Breastfeeding Support

Community Clinics and the Affordable Care Act Requirements

As healthcare reform rolls out, there is an urgent need for prevention strategies to reduce costs and improve health outcomes. Promoting and supporting breastfeeding is a key opportunity for community clinics and health centers to enhance the health of babies and their mothers and prevent future disease, while meeting important requirements of the Affordable Care Act. This brief offers clinics a roadmap for successful implementation of breastfeeding care requirements in the ACA.

The Value of Breastfeeding

Because of the numerous health benefits of breastfeeding for both infant and mother, national and international public health organizations recommend that women feed their infants breast milk exclusively for at least the first six months of life.[1] Infants who consume breast milk receive greater protection against infections and disease than infants who do not consume breast milk.[2] Breastfed infants also receive more protection against a number of costly chronic illnesses, including obesity and asthma, than babies who are not breastfed.[3] Compared to other obesity prevention strategies, breastfeeding appears to provide long-lasting protection. Recent studies show that infants who breastfeed for at least nine months experience a lower risk of obesity for at least a decade.[4]

For mothers, breastfeeding adds protection against breast and ovarian cancers, and against type 2 diabetes.[5] Moreover, lactation burns calories, helping the mother return to pre-pregnancy weight.[6]

Despite these recommendations and advantages, however, fewer than 16 percent of postpartum women are able to maintain exclusive breastfeeding for six months.[7]

Breastfeeding Support and the Affordable Care Act

The implementation of the Affordable Care Act (ACA) requires breastfeeding support—described as comprehensive support and counseling from trained providers as well as access to breastfeeding supplies for pregnant and nursing women[8]—as a Clinical Preventive Service.[9] Although welcomed by mission-driven clinics and health centers, this requirement arrives amid tight deadlines to expand services and institute other major changes.

For several years, WIC agencies and worksites have been developing and testing practices to ensure effective care and support for breastfeeding from the prenatal period through return to work or school. Now, however, implementation of the ACA offers new resources and incentives for community clinics and health centers to vastly improve their own breastfeeding support to patients.

A Policy Update on California Breastfeeding

Produced by the California WIC Association

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Expanding support and services for breastfeeding will advance efforts to meet the Triple Aim framework, the Institute for Healthcare Improvement's foundation for successful health care reform.[10] The Triple Aim requires:

- Improving the patient experience of care
- Improving the health of populations
- Reducing the cost per capita of health care

This brief focuses on how clinics can bolster internal breastfeeding support while contributing to efforts to achieve initiatives such as implementing Patient-Centered Medical Homes, improving customer experience, generating revenue, fulfilling "meaningful use" criteria, and achieving accountable care status. The brief stresses the value of strengthening collaborations with allied community health providers, especially WIC.

Patient-Centered Medical Home

For community clinics immersed in the process of achieving National Committee for Quality Assurance(NCQA) certification as Patient-Centered Medical Homes (PCMH),[11] implementing breastfeeding support satisfies requirements of the PCMH model, particularly if they utilize the expertise of International Board Certified Lactation Consultants (IBCLCs), who offer breastfeeding expertise for both patient care and ongoing staff training. The PCMH model emphasizes:

- Better coordination of care for breastfeeding mothers through referral systems between WIC/community clinics and hospitals
- Training for medical and ancillary staff in obstetric, family practice, and pediatric care to support breastfeeding
- Appropriate staffing as IBCLCs join the care team, either by staff obtaining certification as IBCLCs or, preferably, IBCLCs being hired as ancillary staff

With all obstetric, pediatric, and family practice staff trained in basic breastfeeding support, and IBCLCs available for patient care and ongoing staff training, clinics will provide quality maternity care, as do hospitals and WIC clinics that have taken this comprehensive approach.[12] Better maternity care, in turn, improves mothers' self-management for infant feeding as well as patient satisfaction with clinic maternity services. Finally, improving breastfeeding support bolsters staff confidence and competence.

Generating Revenue: Team Care and Service Reimbursement

Many clinics are adopting the strategy of assigning patients to medical providers and creating a panel, or team, of providers for patients. With all providers and staff responsible for breastfeeding support, and with IBCLCs on staff, providers can manage visits for breastfeeding or refer to IBCLCs for complex problems. In this way, highly trained, but lower-cost, IBCLCs, working with medically licensed providers, can increase points of care and billing opportunities.[13] Estimated clinic reimbursements for IBCLC care and IBCLC costs are shown in Table 1.

Table. 1. Estimated Clinic Reimbursement for IBCLC Care Compared to IBCLC Costs

Lactation Visits	*Breastfeeding Visits**	*30 Patients/ Month***	*Annualized Expense*
Minimum Visits	1	$3,750	$45,000
Average Visits	2	$7,500	$90,000
Maximum Visits	3	$11,250	$135,000
IBCLC $25-$50/hour***	20 hours/week		Salary: $26,000-$52,000 Benefits: $7,800-$15,600

* *Prenatal, postpartum, pediatric, or family practice*

** *At $125/hour Federally Qualified Health Center rate. Reimbursement rate is specifically calculated for each FQHC.*

*** *Salary varies with qualifications (IBCLC-RN, RD) and local salary levels.*

Meaningful Use

Monitoring breastfeeding rates as part of efforts to comply with the "meaningful use" of electronic health records specified by the ACA will contribute to improved HEDIS data in "access to care" and "effectiveness of care" categories. In particular, prevention of childhood obesity is linked to improved rates of breastfeeding.

