United States Lactation Consultant Association

2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560 USA
info@uslcaonline.org
www.uslca.org

CONTAINING HEALTH CARE COSTS HELP IN PLAIN SIGHT

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

Affordable Health Care Begins with Breastfeeding

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

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

United States Lactation Consultant Association

2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560 USA
info@uslcaonline.org
www.uslca.org

CONTAINING HEALTH CARE COSTS HELP IN PLAIN SIGHT

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

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

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

Ellen Chetwynd RN BNS IBCLC, RLC
Licensure and Reimbursement Committee
US Lactation Consultant Association
Carolina Global Breastfeeding Institute
UNC Gillings School of Global Public Health

United States Lactation Consultant Association
2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560 USA
Info@uslcaonline.org
www.uslca.org

Recommended Citation:
Gutowski JL, Walker M, Chetwynd E. "Containing Health Care Costs Help in Plain Sight. International Board Certified Lactation Consultants: Allied Healthcare Providers Contribute to the Solution." Morrisville, NC. United States Lactation Consultant Association, 2010.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Healthcare costs are skyrocketing, with the resulting emphasis on disease prevention. By providing immune protection and ideal nutrition, breastfeeding is a cost-effective means of disease prevention with the accompanying reduction in health care spending. Informed women are initiating breastfeeding at an increasing rate, from 26% in 1970 to 74% in 2009. However, many women struggle to maintain breastfeeding for as long as it is medically indicated and fail to achieve the intensity and duration of breastfeeding that they planned. This is due to poor access to effective breastfeeding support within the medical system, false and misleading infant formula marketing, and societal barriers including; lack of paid maternity leave, unsupportive places of employment, and cultural discomfort with breastfeeding. Consequently, health care dollars are spent on treating diseases and conditions that could have been effectively prevented by breastfeeding. In order to appropriately address this preventative health care gap and the excessive costs that result, consumers, health care providers, insurers and employers need to be able to identify and access qualified lactation consultants to provide services and protect quality of care.

The United States Lactation Consultant Association recommends:

- Recognition of the IBCLC certification for excellence in provision of lactation services
- Delineation of IBCLC-provided lactation services as distinct from other health care services in the medical system
- Credentialing of IBCLCs to standardize proven qualifications, identify sound practice strategies, and maintain appropriate oversight
- Reimbursement of skilled breastfeeding support provided by the IBCLC

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

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

HEALTH CARE COSTS ARE RISING

Burgeoning health care costs in the United States surpassed $2.5 trillion in 2009, accounting for 17.6% of the gross domestic product in the country (Figure 1)[1]. Rapidly rising health care costs have placed a significant strain on the systems used to finance it, including both public and private insurance programs. Curbing this growth has become a major priority of the government, insurers, employers, and consumers.

Hospital care and physician/clinical services account for 51% of each health care dollar spent. Chronic diseases are expensive to treat. They consume 75% of national health expenditures and are the leading causes of death and disability.[2] Obesity alone is found in 1 of every 3 adults and almost 1 in 5 children, costing the health care system an estimated $117 billion annually.[3]

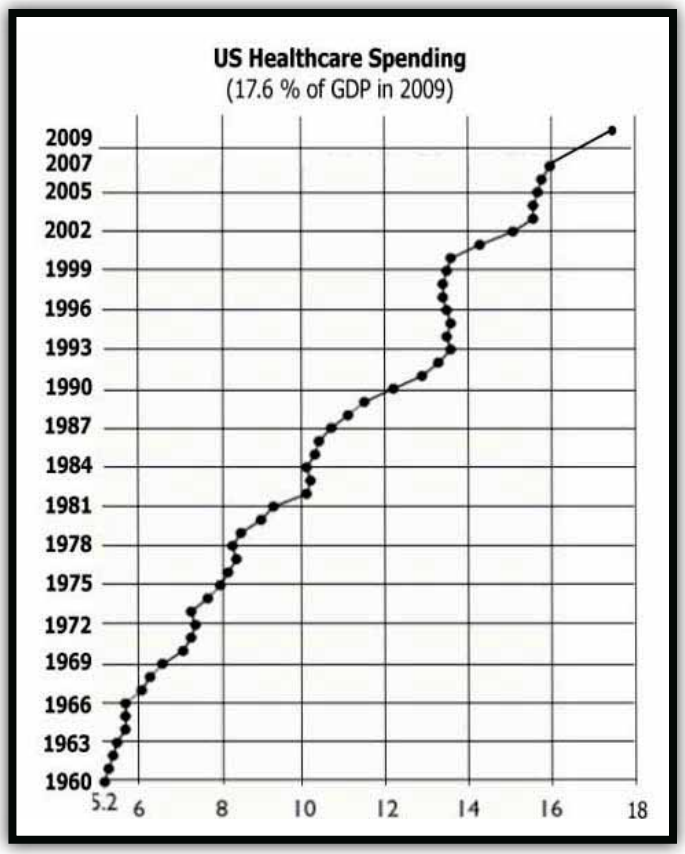

FIGURE 1 OECD HEALTH DATA 2009

[1] A Sisko et al., "Health Spending Projections Through 2018: Recession Effects Add Certainty To The Outlook" -- *Health Affairs* 28, no. 2 (2009): w346-w357.
[2] "Chronic Disease and Health Promotion," *Centers for Disease Control and Prevention*, 2009, http://www.cdc.gov/chronicdisease/overview/index/htm.
[3] "The Campaign to End Obesity-About the Campaign," *Campaign to End Obesity*, 2010, http://www.obesitycampaign.org/.

