally, for primary driver five, comprehensive data tracking system for breastfeeding-- one successful change that was developed and tested is a process to review breastfeeding run charts during weekly team meetings. And this change helped to build buy-in-- increase the belief that a change would lead to improvement, and increase staff comfort level with data to promote and learn from their work.

All of the highly successful changes i just shared-- plus more-- are available as resources in the home visiting breastfeeding toolkit that's found in this link here. And after such wonderful work and leadership by Mary McLane, know that you can also contact her for more resources-- but a big shout out to Mary for all of the work that she did in driving this forward. The slides are also available to you at the file on the Adobe screen. And it will be available on MIECHV portal. So you can easily access the hyperlink there later.

And quickly, this is a snapshot of the change package, including links to specific PDSAs and tools that you would have access to through the home visiting coIIN website. So with that-- I know I went through that quite quickly, but I want to make sure that Sara has some time to give

you specific examples of what they did in Rhode Island. There's a lot of information that we shared.

But we'll have an opportunity to get into questions afterwards. Please feel free to put them into the chat box in the meantime. But at this point, I'd like to turn it over to Sara, who will share with us the work done in Rhode Island as part of the breastfeeding collaborative. Sara?

Thank you, Elaine. And I just want to say thank you to Dr. Meek-- but also to Elaine and Mary Catherine Arbour. Rhode Island relied heavily on both of your expertise as we were doing our coIIN work. And we could not have done it without both of you. So thank you.

I'm going to talk a little bit today about Rhode Island's experience with the breastfeeding coIIN. As everyone knows, we're a small state. It's a little bit easier for us to get together in person to do this work. But that being said, we think some of the ideas and strategies that we implemented could be done at any state.

So we focused our breastfeeding work with four agencies that are listed on your slide. They represent each section of Rhode Island. We have agencies in the southern part of the state, in the Newport area, and also in our urban core. And one of the things that we did when we first started with our coIIN project is to pair each local implementing agency with a CQI coach, so that each agency had some dedicated and regular support from one point person at our team at the Department of Health.

All of our sites actually happen to be Healthy Families America agencies. That wasn't necessarily by design-- but just given where we were with our implementation and MIECHV, and our agency capacity to take on and participate in the coIIN. They had just-- by chance-- ended up being Healthy Families sites.

So we relied very heavily on the Key Driver Diagram, and actually found all four of the components that Elaine just mentioned-- the charter, the Key Driver Diagram, the change package, and the measurement system-- really helpful in our work. I remember the first time that we were at the first coIIN learning session, and working on the charter with our agencies. And that, in itself, was a really interesting process-- with our sites really having to think about what it was they wanted to improve and how they wanted to improve it. So even in that process alone, and the support from the coIIN faculty, was instrumental in our sites being successful and being able to put together their test of change and their measurements.

So I've called out some of the strategies that each of our four agencies have done. And the picture on the slide is our agency-- Community Care Alliance-- in the Woonsocket area-- which is in the Northwestern part of Rhode Island. I think one of the surprising things that we just assumed as a state when we started, is that each one of our agencies had a standardized protocol that when they started talking with families about breastfeeding.

We also have NST in Rhode Island-- as well as Parents as Teachers-- so we just made this assumption that-- great, it's covered during orientation. They all do it at the same time-- and no. So one of the things that has happened, is we have standardized policies and procedures on when

and how to introduce breastfeeding, and when breastfeeding support will be offered and provided.

One of our sites-- actually a few of our sites really strategized and did a lot of PDSAs about when the proper time is to introduce the feeding conversation, and decided that for them, the best thing that worked was having an initial conversation at intake. And for those moms that expressed an interest in breastfeeding, we had an appointment in their home as part of a home visit with a certified lactation counselor.

Most of our agencies also put together a list of breastfeeding benefits, and also a resource list. I was thinking about Dr. Meek, in her presentation earlier, about the cost benefit, and how much money you save by breastfeeding versus formula feeding. And some other agencies-- actually almost all of our agencies to this day still use some kind of document that shows the financial incentives to breastfeed versus formula feed. So we've done that.

We've also provided a basic training to all of our staff. So we've had different iterations of the training that our staff are receiving. Many of our staff have done the Wellstart training. And many have also then gone on and gotten their-- participated in CLC training.

The other thing that we did, is we were more intentional with our collaboration and our alignment with WIC. That goes for both the state level, and also at the local implementing agency level. We're fortunate here at the Department of Health where my colleagues in WIC sit 10 feet away.

So our alignment with WIC became much more intentional because of coIIN. And then our agencies were able to do some more direct work with the WIC sites in their agency. And many of our home visiting agencies actually have WIC sites in their own buildings.

