COC
Continuity of Care

Continuity OF Care IN Breastfeeding Support

A BLUEPRINT FOR COMMUNITIES

NACCHO
National Association of County & City Health Officials

USBC
U.S. Breastfeeding Committee

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Introduction

Major medical and governmental organizations recognize optimal infant and young child feeding as exclusive breastfeeding for six months, and continuing with the addition of age-appropriate complementary feeding for at least one to two years or more.[1,2,3,4] Human milk is the ideal first food uniquely suited for infants' optimal growth and development. Breastfeeding also has a substantial impact on the birthing persons' health, which makes lactation support critical for improving community health.

Within the last decade, overall breastfeeding rates have increased in the United States and most national goals were met; however, when data is disaggregated, these achievements are not equitably shared among subsets of populations. There are persistent disparities in breastfeeding duration rates by race, ethnicity, and socio-economic status. Through the Healthy People 2030 initiative, national objectives have been re-set to focus on the need to increase the proportion of infants who are breastfed exclusively through six months and who are breastfed at one year.

Suboptimal breastfeeding can lead to negative short- and long-term health outcomes for infants and lactating parents, such as increased incidence of infection, diabetes, obesity, and some cancers.[5,6,2,7,8,9,10] One of the drivers of breastfeeding discontinuation is gaps in continuity of care (CoC) for breastfeeding support within communities. CoC in breastfeeding support is achieved by consistent, collaborative, and seamless delivery of high-quality services for families throughout the first 1,000 days, from pregnancy through the child's second birthday. Adequate CoC results in transitions of care that are coordinated and fully supportive of

families throughout their breastfeeding journey. In addition to care coordination, CoC in breastfeeding support also refers to the establishment of proactive, supportive environments where families live, work, play, and raise children through the implementation of organizational policies, systems and environment (PSE) solutions.

As maternal and pediatric care is often not centralized, family units receive direct and indirect support in different settings across the first 1,000 days. Ensuring comprehensive lactation support services during this period will require intentional coordination among the spectrum of lactation support providers and others who interact with families across various community settings in both prenatal and postpartum periods. Unfortunately, in many historically oppressed communities, there is limited availability of community support. Establishing chest/breastfeeding CoC in these communities is key to improving breastfeeding duration and exclusivity rates, advancing equity, and improving overall community health.

This Blueprint, developed with a public health lens, aims to increase local capacity to implement community-driven approaches to support chest/breastfeeding, centered on the needs of populations disproportionately impacted by structural barriers that leads to low rates of breastfeeding. The goal of this resource is to ensure that chest/breastfeeding support services are continuous, accessible, and coordinated, and that community spaces are consistently supportive of chest/breastfeeding families. It is intended for any local-level organization and individual that interacts with pregnant and postpartum families. This document provides seven recommendations to establish CoC and strengthen the landscape of support for chest/breastfeeding within communities. These recommendations are categorized into two themes: improvements within the community infrastructure and capacity building of the lactation workforce.

Though we recognize the critical impact of federal and state influences on community support, the Blueprint focuses on actions that can be taken at the **local level** to spur change. The recommendations are summarized below and delineated with strategies starting on page 23.

Recommendations to Advance Chest/Breastfeeding Continuity of Care in the Community

Community Infrastructure Recommendations

1. Integrate breastfeeding promotion, protection, and support goals into existing community health improvement strategies and as a component of health promotion programs.

2. Create environments that proactively promote, protect, and support chest/breastfeeding throughout the community, in spaces where families live, work, play, worship, shop, travel, receive services, and raise children.

3. Implement a care coordination system across the prenatal through weaning stages, including the development of formal referral systems, follow-up accountability, and hand-off protocols during transitions of lactation care from one provider or setting to another.

4. Develop a shared community breastfeeding database system to track infant feeding consistently for community health collective impact efforts.

Lactation Workforce Recommendations

5. Increase community capacity to provide consistent, tailored, evidence-based lactation education and support by regularly training all individuals who provide services to the family unit.

6. Provide family-centered lactation care that is responsive to the intersectionality of families' multiple identities, their social determinants of health, and other factors impacting their infant feeding journey.

7. Assume a community champion role, beyond the provision of direct services, by identifying and engaging key stakeholders to identify and help remove structural barriers to chest/breastfeeding within systems, organizations, and the community.

Each Blueprint recommendation is supported by practical strategies targeted at different stakeholders to enable advancement of CoC in communities across the country. In addition to recommendations and strategies, the Blueprint includes CoC-related graphic templates, success stories, and a comprehensive list of relevant tools and resources. In addition, there are helpful resources included in the appendix, including the lactation equity language glossary, with the inclusive lactation terms used throughout this document, and some existing continuity of care resources for reference. The Blueprint was spearheaded in the fall of 2018, and since then, over 100 experts working in the lactation field across the U.S. contributed to its recommendations and strategies by graciously sharing experiences and providing valuable input and feedback. For more information about the process of the Blueprint development, see Appendix Pg. 73. See Acknowledgements for more information.

The Need for a Continuity of Care Blueprint to Inform Community Breastfeeding Support

Breastfeeding usually starts immediately after birth in a hospital or home/birth center setting. Initiation rates have increased considerably, due primarily to the implementation of a set of 10 evidence-based maternity care practices, known as the Baby-Friendly Hospital Initiative (BFHI), in over 600 hospitals across the country.[11,12,13] However, there is a significant drop in breastfeeding rates within the first weeks and months following hospital discharge. This is evidenced by consistently low breastfeeding rates of 6-month exclusivity and 12-month duration rate, especially in Black and low-income populations.[14,15,16,17] Unlike the set of recommendations for hospitals to promote, protect, and support families and human milk feeding as an optimal source throughout the hospital stay, there is no clear structured program outlining evidence-based steps on how to promote, protect, and support chest/breastfeeding within community settings and environments, where the majority of the infant feeding journey takes place. This Blueprint seeks to identify a spectrum of opportunities at the community level, beyond maternity care settings.