WIC data indicate that infants who were exclusively breastfed at birth had lower rates of obesity at age four than did infants who were formula fed at birth (Figure 1). And infants exclusively breastfed for six months or longer were less likely to be obese as preschoolers than babies who received any formula (Figure 2). Because many of the babies seen at WIC are also patients at community clinics, community clinics with criteria and guidelines to ensure breastfeeding support will play an invaluable role in improving health outcomes.

Accountable Care Organizations

For clinics striving to achieve certification from NCQA as Accountable Care Organizations (ACO), collaborative support for breastfeeding mothers will address the performance measures for certification of healthy Body Mass Indexes (BMI) for children and reduced hospital readmissions. Breastfeeding support also aligns with the ACO accreditation requirement to involve health plans; health plans will need to provide breastfeeding counseling from trained providers and breast pumps as part of Clinical Preventive Services.

Figure 1. Obesity at Age Four by Type of Feeding

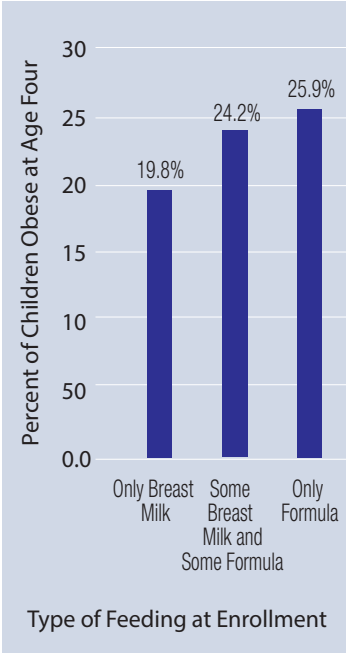
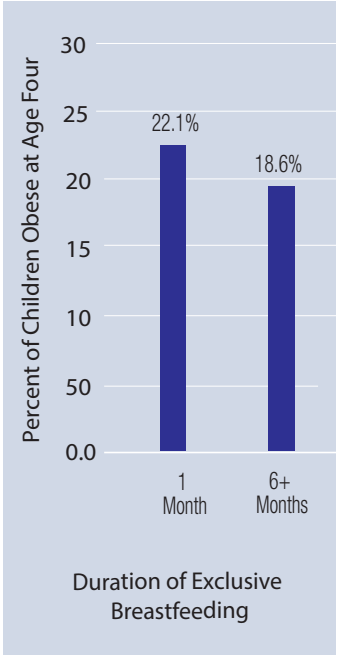


Figure. 2. Obesity at Age Four by Length of Breastfeeding



WIC children who began life fully breastfed had the lowest rates of obesity at age four, and infants exclusively breastfed for six months or more had lower rates of obesity at age four.

Partner with WIC for Best Outcomes

California has 84 local WIC agencies and 650 clinic sites serving WIC clients. Many of the WIC agencies' parent organizations are health centers or county health departments with community clinics, and many WIC sites are co-located with a community clinic, even if there is no corporate relationship. At a minimum, health centers and WIC clinics should have strong referral systems between them for lactation support. Other opportunities can be explored, including co-locating IBCLCs who work part-time for both a community clinic and a WIC site, with memorandums of understanding (MOUs) between WIC sites and clinics that define the use of IBCLCs in both sites.

WIC has a large and culturally competent workforce of IBCLCs. In clinics and medical offices with a Comprehensive Perinatal Services Program (CPSP), IBCLC staffing and even job sharing between CPSP and WIC agencies are great ways to meet program priorities for breastfeeding support. Carefully designed MOUs, electronic timesheets, and patient scheduling records can account for hours billed and patient contacts for each site. For example, Santa Barbara County Public Health Department and San Diego's North County Health Services have both community clinics and WIC programs in their organizations. Staff at these organizations have pioneered joint use of IBCLCs, identified ways to generate income for breastfeeding support, reduced duplicity of services, and improved breastfeeding rates. [7,8]

WIC Resources for Breastfeeding Support

See the following briefs and reports for more on breastfeeding support:

- Maternity Care Matters: Overcoming Barriers to Breastfeeding
- Policy Changes Raise Breastfeeding Rates
- Breastfeeding Can Reduce Obesity
- Ramping Up for Reform: WIC Breastfeeding Toolkit
- Opportunities for Nutrition and Breastfeeding Interventions Under Health Care Reform

For these publications—and more—go to http://www.calwic.org/focus-areas/breastfeeding/health-care-reform and http://www.calwic.org/news-a-publications/publications-library.

Implementation Roadmap

Community clinics and health centers can take steps to build a quality and sustainable continuum of care for breastfeeding support that will move them forward in compliance with ACA requirements. Working with local WIC agencies and hospitals will expedite clinic success in these efforts.