CAN WE DECREASE THE COST OF DISEASE TREATMENT?

Health promotion and disease prevention are effective tools to reduce the incidence of costly acute and chronic illnesses and conditions. Health care agencies have made recommendations to stop smoking, to increase exercise, and to improve general nutrition as the basis of health messages for many years. However they have recently recognized that infant and child nutrition at the outset of life has a strong influence on lifelong health. Authorities are emphasizing the need to promote breastfeeding exclusively for the first six months of life and for at least the first year or two as a part of a healthy diet. This optimal start for both health and nutrition is recommended by most major health organizations and government health agencies (Table 1). Breastfeeding confers reduced health risks across the lifetime for children and their mothers and can improve the quality of life for the entire community.

Table 1: Breastfeeding Recommendations from a Sampling of Professional Organizations

Agency or Organization*	Duration	Exclusivity
United States Department of Health and Human Services[4]	1 year, for as long as both wish	6 months
Centers for Disease Control and Prevention	1 year, for as long as both with	6 months
National Business Group on Health[5]	At least a year	6 months
American Academy of Pediatrics[6]	At least 1 year and beyond as long as mutually desired by mother & child	Approximately 6 months
American College of Obstetricians and Gynecologists[7]	Longer than 6 months and as long as possible	6 months
American Association of Family Physicians[8]	Breastfeeding beyond the first year should be supported as long as mutually desired	6 months
International Lactation Consultant Association[9]	2 years or more is normal. Women should breastfeed as long as they wish	6 months
American Public Health Association	At least 1-2 years and beyond	6 months

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

[4] KR Shealy et. al., "CDC Guide to Breastfeeding Interventions" (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2005), http://www.cdc.gov/breastfeeding/.
[5] National Business Group on Health: "Investing in Maternal and Child Health, An Employer's Toolkit," *Tools for Employers*, 2009, http://www.picosearch.com/cgi-bin/ts.pl.
[6] LM Gartner et al., "Breastfeeding and the Use of Human Milk," Pediatrics 115, no. 2 (2005): 496-506.
[7] ACOG Committee Opinion, "Breastfeeding: Maternal and Infant Aspects," *Obstetrics and Gynecology* 109 (2007): 478-480
[8] AAFP Breastfeeding Advisory Committee, "Breastfeeding, Family Physicians Supporting-Position Paper" American Academy of Family Physicians, (2008),
http://www.aafp.org/online/en/home/policy/policies/b/breastfeedingpositionpaper.html
[9] ILCA Publications - "International Lactation Consultant Association: Position Paper on Infant Feeding," *International Lactation Consultant Association*, 2010, http://www.ilca.org/i4a/pages/index.cfm?pageid=3314

HOW CAN BREASTFEEDING HELP IN HEALTH PROMOTION AND DISEASE PREVENTION?

Human milk is an important building block in human development. It provides perfect nutrition, and is important in the development of a healthy immune system and gastrointestinal tract.[10] Babies who are not breastfed, or who are breastfed for shorter periods of time, are exposed to higher disease risks as infants, children, and adults. Breastfeeding not only reduces the incidence and severity of acute and chronic diseases but is also a cost saving intervention for insurers and self-insured employers.[11] The Agency for Healthcare Research and Quality funded a review that found evidence for the significant reduction of multiple illnesses when a history of breastfeeding was present (Table 2).

Table 2: Risk Reduction for Childhood Illnesses with Breastfeeding[12]

Disease	% Reduction
Acute Otitis Media	50%
Atopic Dermatitis	42%
Gastrointestinal Infection	64%
Lower Respiratory Infection, Hospitalization Rate	72%
Asthma	27%
Overweight	4% for every month
Type I Diabetes	27%
Type II Diabetes	37%
Childhood Leukemia	19%

It is not only the breastfed children who benefit from breastfeeding. A mother who breastfeeds improves her health profile with increased total length of breastfeeding over her lifetime. This is likely to be related to the hormonal influences on the body during lactation.[13] Women who do not breastfeed after pregnancy demonstrate an increased risk for developing ovarian and breast cancer, diabetes, metabolic disease, and heart disease (Table 3).

[10] AM Stuebe, "The Risks of Not Breastfeeding for Mothers and Infants," *Obstetrics and Gynecology* 2, no. 4 (2009): 222-231.
[11] S Ip et al., "A Summary of the Agency for Healthcare Research and Quality's Evidence Report on Breastfeeding in Developed Countries," *Breastfeeding Medicine* 4, no. s1 (2009): s17-s30.
[12] S Ip et al., "A Summary of the Agency for Healthcare Research and Quality's Evidence Report on Breastfeeding in Developed Countries," *Breastfeeding Medicine* 4, no. sl (2009): s17-s30.
[13] Stuebe, "The Risks of Not Breastfeeding for Mothers and Infants."