Continuity of care in breastfeeding support is achieved by consistent, collaborative, and seamless delivery of high-quality services for families from the prenatal period until no longer breastfeeding. Continuity of care results in transitions of care that are coordinated and fully supportive of families throughout their breastfeeding journey.

United States Rates of Any and Exclusive Breastfeeding by Age Among Children Born in 2017

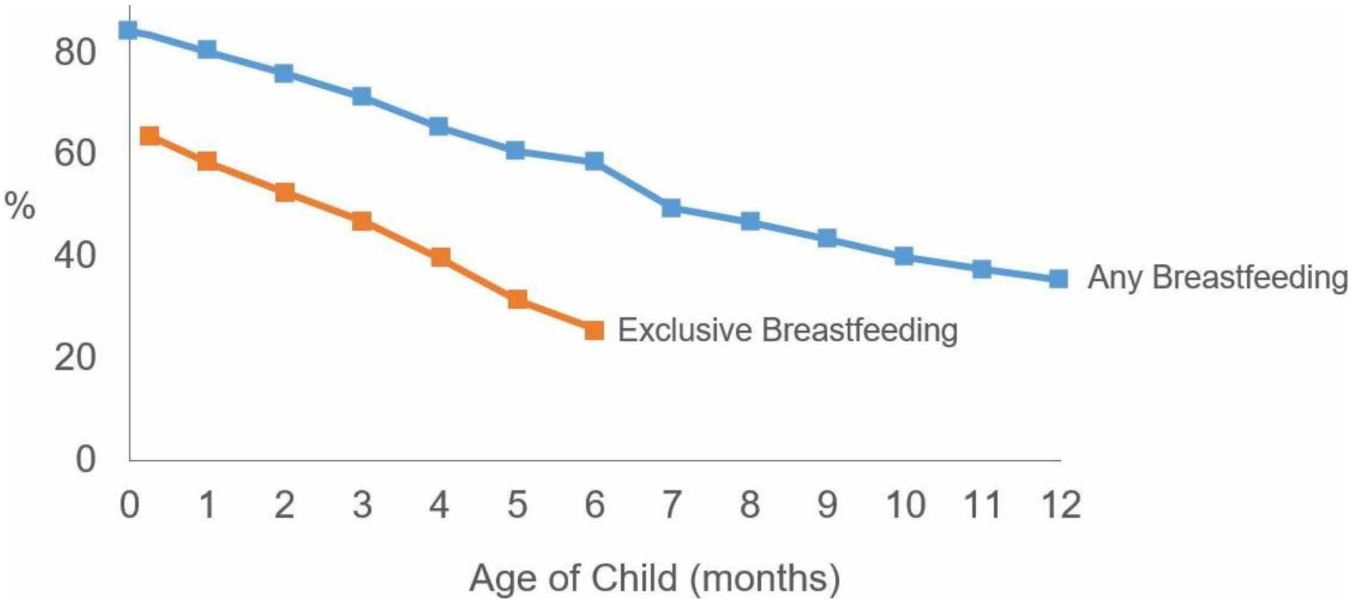


Figure 1: Centers for Disease Control and Prevention. National Immunization Survey 2018-2019.

Research shows breastfeeding support should be organized, predictable, scheduled, and inclusive of ongoing education and support provided by skilled multilevel lactation support providers.[18] Personalized and culturally attuned education and support are critical to meeting the needs of different communities.[19] This support should not be offered reactively, where families are responsible for seeking assistance and initiating the contact.[18] Improving the community context to build this lactation safety net requires skills beyond physical lactation management knowledge. It needs collective and intentional planning, coordination, and implementation by many stakeholders.

In addition to timely access to direct care, community support also includes the presence of environments that proactively support breastfeeding within all community spaces, so families can continue chest/breastfeeding wherever they are.[20,144] The consistent availability of these enabling environments is critical for increasing breastfeeding rates. Based on this evidence, it is imperative to create systems of lactation care continuity to increase breastfeeding rates, especially for duration and exclusivity. To ensure families meet their chest/breastfeeding goals, they need a coordinated, comprehensive care stream that fully supports the entire family unit throughout pregnancy until weaning. This process of establishing CoC in community lactation support involves the coordination of care providers and agencies in different settings within a community. Without this lactation safety net, there is a fragmented care transition to the community setting, and many families fall through the cracks and discontinue breastfeeding prematurely.

Without this lactation safety net, there is a fragmented care transition to the community setting, and many families fall through the cracks and discontinue breastfeeding prematurely.

The continuity of care theory and framework have been poorly explored in the context of community lactation support. Understanding which factors predict CoC in other health fields may help direct efforts at improving community-level lactation support intervention efforts.

Breastfeeding as a Public Health Priority

Breastfeeding and human milk feeding are the normative standard of infant feeding for optimal growth and development of children.[2,21,22] Leading health authorities recommend breastfeeding exclusively for about six months of life and continuing breastfeeding with complementary age-appropriate foods for at least one and two years or longer.[23,2,4] Human milk feeding is also a human right and a matter of food security [24,25] and food safety, especially during emergencies.[4,26,27,28] Low rates of exclusive breastfeeding and early breastfeeding cessation (suboptimal breastfeeding) have adverse short- and long-term health outcomes for infants, birthing persons, and the community, resulting in higher financial healthcare costs and increased health inequities.[29,6,30,5,31] Therefore, it is a public health priority to promote, protect and support chest/breastfeeding equitably.