Some of the fun things that happened were breastfeeding brunches. A few of our sites began holding regular breastfeeding brunches-- either on their own, or in collaboration with other programs, such as Early Head Start. And what was really wonderful is that we were able to have WIC staff on site-- including the WIC peer counselors and some of the nutritionists-- and really have it be a team celebration, not just a home visiting families celebration.

Other strategies that we tested was accompanying the family to a pediatric and or OBGYN appointment to support the feeding plan. We found this actually to be a very effective strategy, where families, and the family visitors, and the OBs, and the pediatricians were all on the same page about the families feeding intention. We also did self-efficacy scales with the parents-- with the moms. And most of our sites completed a My BFT-- a 3 question breastfeeding tool-- with families.

And this is just an example of the questionnaire that one of our sites used. It is available on the coIIN website. And this is a questionnaire that some of our sites used with families about their intention to breastfeeding-- their feeding plan.

One of the things that many of our sites found useful was including the family in this, and asking families-- or asking moms-- who would be available to support them during their-- with their breastfeeding plans, and what barriers might get in the way to them breastfeeding. So those conversations by themselves were very helpful.

Lessons learned-- we had a lot of lessons. There are probably too many for this slide. But some of the wonderful things that happened, is that-- as a culture in our family visiting programs-- we had an increased knowledge and enthusiasm about the breastfeeding. And that happened at the individual LIA level, but it also happened at the family visiting statewide level.

And as part of those conversations, we were able to take the time to actually review our current processes, and standardize those. I started off at the beginning by saying, you know, we just assumed that agencies had standardized policies and procedures about when they're going to talk about breastfeeding-- and even if they did, were they being implemented. So this was a wonderful time for us to, kind of, standardize that work.

It also set us up for success with the MIECHV benchmarks. Our old benchmark related to breastfeeding was exclusively breastfeeding at 12 weeks. And many of our sites struggled with improving on that benchmark. So the coIIN work that we were doing set that benchmark very nicely at the time. And now we feel like we're in even a better position to meet the revised breastfeeding benchmark of any breastfeeding at six months of age.

We also love the spread model. And, as Elaine said, CQI is really about stealing shamelessly. And so we actually wholeheartedly believe in that motto, and have shared that with our LIAs that were not able to participate in coIIN.

In Rhode Island, we have monthly model meetings. So the supervisors either from HFA, PAT, and NFP get together with their model contact at the Department of Health. And CQI is always on the agenda. And the enthusiasm for what LIAs shared with other LIAs that were not participating in coIIN-- and even those that were participating in coIIN-- actually started to take up a significant portion of our meetings, because there were so many ideas shared. And so stealing shamelessly happened and continues to happen at all of our meetings.

It was also a really wonderful opportunity-- these model meetings-- because sites would tell you, OK, what didn't work. What worked. And knowing that it was OK to try something and say that it didn't work-- but sometimes another agency would try something and said, OK, we did it, but we just tweaked it like this based on what we learned from you, or from another agency-- so that was really-- that's been really key.

And then we were able to see that we had a huge demand as we were doing coIIN for CLC training. And I've seen a lot of questions about CLC training in the chat. It is something that many of our family visitors did in conjunction with WIC staff in Rhode Island. The bonding that occurred as staff went through CLC training together was pretty amazing. But now we have a real dynamic work force that feels prepared to talk about breastfeeding, and a new cadre of CLCs that are out there in the community.

We mentioned earlier that the partnership with WIC is key. Our work with our state breastfeeding coordinator-- Ashley [? Beller-- ?] was much more intentional than it was before we began this process. And there's just a quote from her about increasing breastfeeding support throughout the state, and our building our capacity-- Ann [? Boronne, ?] our WIC Program Director.

Many of our participants in family visiting are also the same WIC participants. And families even commented to us that they felt better supported in breastfeeding from both now WIC and family visiting, because of this shared messaging, and the support that they were getting from both family visiting and their WIC sites.

The CQI continues in Rhode Island even without participating in the breastfeeding coIIN, and specifically focusing on breastfeeding. As I mentioned earlier, we talk a lot about CQI at our individual model meetings, so that's really helped embed a CQI culture within all of our agencies. So we only had four sites participating in breastfeeding coIIN. But each of our LIAs-- whether they participated or not-- has done something now related to CQI in breastfeeding.

We love a process map in Rhode Island. We process map many topics. And so you can see it up there, we do love our process maps. And so we will go to the process map when we can-- if we're running into barriers, or there's something that we want to talk through.

And the participation in coIIN actually led us to have a state-led collaborative. We just finished another CQI collaborative focused on family engagement. And we've also been able to develop our own expertise here at the Department of Health through our participation in the HV coIIN. We've had really great leadership from the coIIN faculty that have really prepared us for that. And that's it.