Table 3: Maternal Risk Reduction from Breastfeeding	
Disease	**Risk Reduction**
Diabetes[14]	12%
Metabolic Syndrome[15]	8.4%
Ovarian Cancer[16]	21%
Breast Cancer[17]	4.3%
Coronary Artery Disease[18]	23%
Aortic Calcifications[19]	22%
Coronary Calcifications[20]	15%

Promoting, protecting and supporting breastfeeding medically and culturally have the potential to make a profound impact on health care spending and on the health status of the United States population.

WHAT IS THE ECONOMIC COST OF NOT BREASTFEEDING?

The cost of formula feeding to society is profound. In 2001, the USDA estimated that $3.6 billion would be saved annually on the treatment of otitis media, gastroenteritis, and necrotizing enterocolitis if the breastfeeding rates were moderately improved to meet the Healthy People 2010 goals of 75% initiating breastfeeding and 50% breastfeeding at 6 months.[21] This is a gross underestimate of the possible savings as it only covers three acute childhood illnesses, and does not bring breastfeeding rates to the level recommended by health organizations (see Table 1). Cost burdens for suboptimal breastfeeding rates include the following:

[14] KT Ram et al., "Duration of Lactation is Associated with Lower Prevalence of the Metabolic Syndrome in Midlife–SWAN, the Study of Women's Health Across the Nation," *Am J Obstet Gynecol* 198, no. 3 (2008): 268e1-268e6.
[15] Ibid.
[16] Ip et al., "A Summary of the Agency for Healthcare Research and Quality's Evidence Report on Breastfeeding In Developed Countries."
[17] Ibid.
[18] AM Stuebe et al., "Duration of Lactation and Incidence of Myocardial Infarction in Middle-to-Late Adulthood," *Am J Obstet Gynecol* 200, no. 2 (2009): 138e1-138e8
[19] EB Schwarz et al., "Lactation and maternal measures of subclinical cardiovascular disease," *Obstetric and Gynecology* 115, no. 1 (2010): 41-48
[20] Ibid.
[21] J Weimer, *The Economic Benefits of Breastfeeding: A Review Analysis*, Food Assistance and Nutrition Research (United States Department of Agriculture, 2001), http://www.ers.usda.gov/publications/fanrr13/.

- If 90% of US families complied with the medical recommendations to breastfeed exclusively for 6 months $13 billion could be saved annually and approximately 900 infant deaths could be prevented each year.[22]

- Assuming a 2-28% insulin dependent diabetes mellitus rate attributable to not breastfeeding, a low estimate of $1.19 billion, or a high estimate of $1.3 billion could be saved annually by improving breastfeeding rates, duration, and exclusivity.[23]

- $850 million per year in federal funds are spent by WIC to buy formula for families who could be breastfeeding.[24]

HOW IS THE UNITED STATES SUPPORTING BREASTFEEDING?

Breastfeeding rates in the United States are lower than they should be. At the 25th Anniversary of the Surgeon General's Workshop on Breastfeeding and Human Lactation, Steven K. Galson, MD, MPH, Acting Surgeon General at the time stated that, "Rates of exclusive and sustained breastfeeding remain low. Less than one-third of infants are exclusively breastfeeding at 3 months of age, and almost 80% of infants in the United States stop breastfeeding before the recommended minimum of one year. Furthermore, unacceptable racial/ethnic and socioeconomic disparities in breastfeeding persist"[25] (Figure 2).