Overall breastfeeding rates have increased in the U.S. in the previous decade, with 84.1% of infants initiating breastfeeding in 2017; however, only 25.6% were exclusively breastfed through 6 months, and only 35.3% continued breastfeeding through 12 months[32] (**Figure 1**). Moreover, this achievement is not equitably shared across all subsets of the population, as significant breastfeeding disparities persist by race, ethnicity, socioeconomic status, and geography. The breastfeeding initiation rate for non-Hispanic Black infants was 73.7%, with 21.2% exclusively breastfeeding through 6 months and 26.1% continuing breastfeeding at 12 months. Among low-income families, the breastfeeding initiation rate was 76.6%, with 20% exclusively breastfeeding through 6 months and 27% at 12 months (**Figures 2, 3**). Recognizing the public health imperative of improving breastfeeding duration rates, two national goals were included in the Healthy People 2030 initiative: increasing the proportion of infants who are exclusively breastfed through 6 months to 42.4% and continuing to breastfeed through 12 months to 54.1%.

Racial and socioeconomic disparities of 6-month Exclusive Breastfeeding persist, with Hispanic infants, Black infants, and those under 100% of poverty level impacted the most.

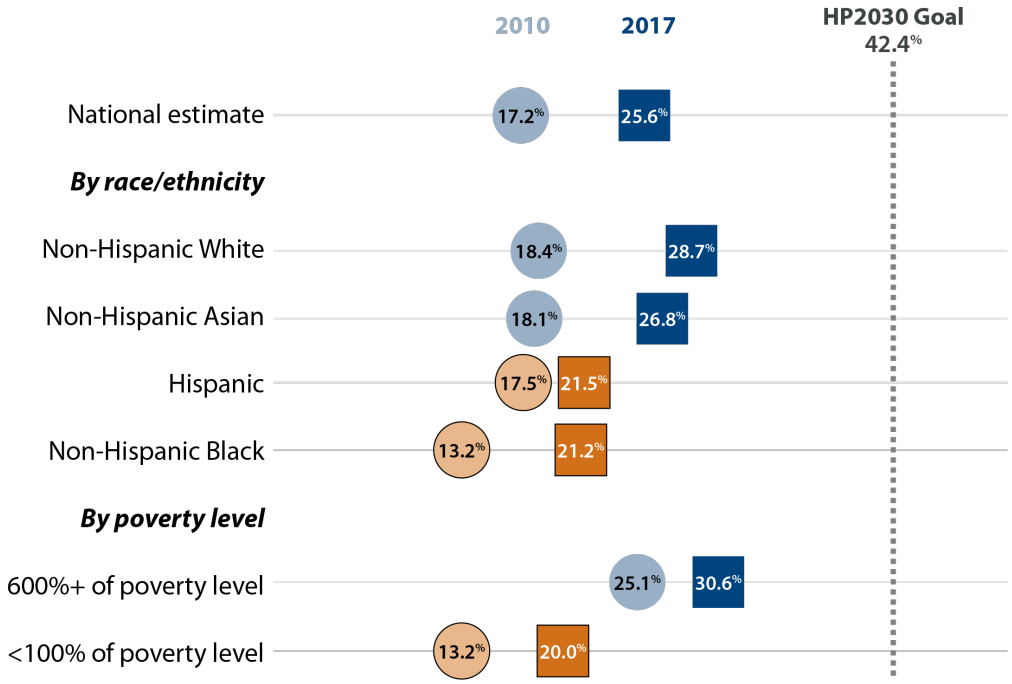


Figure 2: Disparities in exclusive breastfeeding at 6 months rates, with data from the CDC National Immunization Survey-2017 & the Healthy People 2030 Objectives

Racial and socioeconomic disparities of Breastfeeding at 12 months persist, with Black infants and those under 100% of poverty level impacted the most.

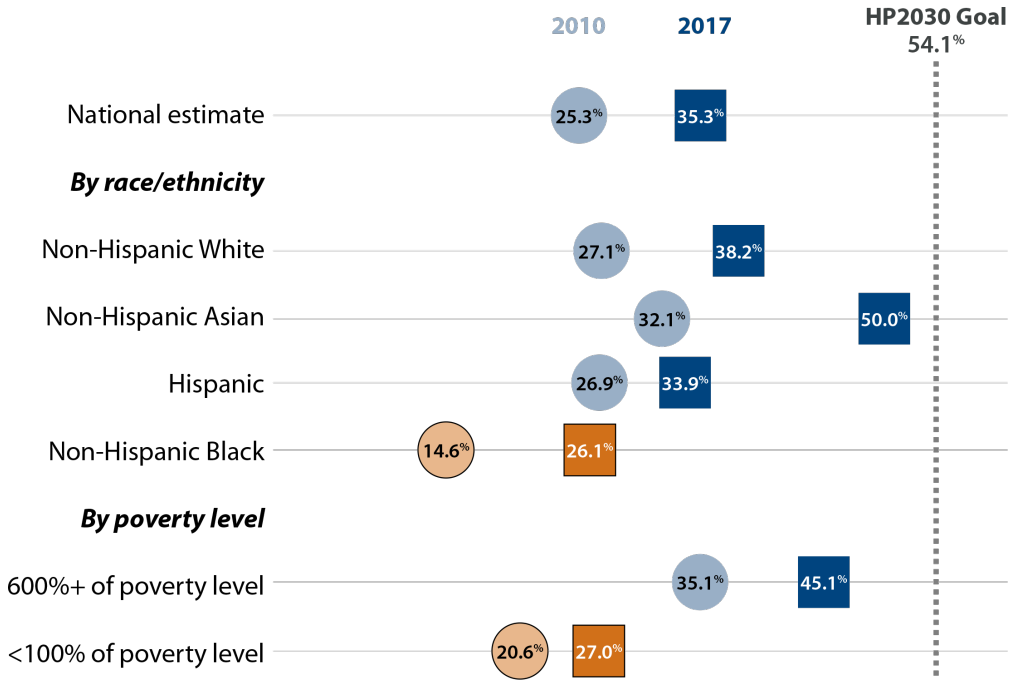


Figure 3: Disparities in exclusive breastfeeding at 12 months rates, with data from the CDC National Immunization Survey-2017 & the Healthy People 2030 Objectives