Well thank you, Sara. But I don't want to close out, because we have this time that we've been able to carve out at the end for a dialogue among us-- for you, and for Elaine, and for Dr. Meek-- you know, we tried to-- thank you Dr. Meek for responding to questions in the chat, or comments in the chat. I know we didn't get to everyone, but we haven't had a chance to also open it up for comments or questions about the coIIN work that you were leading as faculty Elaine, or the work that you did in Rhode Island. So let's see if folks have comments.

So I'm looking at the comment from Denise. Don't know if anyone wants to respond to that, just because it's at the top of the pile. And she's commenting on a troubling trend.

Oh, I--

Looks like lots of people are writing back. I'm sorry, go ahead.

I was just going to say, having the right to breastfeed, and feeling comfortable and supported in breastfeeding are two different things. A lot of individuals still do not know that we have right to breastfeed laws. We actually have a federal right to breastfeed law that says anywhere that the mother and her baby have their right to be, she is protected in breastfeeding. But there are also state laws as well. And whichever is the stronger one supersedes.

But you know, I think social media has been a good route to try to address some of these issues, whether it's a particular business, a particular location, a museum, a store-- you know, wherever it may be. Those mothers that feel empowered to do so have definitely been able to make some progress through the use of social media.

I think for mothers who already feel somewhat uncomfortable breastfeeding, breastfeeding in public for them can be more and more of a challenge. And some moms have these active babies that constantly, sort of, pop off the nipple and look around. So the mother may feel a little bit more exposed-- I mean there are definitely all sorts of wraps, and devices, and things to provide a little bit more coverage. But some of the state breastfeeding coalitions actually pass out some little cards-- kind of, business-sized cards that the mother can keep to actually show whoever might be addressing her that-- you know, what their state breast feeding law is. And I think that mothers who do experience those problems-- reporting it back to the state breastfeeding coalition can be helpful as well in terms of trying to address the problem.

But you know there are still people out there who don't want to see women breastfeed in public. They tend to not have much of a problem with other women's body parts being exposed in other arenas. But somehow, in the act of breastfeeding the baby, comes questionable or objectionable in some individual's minds. But I think it will get better over time-- the more women that we have breastfeeding, the better. And certainly, in other countries, it's-- you know, nobody thinks twice about the woman breastfeeding in public. But there's definitely [INAUDIBLE] here.

Thank you, Joan.

May I--

[INTERPOSING VOICES]

Other comments--

--just add--

Yes, please, I was--

This is Elaine. And I just wanted to echo Joan's comments regarding the use of social media. There's a lot of supports now on Facebook like mommies groups that really can be a resource to many of you that are working with families-- just to identify some local groups.

Because they're the support group that families can turn to at any hour. And it's really remarkable-- the kind of, just, energy and empowerment that that provides folks. So take a look at that for your local Facebook group, mother's groups-- those kinds of things. It really is remarkable.

Thank you, Elaine. Folks have questions or comments to build off of Sara's work and the work of her teams in Rhode Island?

May I say, I do see that Christine has a question regarding coIIN collecting data on extensive breastfeeding. And I'm just wondering-- Christine, I don't think Mary Catherine's on the line any more. But are you referring to breastfeeding beyond six months, 12 months, or even beyond that? Is that what you mean by extended breastfeeding? And you can often put it into the chat box.

If so, it's my understanding that we really are only collecting it up to six months. But we can also follow up with you on that.

Thanks, Elaine. I saw that question and wondered about circling back to that. So thanks for picking that up.

--like people are answering the questions in the chat box now.

They are. Any thoughts about hot topics-- about incarcerated moms-- which was a hot topic in New Mexico and in Colorado around marijuana use in the state that has legalized marijuana?

Well for the incarcerated mom in general, I think--

[AUDIO OUT]

Joan, I think we lost you.

Oh. Hello?

Are you there? Yes, we can hear you now. You faded out for a bit.

Oh, sorry. I think in terms of the incarcerated mother, regardless of why she's incarcerated, it would be ideal if her right to breastfeed is still continued in spite of her situation. It's not her baby's fault that, you know, her mother happens to be-- his or her mother happens to be incarcerated. And I think we should be proactive in supporting that mother's right to breastfeed and that child's right to be breastfed whenever possible. There are definitely logistic challenges with that.

But I think the courts have pretty much-- for the most part-- have supported the child's right to be breastfed. I know I've been asked to weigh in-- just individually-- on some particular cases that have come up-- not only with incarceration, but with child custody situations that come up. But I-- you know, I think we should do what we can to support the incarcerated moms to breastfeed.

And I think, in terms of the drug use issue, it varies state to state-- in terms of removal of the child from the mother-- the potential legal action against the mother. But again, keeping that mother and baby together as much as possible, allowing the mother to breastfeed, sometimes is an impetus for change in terms of social behaviors. So you know, there's not an easy answer to that.