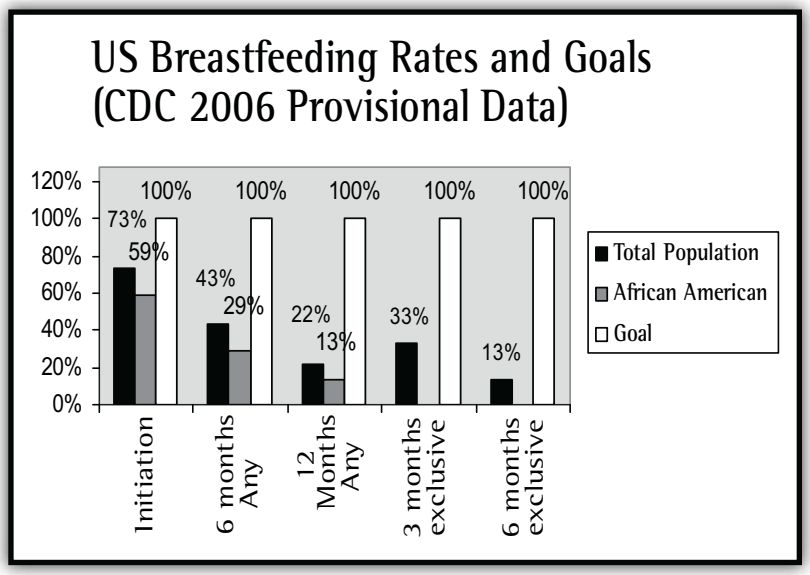

FIGURE 2

[22] M Bartick and A Reinhold, "The Burden of Suboptimal Breastfeeding in the United States: A Pediatric Cost Analysis," *Pediatrics* 125, no. 5 (2010): e1048-e1056.
[23] JM Riordan, "The cost of not breastfeeding: a commentary." *J Hum lact* 13, no. 2 (1997): 93-97.
[24] Z Neuberger, "WIC food packages should be based on science: foods with functional ingredients should be provided only if they deliver health or nutritional benefits," 2010, *Center on Budget and Policy Priorities,* http://www.cbpp.org/cms/index.cfm?fa=view&id=3201#_ftnref2.
[25] SK Galson, "Surgeon General Perspectives. The 25th Anniversary of the Surgeon General's Workshop on Breastfeeding and Human Lactation: The Status of Breastfeeding Today," *Public Health Reports* 124 (June 2009): 356-358.

In an effort to improve health and bring down the costs of preventable disease, many health care and government agencies are creating programs and policies to encourage higher breastfeeding rates.

- WIC food packages were adjusted in 2009 to provide greater incentives for continued breastfeeding.[26]
- The Joint Commission has added "Exclusive breast milk feeding during the newborn's entire hospitalization" to the Perinatal Core Measures Set. Exclusive breastfeeding was identified as most relevant to patient safety and quality of care.[27]
- The Surgeon General and the Department of Health and Human Services created a "Blueprint for Action on Breastfeeding" in 2000. This document is being updated and a new version will be released in the fall of 2010.[28]
- The US Department of Health and Human Services, Health Resources and Services Administration, created the Business Case for Breastfeeding; a program whose goal is to provide the materials needed to make workplaces more breastfeeding friendly.[29]
- The Centers for Disease Control and Prevention initiated the maternity Practices in Infant Nutrition and Care (mPINC) survey to evaluate and give feedback to hospitals regarding their success in providing evidence based practices that support breastfeeding.[30]

WHAT DOES THE NEW PATIENT PROTECTION AND AFFORDABLE CARE ACT SAY ABOUT BREASTFEEDING?

There are two sections in the new Patient Protection and Affordable Care Act[31] that are concerned with breastfeeding.

- Section 4207:" Reasonable Break Time for Mothers"
    - Businesses of greater than 50 employees provide unpaid break time, and a place other than a bathroom, for nursing mothers to express their milk up until a year of age.
- Section 2713: "Coverage of Preventive Health Services"
    - United States Preventive Services Task Force (USPSTF) recommendations for breastfeeding include; pre and postnatal breastfeeding education, formal breastfeeding evaluations undertaken by trained caregivers in the hospital and out patient care settings, followed by interventions to correct problems as needed.

---

[26] USDA National Agricultural Library: wicworks, "Breastfeeding Support, a Review," 2010, http://www.nal.usda.gov/wicworks/Sharing_Center/CO/BF_SupportReview.pdf.
[27] Joint Commission National Quality Care Measures, "Specifications Manual for Joint Commission National Quality Core Measures (2010A2)," 2010, http://manual.jointcommission.org/releases/TJC2010A/.
[28] Department of Health and Human Services and Office of Women's Health, *HHS Blue print for Action on Breastfeeding* (Washington DC: U.S. Department of Health and Human Services, Office of the Surgeon General, January 2010., 2000), http://www.womenshealth.gov/archive/breastfeeding/programs/blueprints/bluprntbk2.pdf.
[29] Office of Women's Health, "The Business Case For Breastfeeding - Steps For Creating A Breastfeeding Friendly Worksite," *Womenshealth.gov*, 2009, http://www.womenshealth.gov/breastfeeding/programs/business-case/.
[30] Centers for Disease Control and Prevention, *2007 Maternity Practices in Infant Feeding Care (mPINC) Sample Benchmark Report*, 2007, http://www.cdc.gov/breastfeeding/pdf/Sample_Benchmark_Report_text.pdf.
[31] C Rangel, *Health Care Bill - H.R.3590: Patient Protection and Affordable Care Act*, 2010, http://www.opencongress.org/bill/111-h3590/show.

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

USPSTF recommendations are based on evaluation of the quality and strength of the evidence for the service, the net health benefit associated with the service, and the level of certainty that this benefit will be realized if these services are provided in primary care.[32] Breastfeeding has a "B" rating within the USPSTF recommendations making this coverage mandatory for public and private insurers with no cost sharing requirements. Furthermore, USPTF recommendations have been adopted by Bright Futures, an initiative of the Maternal and Child Health Bureau of the Health Resources and Services Administration (HRSA). Bright Futures recommendations are supported and coordinated by the American Academy of Pediatrics.[33,34] Their joint mission is to improve the quality of health services for children through health promotion and disease prevention.