**Circles indicate 2010 data. Squares indicate 2017 data. Outlined shapes indicate populations with low rates of breastfeeding. Note: Data not available for Hawaii, Pacific Islanders, or American Indian groups*

Negative Outcomes of Suboptimal Breastfeeding

Despite improvements in initiation rates, early breastfeeding cessation and low rates of exclusive breastfeeding at recommended levels persist. Breastfeeding rates drop significantly within the first months postpartum, with the highest discontinuation rates occurring within the first two to four weeks postpartum.[33,14,15,16,17]

The negative outcomes associated with early breastfeeding cessation for infants include an increased incidence of infectious morbidity, including otitis media, gastroenteritis, and pneumonia, and elevated risks of childhood obesity, type 1 diabetes, leukemia, and sudden unexpected infant death syndrome (SUIDS).[34,35,6,31,36,37] In addition to the short-term disease risk reduction, there are several positive long-term public health outcomes of breastfeeding, including reduced risk of obesity, hypertension, type 2 diabetes, cardiovascular disease, hyperlipidemia, and some types of cancer.[38,39] For birthing persons, the risks of suboptimal breastfeeding include an increased incidence of premenopausal breast cancer, ovarian cancer, retained gestational weight gain, type 2 diabetes, hypertension, myocardial infarction, and metabolic syndrome.[7,8,9]

Human milk feeding has a dose-response relationship, with exclusivity and longer lactation duration increasing positive health outcomes for lactating parents and breastfed children.[31,40,37,41] While human milk is beneficial to almost all breastfeeding parents and infants, the benefits may be significantly greater for families of color and those living in communities who are inequitably burdened by adverse health outcomes.[42]

Structural Barriers Leading to Suboptimal Breastfeeding

Research shows that 60% of U.S. parents discontinued breastfeeding before they desired for several reasons, including the perception of inadequate milk supply, latching difficulties, and painful breasts or clogged milk ducts.[43,14,44,16] These concerns could be addressed by preventative, coordinated, community-based, skilled lactation support.[17,45]

While many communities with lower rates of breastfeeding may lack consistent community support from providers and institutions, Black, Indigenous, and other People of Color (BIPOC) families often face additional challenges in navigating systems of oppression at interpersonal and institutional levels. For instance, research shows that Black parents are more likely to return to work earlier and work in environments not conducive to breastfeeding.[46,47,48] Provider and institutional racism, implicit bias, and discrimination also adversely affect the breastfeeding journey for many Black families.[49,50] In addition, Black families are more likely to deliver at birthing facilities that do not implement evidence-based maternity care practices that support breastfeeding,[51] which makes them less likely to initiate and more likely to discontinue breastfeeding early. Therefore, they have an increased need for proactive, ongoing breastfeeding support, both before and after birth. Access to timely lactation support and supportive environments is an issue of equity and social justice.[52]

Community Chest/ Breastfeeding Landscape

Families need consistent supportive environments and different levels of skilled lactation support at various times throughout the first 1,000 days. During this unique period of opportunity when foundations of optimum health, growth, and neurodevelopment across the lifespan are established,[53,4] many families may or may not reach their goals, stop breastfeeding, and become pregnant again, restarting the circle of needed lactation care. Sometimes, chest/ breastfeeding continues throughout pregnancy and culminates with *tandem feeding* (chest/breastfeeding both older sibling and new baby).

Ideally, during the prenatal period, parents should receive ongoing, evidence-based breastfeeding education during routine appointments and be connected with community lactation support providers and support groups for education and peer support interaction. Prenatal infant feeding education, including the provision of informational materials and interpersonal support, improves maternal preparedness for managing lactation physiology and helps increase duration and exclusivity of breastfeeding.[54,55,56,57] During the immediate perinatal period, most commonly in inpatient hospital or birth center settings, both birthing and postpartum unit personnel should support the implementation of evidence-based maternity care practices that facilitate breastfeeding, such as skin-to-skin and breastfeeding immediately post-birth and rooming-in. During hospital discharge, families should be formally connected with a lactation support provider by proper referral mechanisms and be thoroughly educated on all lactation support services options within their region. Ideally, the first post-discharge lactation support encounter should take place within 24-48 hours.[58] These first few weeks (birth to around 6-8 weeks) are critical in the infant feeding journey, where many lactation management difficulties and concerns arise.[59] Timely access to skilled lactation support is key, for this is a period when many families are overwhelmed; they either discontinue chest/breastfeeding or start supplementing with commercial milk formula, and experience constraints in accessing professional help.[60,61] In many communities, there may be limited support available, making referrals and service coordination difficult. Further complicating families' and providers' navigation is confusion regarding the types of individuals providing lactation care.

Lactation support providers (LSPs), breastfeeding medicine specialists, breastfeeding peer counseling programs, and lay mother-to-mother support are essential sources of information and guidance for pregnant and postpartum parents to breastfeed.[29] These professionals may work or volunteer as part of a formal system such as the hospital, health centers, home-visiting programs, and community peer support networks, or be stand-alone providers. Support is delivered in a variety of ways including home visits, telephone calls and text messages, web-based formats, and through in-person and online groups.[55,62] Additionally, lactation education and support may be provided during prenatal, newborn and routine well-baby visits, depending on the skills and capacity of the clinical staff or as part of a multi-

disciplinary team within the entity where prenatal, postpartum, and pediatric services take place. There are also LSPs in the community that operate private practices, and typically charge a service fee or receive reimbursement through health insurance plans. Since the implementation of the Affordable Care Act, lactation services and supplies have been covered by insurance providers; however, reimbursement remains a challenge for many LSPs. In many federal qualified health centers (FQHCs), these services are charged to the health insurance provider or based on a sliding fee scale.