But you know, as a pediatrician, I would say I would like for that baby to continue breastfeeding in those situations as much as possible. But we sometimes have to advocate for policies that will

support that. And you know, the jail-- they might want to do it, but they don't necessarily know how to do it, or how to store breast milk. So that's another area where we might need to be of assistance.

There's a question about how to address hospital's lack of support with breastfeeding for new moms who are delivering. The hospital was not supportive [INAUDIBLE] here in the states-- or in a hospital that doesn't have Baby-Friendly policies.

Well there is a-- besides Baby-Friendly-- the Joint Commission. If the Joint Commission accredits the hospital, there is a mandatory perinatal care core measure on exclusive breast feeding. So even if the hospital is not working on Baby-Friendly, if they're a larger facility, they are supposed to be collecting data, and monitoring their exclusive breastfeeding rates.

You know, hopefully we'll see more and more hospitals that do actually implement the ten steps to successful breastfeeding. But you know, it can be an uphill battle for mothers in facilities where those ten steps are not in place, and where staff haven't been trained, and where formula feeding is the norm, and where skin-to-skin care doesn't routinely happen. So again, I think that's an area for advocacy, for those of us who work in or around the hospital systems, to try to get more facilities on board. And you know, I mentioned that the CDC has supported two major initiatives to get more hospitals designated as Baby-Friendly. And you know, I believe there may be another one, kind of, coming down the pipe.

So it's another opportunity for hospitals, potentially, to get some assistance in doing that with quality improvement steps-- to get those pieces in place. If the mother has a choice about where she delivers-- which she might not always have-- but if she does, going to a hospital that is either already designated as Baby-Friendly, or working on Baby-Friendly designation, she's probably less likely to encounter barriers in that particular situation. But for anyone that works within the health care system, I think we need to be very proactive about trying to get some of those policies changed.

Thank you, Joan. So, with apologies-- because I see that you all have been so responsive-- this is Nancy-- about typing in the questions for Jump Start the Brain. And I didn't want to distract you by moving the slides. But for our evaluation people who really diligently try and tie your pre and post-test responses together-- Kate, because we're getting close to the top of the hour-- when we have to stop-- could you just quickly pull up the polls. And if you would be kind enough to just respond.

Yes, there are racial and ethnic differences in breastfeeding. So we all are clear about that. The next one, Kate.

Choose the number to complete the sentence-- how many babies out of five in the US receive breast milk.

Kate-- I was going to ask you to broadcast that one. But you moved on. So for those of you who couldn't see, about 75% of you thought that the answer was four, which is the correct answer.

A mother's intention to breastfeed her baby prior to delivery-- does it affect rates of breastfeeding and initiation or duration? So the question is, does the statement to say that intention has no effect.

And I'll give it just a sec. But it appears that about-- it's been switching. About 80% of you think that the statement is false. And that is false. OK Kate, the last one.

Can I make a comment on that one, [INAUDIBLE]?

Yes please-- absolutely.

So while we know that mother's intention does impact her rates of breastfeeding, we also know that mothers who did not intend to breastfeed necessarily when they come into the hospital sometimes do start breastfeeding. So I think we need to, kind of, have an open mind about the mothers typically will make the decision and continue that. But sometimes, they can be changed in a positive fashion-- they didn't plan to breastfeed, but when they have a supportive environment, when they're at a Baby-Friendly hospital, they actually will sometimes change. And some of those moms actually will breastfeed for a long period of time, even though they hadn't planned to.

Thank you, Joan for that. So the last question is that, indeed, all states do have breastfeeding coalitions. So if that's not something that you were aware of, we encourage you to check that out in terms of making those connections. Thanks, Kate. You can pull it down.

And we have a link for-- if somebody could post it while I just close out the webinar-- for the link on the Wellstart. That would be great. So here is the link to our evaluation survey. And we've reached the end of our webinar, which we will now conclude. And we appreciate your responses to our evaluation poll, because your feedback is important to us.

But before we close, I wanted to just put in one more comment about a reminder to watch for our August home visiting home runs newsletter, which will be on breastfeeding. And we expect the release on August 22. There will be an article on the importance of breastfeeding from the American Academy of Pediatrics describing strategies from a learning community on breastfeeding led by the Association of State and Territorial Health officials, and how that applies to MIECHV programs, specifically, and then an article about the strategies that the Northeast Florida Healthy Smart coalition-- a local implementing agency-- has been using to improve its breastfeeding rates. And in addition, we'll have our monthly roundup of resources and the upcoming events.

So a big thank you to all of our presenters. We thank you for joining us today. We hope to see some of you at the all [INAUDIBLE] awardee meeting in September. And this concludes our webinar. Thank you for joining us. And thanks everyone for--