Despite mandates given to increase breastfeeding rate and duration, the healthcare system has lagged behind in the provision of breastfeeding support services. The Kaiser Family Foundation State Medicaid Coverage of Prenatal Services: Summary of State Survey Findings note that despite the recognition of the importance of breastfeeding in improving health, coverage of breastfeeding support services for low-income women is far from universal.[35] Their report from November 2009, stated that Medicaid covered breastfeeding education services in only 25 states; and even fewer, 15 states, covered individual lactation consultations.[36]

WHO SHOULD PROVIDE BREASTFEEDING SUPPORT?

Research shows that the role of the health care provider is critical to breastfeeding success.[37,38,39,40,41,42] Despite the US Breastfeeding Committee's Core Competencies in

[32] ND Calong et al., "Primary Care Interventions to Promote Breastfeeding: U.S. Preventive Services Task Force Recommendation Statement," *Annals of Internal Medicine* 149, no. 8 (2008): 560-564.
[33] Bright Futures and American Academy of Pediatrics, "Recommendations for Preventative Pediatric Health Care: Bright Futures Periodicity Schedule," brightfutures.aap.org, 2008, http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf.
[34] American Academy of Pediatrics, Section on Breastfeeding. "Breastfeeding and the Use of Human Milk." Pediatrics 115, no. 2 (2005): 496-506
[35] "State Medicaid Coverage of Perinatal Services: Summary of State Survey Findings - Kaiser Family Foundation," http://www.kff.org/womenshealth/8014.cfm.
[36] http://www.kff.org/womenshealth/upload/8014.pdf
[37] Calong et al., "Primary Care Interventions to Promote Breastfeeding: U.S. Preventive Services Task Force Recommendation Statement."
[38] Castrucci et al., "A Comparison of Breastfeeding Rates in an Urban Birth Cohort, "*Journal of Public Health Management* 12, no. 6 (2006): 578-585
[39] Castrucci et al., "Availability of lactation counseling services influences breastfeeding among infants admitted to neonatal intensive care units." *Am J Public Health* 21, no. 5 (2007): 410-415
[40] MJ Heinig, "The Cost of Breastfeeding Support: A Primer," *J Hum Lact* 17, no. 2 (2001): 101-102.
[41] MIC de Oliveira, LAB Camacho, and AE Tedstone, "Extending Breastfeeding Duration Through Primary Care: A Systematic Review of Prenatal and Postnatal Interventions," *J Hum Lact* 17, no. 4 (2001): 326-343
[42] US Department of Health and Human Services, *Healthy People 2010: Maternal, Infant, and Child Health* (Washington, DC: US Department of Health and Human Services, 2000), http://www.healthypeople.gov/document/html/volume2/16MICH.htm.

Breastfeeding Care for All Health Professionals,[43] many health care providers are unable to provide effective and appropriate lactation care and services because such training was absent in their academic preparation and/or has not been acquired through continuing education.[44] Deficiencies in breastfeeding management are seen in pediatricians,[45] obstetricians,[46] family practitioners,[47] clinic nurses and public health nurses,[48] pediatric nurse practitioners,[49] hospital staff nurses;[50] neonatal intensive care nurses,[51] and WIC personnel.[52] Furthermore, effective lactation support is time intensive with an average consultation lasting one hour.[53] These extended visits are often difficult for providers to accommodate as their time is already at a premium according to the American Journal of Medicine.[54]

Utilization of International Board Certified Lactation Consultants for breastfeeding support is a cost effective solution. They provide safe and effective care with resulting improvements in breastfeeding initiation, duration, and exclusivity—all of which result in reduced health care claims. Research has shown that IBCLCs have a positive effect on breastfeeding success (Table 4).Their clinical competencies encompass a broad range of lactation care and services.[55]

IT HAS BEEN ESTIMATED THAT 71% OF LACTATION CARE AND SERVICES CANNOT BE DEFERRED TO NURSING OR NON CLINICAL STAFF. [75]