Another established community lactation support source is the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) breastfeeding peer counseling program, which may include individual and group education and counseling conducted by peer counselors and other LSPs to pregnant and postpartum families. This program is restricted to income-qualifying families, and most clinics often have a heavy caseload. Other no-cost popular group support programs include stand-alone Baby Cafés, which provide free, informal, ongoing, high-quality drop-in lactation care, Breastfeeding USA, and La Leche League groups, which are mother-to-mother support and encouragement groups. Additionally, there are similar versions of individual and group support that specialize in providing culture-specific education and support, such as Mocha Moms, Black Mothers Breastfeeding clubs, and ROSE Baby Cafés. As a result of the COVID-19 pandemic, many of these groups have moved to online spaces, reflecting a growing need to utilize telehealth for individual and group lactation support to improve access to care when onsite support is challenging for different reasons.

Finally, many maternal and child health home visitation programs include breastfeeding education and support in their services. Both the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and Healthy Start programs administered through the Health Resources & Service Administration (HRSA) Maternal and Child Health Bureau (MCHB) track breastfeeding indicators among families served.[63] Other programs like Early Head Start program and the Nurse Family Partnership programs may offer similar support and tracking.

In addition to direct skilled lactation support services, community support also includes the presence of environments that proactively support breastfeeding within community spaces so families can continue chest/breastfeeding wherever they are.[64] The consistent availability of these enabling environments is a critical part of CoC in community lactation support. These may include worksites, Early Care and Education (ECE settings), schools and universities, local businesses, places of worship, health centers and other healthcare and social services delivery spaces, community-based organizations (CBOs), and government buildings and spaces, such as city hall, courts, libraries, public parks, county jails and prisons, airports, and other transportation spaces.

While there are a wide variety of locations and providers where breastfeeding can be promoted, taught, and supported, there is a disjointed approach to CoC as it applies to breastfeeding.[47] Often programs and stakeholders within the local health system operate in silos, without awareness of or relationships with others that provide similar or complementary services in the community.[63] In addition to providing critical support to families during the first 1,000 days, establishing these linkages among key community stakeholders (**Figure 4**) across clinical and community sectors is necessary to strengthen collective capacity to address structural barriers and CoC breakdowns that contribute to inequitable breastfeeding rates.[65]

The consistent availability of these enabling environments is a critical part of CoC in community lactation support.

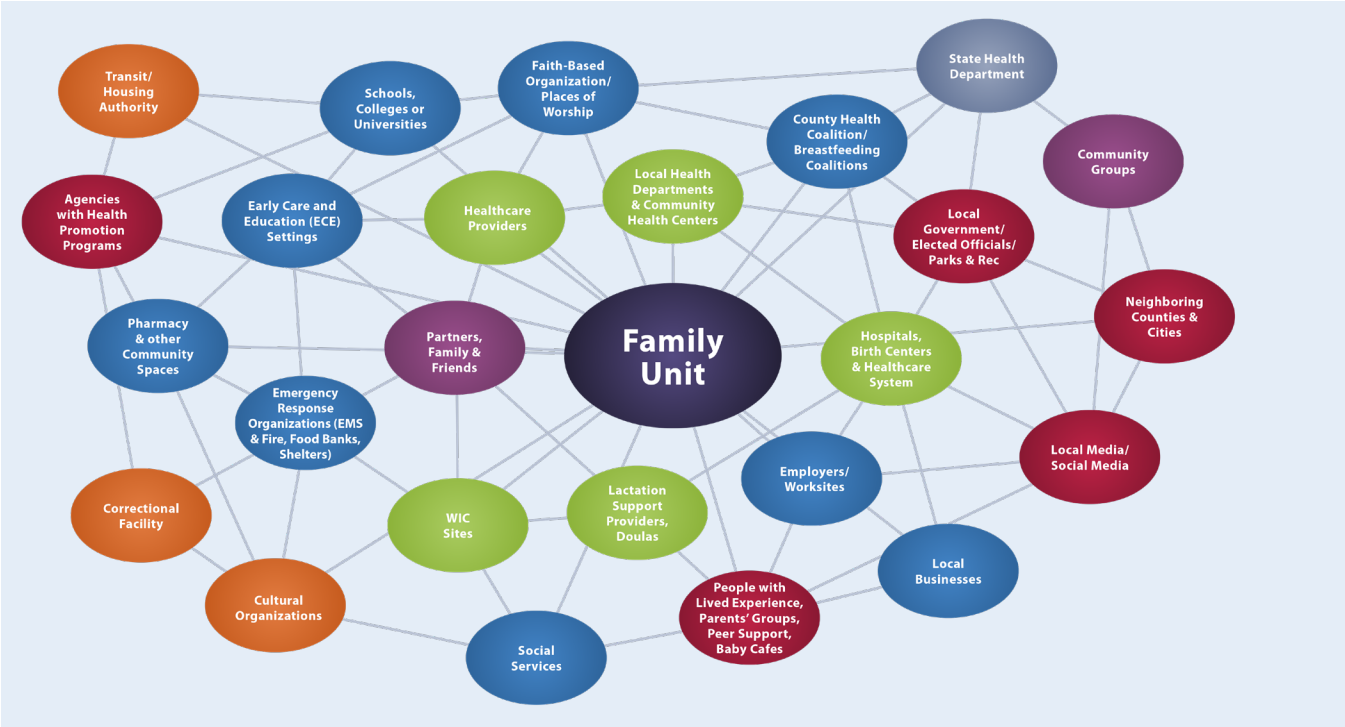


Figure 4: Local Health System for Chest/Breastfeeding: Families need consistent support environments and different levels of skilled lactation support at various times during at least the first 1,000 days.