Clinic Steps to Implement Breastfeeding Services

- Evaluate internal and external gaps in breastfeeding support. Help with assessment can be obtained from WIC agencies that have completed this analysis.
- Establish a clinic Breastfeeding Support Task Force.
- Identify needs for, and goals to improve, staff education and training, staffing for breastfeeding support, and billing and reimbursement options.
- Incorporate breastfeeding support into ongoing or planned initiatives, such as PCMH, ACO, and Meaningful Use.
- Plan to extract and include in QI measures breastfeeding, BMI, hospital admissions, and correlative health data in electronic medical records.
- Call a meeting of all local organizations—delivery hospitals, WIC agencies, the local breastfeeding coalition, health plans, and durable medical equipment providers (breast pumps)—to discuss working together to establish a continuum of care for breastfeeding

Implementing the breastfeeding requirement of the ACA offers clinics new opportunities to expand breastfeeding support and patient satisfaction. Partnering with WIC agencies is a smart way to boost success.

Notes

1. American Academy of Pediatrics and World Health Organization. The global strategy for infant and young child feeding. Geneva: World Health Organization, 2003.

2. Scariati PD, Grimmer-Strawn LM, Fein SB. A longitudinal analysis of infant morbidity and the extent of breastfeeding in the United States. Pediatrics, 1997; 99(6):1-6.

3. Ip S, Chung M, Rama G, et al. Breastfeeding and maternal and infant health outcomes in developed countries. Agency for Healthcare Research and Quality, 2007. http://www.ncbi.nlm.nih.gov/books/NBK38337/.

4. Owen CG, Martin RM, Windup PH, et al. Effect of infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. Pediatrics, 2005;115:1367-1377.

5. Ip S, Chung M, Rama G, et al. Breastfeeding and maternal and infant health outcomes in developed countries. Agency for Healthcare Research and Quality, 2007. http://www.ncbi.nlm.nih.gov/books/NBK38337/.

6. Dewey KG, Heinig MJ, Nommsen LA. Maternal weight-loss patterns during prolonged lactation. American Journal of Clinical Nutrition, 1993;58(2):162-266.

7. Provisional analysis of 2009 data. Breastfeeding among U.S. children born 2000–2008. CDC National Immunization Survey, 2008. http://www.cdc.gov /breastfeeding/data/NIS_data/index.htm.

8. Preventive services covered under the Affordable Care Act. http://www .healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

9. See Office of Legislative Council, House of Representatives. Compilation of Patient Protection and Affordable Care Act sections 4003, 4004 and 4108. http: //housedocs.house.gov/energycommerce/ppacacon.pdf.

10. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, health, and cost. Health Affairs, 2008;27(3):759-769. http://content.healthaffairs.org /content/27/3/759.full.

11. See NCQA, Patient-Centered Medical Home. http://www.ncqa.org/Programs /Recognition/PatientCenteredMedicalHomePCMH.aspx.

12. See the following publications from California WIC Association: Maternity care matters: Overcoming barriers to breastfeeding, 2012. http://www.calwic .org/storage/documents/bf/2012/Maternity%20Care%20Matters_2012.pdf; Policy changes raise breastfeeding rates, 2012. http://calwic.org/storage/WIC_WORKS _Policy_Changes_Raise_Breastfeeding_Rates.pdf; and Breastfeeding can reduce obesity, 2012. http://calwic.org/storage/WIC_WORKS_Breastfeeding_Can _Reduce_Obesity.pdf.

13. For examples of IBCLCs working with licensed providers to bill for lactation, see California WIC Association, Ramping up for reform: Quality breastfeeding support in preventive care, 2012. http://www.calwic.org/storage/documents /bf/2012/Ramping_up_for_Reform-WIC_Breastfeedling_Toolkit_2012.pdf/.

14. See NCQA publications: List of HEDIS 2013 measures. http://www.ncqa.org /Portals/0/HEDISQM/HEDIS2013/List_of_HEDIS_2013_Measures_7.2.12 .pdf, and HEDIS quality measurement, 2013. http://www.ncqa.org /HEDISQualityMeasurement/HEDISMeasures/HEDIS2013.aspx.

15. Figures 1 and 2 are from California WIC Association, Breastfeeding can reduce obesity, 2012. http://calwic.org/storage/WIC_WORKS_Breastfeeding _Can_Reduce_Obesity.pdf.

16. See NCQA, Accountable Care Accreditation Organization. http://www.ncqa .org/Programs/Accreditation/AccountableCareOrganizationACO.aspx and http ://www.ncqa.org/Portals/0/ACO/ACO-web.pdf; and Health Care.Gov, Accountable Care Organizations: Improving care coordination for people with Medicare. http: //www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a .html.

17. For more specific examples, see California WIC Association, Ramping up for reform, 2012. http://www.calwic.org/storage/documents/bf/2012/Ramping_up _for_Reform-WIC_Breastfeedling_Toolkit_2012.pdf.

18. For more information, go to http://www.calwic.org/focus-areas /breastfeeding/health-care-reform or http://www.calwic.org.

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Photos: California WIC Association

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