[43] United States Breastfeeding Committee, *Core Competencies in Breastfeeding Care for All Health Professionals* (Washington DC, 2009).
[44] GL Freed et al., "National assessment of physicians' breast-feeding knowledge, attitudes, training, and experience. Breast-feeding education of obstetrics-gynecology residents and practitioners," *Journal of the American Medical Association* 273 (1995a): 472-476.
[45] LB Feldman-Winter et al., "Pediatricians and the promotion and support of breastfeeding," *Arch Pediatr Adolesc Med* 162, no. 12 (2008): 1142-1149.
[46] ML Power et al., "The effort to increase breast-feeding. Do obstetricians, in the forefront, need help?," *J Reprod Med* 48, no. 2 (2003): 72-78.
[47] GL Freed et al., "Breast-feeding education and practice in family medicine," *J Fam Pract* 40, no. 3 (1995c): 297-298
[48] KA Szucs, DJ Miracle, and MB Rosenman, "Breastfeeding knowledge, attitudes, and practices among providers in a medical home," *Breastfeeding Medicine* 4, no. 1 (2009): 31-42.
[49] P Hellings and C Howe, "Breastfeeding knowledge and practice of pediatric nurse practitioners," *Journal of Pediatric Health Care* 18, no. 1 (2004): 8-14.
[50] AM Nelson, "Maternal-newborn nurses' experiences of inconsistent professional breastfeeding support," *J Adv Nurs* 60, no. 1 (2007): 29-38.
[51] R Cricco-Lizza, "Formative Infant Feeding Experience and Education of NICU Nurses," *The American Journal of Maternal/Child Nursing* 34, no. 4 (2009): 236-242.
[52] AJ Khoury et al., "Improving breastfeeding knowledge, attitudes, and practices of WIC staff," *Public Health Reports* 117 (2002): 453-462.
[53] KA Bonuck et al., "Randomized, Controlled Trial of a Prenatal and Postnatal Lactation Consultant Intervention on Duration and Intensity of Breastfeeding up to 12 Months," *Pediatrics* 116, no. 6 (2005): 1413-1426
[54] GC Kane et al., "The anticipated physician shortage: meeting the nation's need for physician services," *The American Journal of Medicine* 122, no. 12 (2009): 1156-1162.
[55] Professional Practice - International Lactation consultant Association," *International Lactation Consultant Association*, 2010, http://www.ilca.org/i4a/pages/index.cfm?pageid=3354.

Table 4: Effectiveness of IBCLCs	
Setting	**Effect of IBCLCs on staff**
WIC	More mothers initiate breastfeeding[56]
Primary Care	Promote a longer duration of breastfeeding[57]
NICU	Breastfeeding rates 50% compared to 36% without an IBCLC[58]
Hospitals	2.28 times increase in the odds of breastfeeding at discharge[59]
Medicaid mothers with IBCLC contact in hospitals	4.13 times increase in the odds of breastfeeding at discharge[60]

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

[56] S Yun et al., "Evaluation of the Missouri WIC (Special Supplement Nutrition Program for Women, Infants and Children) breast-feeding peer counseling programme.," *Public Health Nutr* 13, no. 2 (2009): 229-237.
[57] SE Thurman and PJ Allen, "Integrating lactation consultants into primary health care services: are lactation consultants affecting breastfeeding success?," *Pediatric Nursing* 34, no. 5 (2008): 419-425.
[58] BC Castrucci et al., "Availability of lactation counseling services influences breastfeeding among infants admitted to neonatal intensive care units," *Am J Public Health* 21, no. 5 (2007): 410-415.
[59] BC Castrucci et al., "A Comparison of Breastfeeding Rates in an Urban Birth Cohort," *Journal of Public Health Management* 12, no. 6 (2006): 578-585.
[60] Ibid.

WHAT IS AN INTERNATIONAL BOARD CERTIFIED LACTATION CONSULTANT?

Lactation Consultants (IBCLCs) have been working in the health care field for 25 years in the United States and around the world. The certification can be added to an existing health care profession, or function as a stand-alone certification.

The IBCLC works in hospital maternity and pediatric care units to provide clinical lactation services and lactation education to staff. In the outpatient setting, lactation consultants work independently, or in medical practices or public health settings. Lactation consultants can be employed by corporations to provide work place lactation services or work for government or other health care agencies. Their expertise is used to develop and implement policies to support, protect, and promote breastfeeding. Some IBCLCs carry out breastfeeding-related research.

Depending on their background IBCLCs must have accrued 300-1000 hours of supervised lactation specific clinical experience and 45-90 hours of didactic education in human lactation and breastfeeding. Following this education and training, they must pass an independent criterion referenced exam which tests this knowledge and provides a standard for IBCLC certification.

Other training programs and certifications exist providing basic knowledge of counseling for lactation support. Generally these are 15 to 45 hour courses with no prerequisites.

IBCLCs are specifically trained to deliver clinical lactation services. However, although utilization of the IBCLC has been recommended by the Centers for Disease Control and Prevention, they note that a lack of third party reimbursement for the IBCLC is a barrier for many women requiring professional lactation services.[61]

[61] Shealy et al., "CDC Guide to Breastfeeding Interventions." *US Center for Health and Human Services:* Center for Disease Control (2005)

WHY IS HEALTHCARE SUPPORT OF BREASTFEEDING IMPORTANT?

Breastfeeding has been called the great equalizer, providing the best start in life regardless of the social or economic background of the family. It is also a healthcare equalizer, reducing the need for later health care services. Human milk is free and nutritionally adapted to the needs of infants and children worldwide, despite the quality of a mother's diet or her socioeconomic status. A woman does not need to be wealthy to provide her baby with her own milk but in doing so she provides superb nutritional, immunologic, developmental, psychological, social, economic, and environmental advantages.

Women are significantly more likely to achieve their breastfeeding goals if they are supported prenatally, in the maternity care facility and after discharge. A new mother can be hormonally labile, recovering from surgery and/or birth, suffering from fatigue, and learning how to fit a baby into their lives. If breastfeeding problems exist, women confront them every two or three hours around the clock. Difficult breastfeeding is grueling, and if support is not initiated immediately, the breastfeeding relationship can be lost within a matter of days or sometimes even hours affecting that mother, child, and family's future for the rest of their lives. The support she needs is typically limited to a few visits, with rare cases requiring prolonged assistance.