See full page image in Appendix, pg 75

Continuity of Care

Continuity of Care Overview

Continuity of Care (CoC) is an established feature of healthcare and a frequent goal of quality improvement processes. CoC is associated with increased patient satisfaction, greater adherence to medical advice, reduced hospital readmissions rates, healthcare costs, and equitable universal high-quality care.[66,67,68] There are several names and definitions for CoC, such as care continuum, transition of care, and integrated care. In general, they refer to the movement of healthcare delivery across different providers and different settings.[69,66]

The overall concept is that services should be **consistent and collaborative across time and various providers and settings**. This integration of care optimizes continuity, consistency, and quality of care while ensuring interdisciplinary cooperation from multi-level providers in different settings and cost-efficiency.[70,71]

Continuity of Care in Chest/ Breastfeeding Support

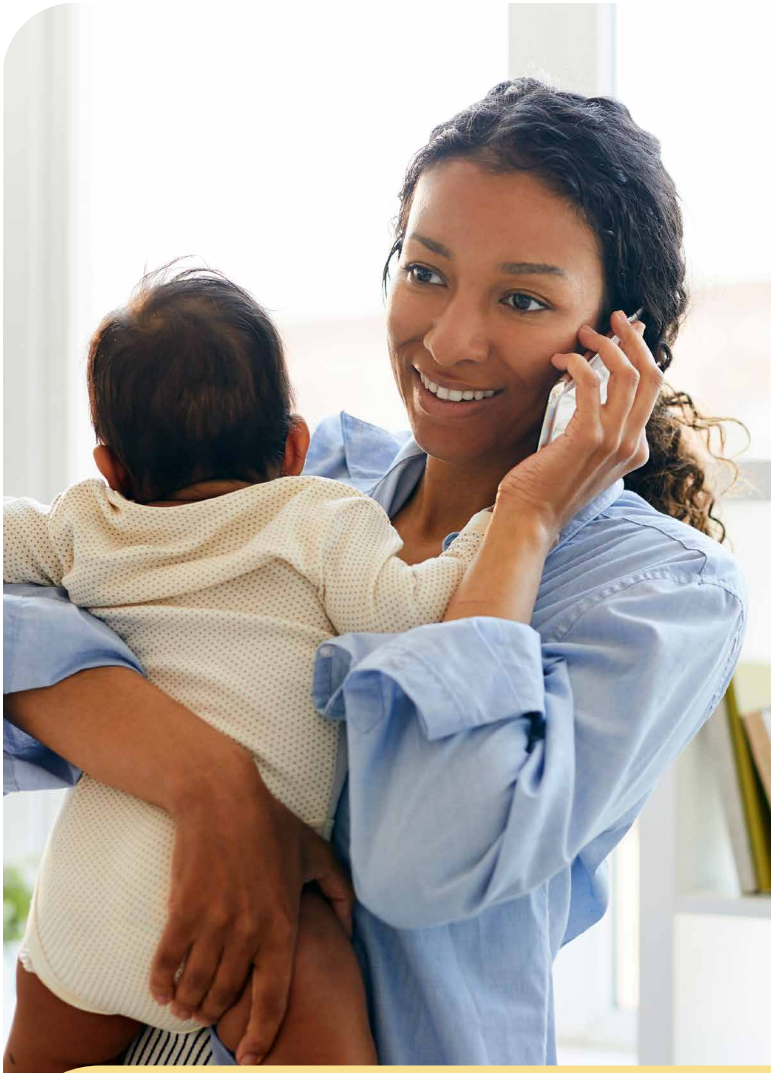
Chest/breastfeeding is a complex journey, influenced by its dyadic nature and multiple external factors. A family unit transitions across multiple providers and settings during the first 1,000 days. Continuity in chest/ breastfeeding support is achieved when multiple providers deliver consistent, compassionate care that is responsive to the infant's and family's changing needs.

Problematic transitions of care occur in nearly all types of healthcare settings, and especially when patients leave where they gave birth to receive care in another setting or at home.[67] When there is lack of chest/breastfeeding CoC, or ineffective transitions of care, parents are less likely to initiate chest/ breastfeeding, or unable to breastfeed exclusively or for the recommended duration, which may lead to negative health outcomes associated with suboptimal breastfeeding rates. In addition, when parents transition back to the workplace and other community settings, they may experience gaps in CoC, resulting in the end of their chest/breastfeeding journey.[72,46,47,48]

Continuity of Care Perspectives

There are always two perspectives to take into account, since CoC can be perceived differently by the patient and by providers.[73,74,75]

1. The patient's perspective refers to whether there are seamless transitions within their care as they move along chronologically or *longitudinally*. It is important to consider the use of the patient-centered approach, which is care delivered in a respectful, compassionate manner and includes family members in the care plan. Patients often assume continuity occurs until they experience gaps.[72]
2. The providers' perspective refers to whether there are *vertically* integrated systems of care and collaboration among providers, and it focuses on the transfer of appropriate health information, and coordination of models of service delivery, patient records keeping and sharing between providers, and improved patient outcomes. This aspect relates to the quality improvement of care.



Both provider and patient perspectives are critical to continuity of care

Continuity of care is how one patient experiences care over time as coherent and linked; this is the result of good information flow, good interpersonal skills, and good coordination of care among providers (Reid et al., 2016).

In the context of infant feeding, families experience CoC chronologically or horizontally, from the prenatal period until breastfeeding is discontinued.[76] Because the family unit is cared for by multiple providers in different settings, parents often complain about conflicting messages from obstetricians, pediatricians, lactation consultants, and peer counselors. This inconsistent messaging is due to a lack of vertical integration of care across providers and settings to ensure they develop a common interprofessional communication terminology and disseminate consistent and accurate information to the families.

During any given encounter, parents should perceive that the decisions about their infant's care are based on evidence. Also, families should receive consistent advice from providers. Parents want to feel that all providers know their infant's medical history and current care plan, without having to repeatedly share the same information. When parents need to retell their and their baby's medical history every time they see a provider, or when they receive conflicting advice on feeding strategies, their perspective is that there is a lack of continuity.[77]

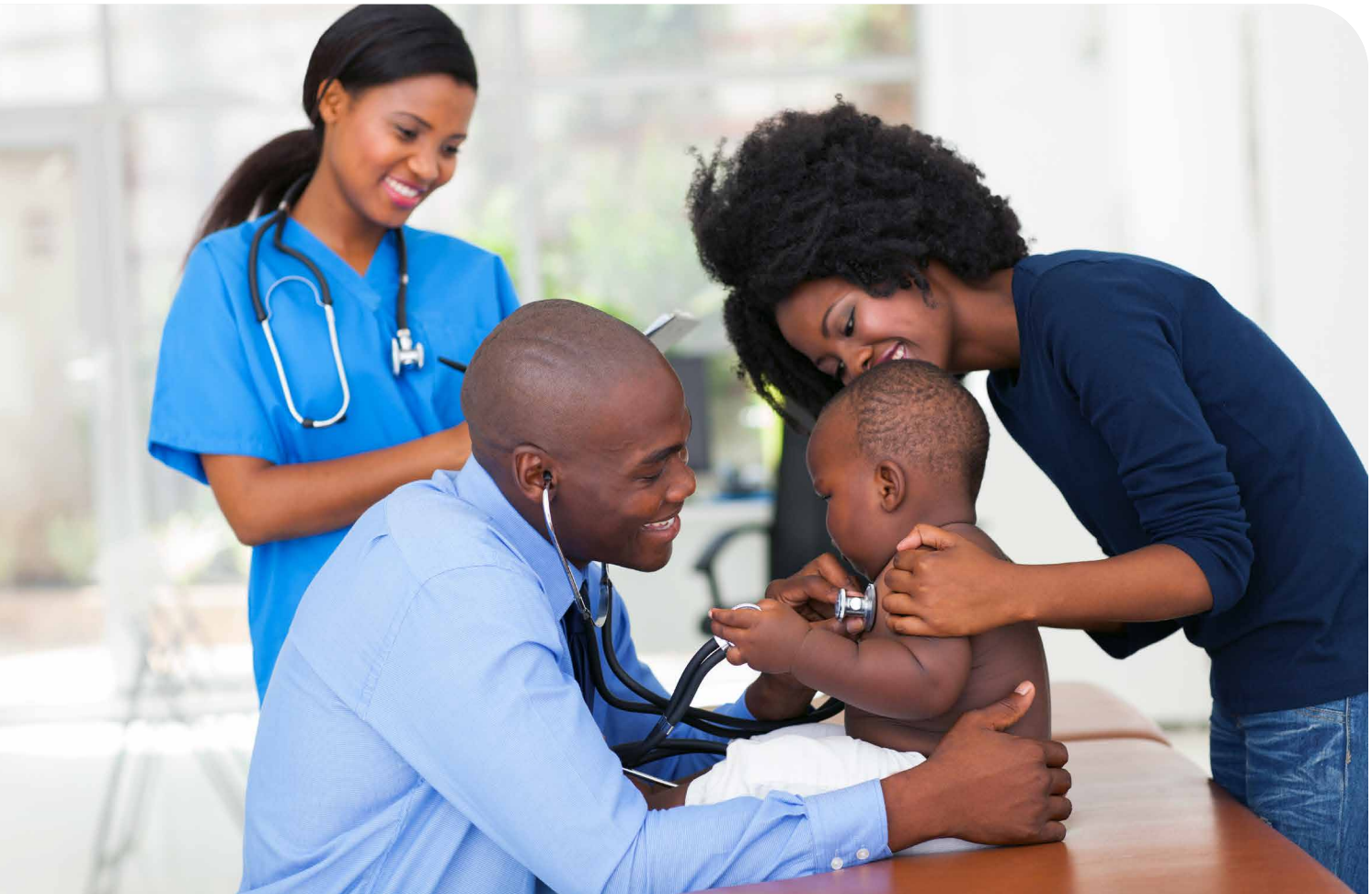
Continuity of Care Dimensions

Although CoC is understood differently across health disciplines, there is consensus about three dimensions: informational, relational and (clinical) management.[68,78] The dimensions are closely related and aim to ensure high-quality care.[65,79,80] To achieve CoC in lactation support, each dimension must be incorporated into community lactation support efforts.

Information continuity refers to the connectedness and coherence of how relevant information from prior health-related events 'travels' throughout the local health system and is available over time to help inform current care and make it appropriate for the individual and their condition. Information is the common thread that links care from one provider to another and from one health event to another. Documented information includes the health history and patient's values, preferences, social support, and social context. In the context of lactation support, informational continuity addresses the importance of providers having access to medical records and private health information (PHI) related to lactation management. However, lactation support providers in the community rarely have access to hospital charts and feeding history, electronic systems are not interoperable (do not 'talk' to each other), and other important prenatal information is inconsistently shared from one provider to another. In addition, this continuity relates to the consistency of information provided to the family across settings and personnel.[75]

Relational continuity recognizes the patient as a whole person. It refers to an ongoing therapeutic relationship between a patient and one or more providers. It not only bridges past and current care but also provides a link to future care. A consistent core of personnel can give patients a sense of predictability and coherence in their care.[79] In the context of lactation support, relational continuity refers to the interpersonal aspect of the family unit and provider relationship, including the support and encouragement to the family unit through the development of trusting relationships between families and care providers.[75] Research shows that parents place their trust in supportive providers who are non-judgmental, encouraging, reassuring, sympathetic, patient, and understanding. Unhelpful professionals were described as bossy, judgmental, inaccessible and uncaring, projected a lack of belief in the parent's ability to breastfeed successfully, and giving 'standardized' or prescriptive advice.[44]