The most common problems treated by IBCLCs are suppressed lactation, latching difficulties, pain, slow weight gain, oversupply, and jaundice.[62] Li et al identified 35 different self-reported reasons that mothers wean in the first year.[63] IBCLC support could impact all of these reasons to wean with evidence-based clinical interventions and proper follow-up.

Women who want to breastfeed and are unsuccessful in achieving their goals can be reminded of their loss each time they give their baby formula, experience an infant illness, or see other women breastfeeding. A family with breastfeeding issues needs access to lactation support locally and quickly with minimal effort. A small investment in lactation care and services early in a child's life reaps a long term positive return on investment.

[62] BA Curtis, "Integrating Breastfeeding Advocacy within a Pediatric Practice: A Financially Viable Model Presenter," in *Southwestern Division, Pediatric Alliance* (presented at the 8th annual forum for improving children's healthcare national initiative for children's healthcare quality thrive together, Grapevine, TX 2009).

[63] R Li et al., "Why mothers stop breastfeeding: mothers' self-reported reasons for stopping during the first year." *Pediatrics* 122, no. Suppl 2 (2008): s69-s76.

IS REIMBURSEMENT FOR LACTATION CONSULTANTS COST EFFECTIVE?

One study done by the Commonwealth of Virginia analyzed the cost of standard provision of breastfeeding services and equipment to medical assistance clients and found that it was at least cost neutral. They determined that given the overwhelming scientific evidence regarding the benefits of breastfeeding, and the fact that the services provided are at least cost neutral and likely cost saving, the Medicaid State Plan should cover comprehensive breastfeeding services, including supplies and education for Medicaid recipients.[64]

The highest concentration (45%) of flat fees for outpatient lactation consultant's services range from $50-110 (median cost $80) per counseling session.[65] If 1000 never-breastfed infants are covered by a health insurer, up to $614,000 would be expected to be spent for just the three acute childhood illnesses in the first year of life as described by Ball and Wright.[66] The National Business Group on Health recommends insurance coverage of up to five postpartum lactation consultant visits per pregnancy delivered by an IBCLC. If 1000 breastfeeding mothers received five lactation consultant visits at $80/visit, the $400,000 spent for this care still represents a cost savings to insurers $214,000 if the lactation services are fully covered.[67] It is estimated that approximately 30% of breastfeeding mothers' would need outpatient lactation consulting services[68] for breastfeeding difficulties, lowering insurance expenditure to $120,000 and saving $494,000 in health care expenditures.

Often mothers must pay out of pocket for breastfeeding support services. This creates disparity in care placing vulnerable populations at the greatest risk for breastfeeding failure. It contributes to low breastfeeding rates among lower socioeconomic status and African American mothers leaving these populations at greatest risk for increased health care needs from infancy through the lifespan.[69]

---

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

[65] United States Lactation Consultant Association, "Lactation Consultant Survey" (Private Communication, 2009).

[66] TM Ball and Al Wright, "Health Care Costs of Formula-feeding in the First Year of Life," *Pediatrics* 103, no. 4 (1999): 870-876.

[67] "NBGH: Investing in Maternal and Child Health Toolkit," (2009) http://www.businessgrouphealth.org/preventive/topics/breastfeeding.cfm#10

[68] KG Dewey et al., "Risk Factors for Suboptimal Infant Breastfeeding Behavior, Delayed Onset of Lactation, and Excess Neonatal Weight Loss," *Pediatrics* 112, no. 3 (2003): 607-619

[69] KS Scanlon et al., "Racial and Ethnic Differences in Breastfeeding Initiation and Duration, by State --- National Immunization Survey, United States, 2004--2008," *Morbidity and Mortality Weekly Report*, 2010.

HOW ARE LACTATION CARE AND SERVICES CURRENTLY REIMBURSED?

Professional IBCLCs currently obtain reimbursement in a variety of ways generating a wide range for billed charges and payments received.

Employers, such as hospitals, doula services and WIC agencies provide in-patient and/or out-patient lactation support. Commonly the work of the IBCLC is rolled into the total cost of care without a separately identifiable cost center. In these situations there is no billing for the service and no reimbursement. This regularly causes inadequate lactation consultant staffing or no staffing due to budgetary constraints.

Lactation services are sometimes billed as nurse visits in medicals settings. These visits are reimbursed, but do not accurately identify the provider as an IBCLC or the service rendered. They often result in departmental revenue losses because of the low level of reimbursement available for nursing care. Lactation programs have been discontinued due to negative financial outcomes in these cases.

An independent, outpatient IBCLC may bill using standard Healthcare Common Procedure Coding System numbers (HCPS) and Diagnosis Codes (ICD-9) from a medical super bill.[70] The clients typically will be self-pay and are provided with paperwork to seek reimbursement on their own. Billing usually is done under registered nurse (163WL0100X) or specialist (174400000X) National Provider Identifier (NPI) numbers or under another NPI category that is not reflective of the IBCLC credential or service provided. It is difficult to obtain any or appropriate reimbursement for those independently billing with these NPI Categories.
IBCLCs working in the outpatient care setting within the medical care system who possess credentials such as physician, nurse practitioner, or dietician can bill commensurate with these credentials and their services will be covered by insurance at the usual professional rates. IBCLC services are also sometimes billed “incident to” another licensed and reimbursable health care professional under established patient visit codes and billing criteria. When the physician and IBCLC “share” the same patient on the same day their work is combined and billed under the MD at 100% of the fee schedule. The physician must provide a face-to-face portion of the evaluation and management service.[71] IBCLC / physician “shared visits” provide a “work around” for the lack of reimbursement otherwise available for the service, but necessitate complicated and sometimes limiting patient flow strategies. These physician’s rates are not cost-effective for insurers because lactation services could be provided at lesser rates by IBCLCs than by physicians.

Additionally, insurers often do not consider lactation education or consultations a medical necessity, and / or it is not a covered benefit.

---

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

DOES THE CURRENT SYSTEM PROVIDE SUFFICIENT LACTATION SERVICES?

Lack of financial reimbursement for IBCLC services has resulted in poor availability of IBCLCs in health care and public health care systems.

General staffing guidelines typically have referred to the statistic of 1 FTE per 1000 deliveries at birthing facilities. This number only represents the 3-5 day window of care during the hospital stay. The CDC Breastfeeding Report Card uses a ratio of the number of IBCLCs per 1000 births as a process indicator for breastfeeding support. Unfortunately, this number does not take into consideration the number of hours worked by the IBCLCs.[72] An unpublished survey by the United States Lactation Consultant Association identified that the majority of IBCLCs in all settings work part-time.[73] An IBCLC on staff working 10 hours a week is far different than one working 40 hours a week and has a powerful impact on level of lactation support.

Recently, Mannel and Mannel (2006) identified breastfeeding support needs and recommended staffing ratios for birthing facilities based on data collected over a two year period from a large tertiary care teaching hospital.[74] Francis-Clegg and Francis (2010) also report data collected from time studies used in a lactation staffing analysis for a corporation of 23 hospitals over a year. Results of both analyses of the time needed to provide care were similar[75] at one Full Time Equivalent (FTE) for approximately 780 births only for the hospital stay. Additional staffing is required for NICU admits 1 FTE/ 235 infants, as well as outpatient consultations and telephone follow-up, education, program development, administrative tasks and research.

Francis-Clegg and Francis delved further into the job responsibilities of lactation consultants and identified some lactation services which could be effectively performed by bedside nurses IF they received excellent lactation support training. It was determined that 71% of the tasks still needed to be delegated specifically to the IBCLC.
Suitable lactation consultant staffing remains elusive as poor breastfeeding outcomes clearly indicate more services are needed.

---

[72] Centers for Disease Control and Prevention, "Breastfeeding: Data: Breastfeeding Report Card | DNPAO | CDC," CDC: *Breastfeeding*, 2009, http://www.cdc.gov/breastfeeding/data/report_card.htm.
[73] C Chamblin, "Survey Results: Reimbursement for Lactation Consultants," 2007.
[74] R Mannel and RS Mannel, "Staffing for Hospital Lactation Programs: Recommendations From a Tertiary Care Teaching Hospital," *J Hum Lact* 22, no. 4 (2006): 409-417.
[75] S Clegg, "Justification for the Lactation Consultant Role" (presented at the International Lactation Consultant Association Conference, Philadelphia, 2006).

SUMMARY

Breastfeeding is a low cost and effective preventative health measure.

Government agencies and other health organizations recommend exclusive breastfeeding for 6 months, the addition of complementary foods at that time, and breastfeeding continuing for 1-2 years for optimum nutritional benefits and provision of life-long immunities. The importance of breastfeeding is reflected in policy statements and activities in government agencies, as well as inclusion in the Patient Protection and Affordable Care Act.

Statistics show breastfeeding duration and exclusivity is far below recommended levels. This disparity is a reflection of the low level of support provided to breastfeeding women from within the healthcare system.

Lactation consultants with the IBCLC credential provide high quality and cost effective care to breastfeeding families, but in order to provide equitable breastfeeding support to all families, IBCLCs must be fully integrated into the health care system and appropriately reimbursed. Consumers, health care providers, insurerers and employers need the ability to identify and access qualified lactation consultants to provide services and protect quality of care.

RECOMMENDATIONS

The United States Lactation Consultant Association recommends:

- Recognition of the IBCLC certification for excellence in provision of lactation services
- Delineation of IBCLC provided lactation services as distinct from other health care services in the medical system
- Credentialing of IBCLCs to standardize proven qualifications, identify sound practice strategies, and maintain appropriate oversight
- Reimbursement of skilled breastfeeding support provided by the IBCLC

For more information contact:

United States Lactation Consultant Association
WWW.USLCA.ORG

2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560 USA
Phone: 919-861-4543
Email: Info@uslcaonline.org