Management continuity refers to the consistent and coherent management by different providers through coordinated and timely provision of services, emphasizing the content of care plans to ensure consistency. This dimension emphasizes the importance of interprofessional communication and consistent implementation, especially when a patient is cared for by many providers in different settings. Within lactation support, management continuity refers to the seamless care transitions through intentional coordination of care. It should be assured both horizontally — from pregnancy to breastfeeding cessation — and vertically across providers and settings so parents progress through the first 1,000 days timeline. Seamless care for the breastfeeding unit presents special challenges because of the inherent segmentation of the healthcare system.[75] In the U.S., care is typically separated for the members of a breastfeeding family unit: the obstetrician or midwife provides care for the pregnant/birthing person and the pediatrician for the infant.[81] These and other professionals, such as nurses and lactation support providers, interact with the family unit during different periods across the continuum and have the ability to have either a positive or negative impact on the chest/breastfeeding journey of families served.



The Circle of Care model, developed by Price & Lau (2013), is defined as an individual patient's healthcare system. The illustration and concept helps to understand the three dimensions of CoC focused on provider's perspective, since addressing challenges in CoC are within (multiple) providers' sphere of influence. Provider connectedness describes the cohesiveness of the relationships among providers within a circle of care. This model illustration was adapted to breastfeeding continuity of care (**Figure 5** below). The circle of care consists of the patient, providers, other agents, and the information repositories (paper and electronic) related to that patient. It is self-organizing, can span organizations, and changes based on the needs of the patient and availability of resources.

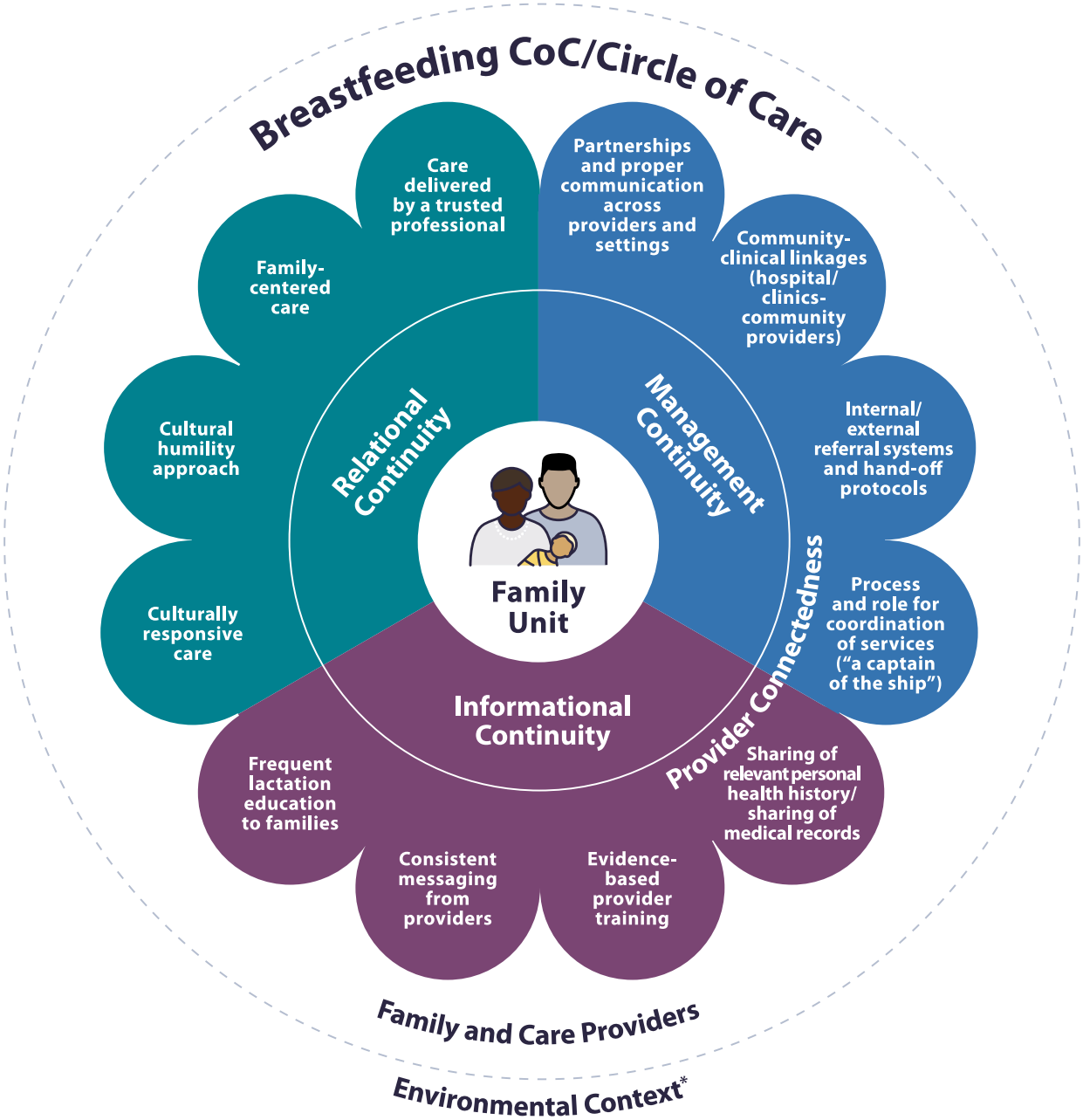


Figure 5: Environmental Community CoC Context. **Environmental Community CoC Context (includes supportive breastfeeding policies, systems and environmental solutions, addressing SDOH and other socioeconomic factors impacting infant feeding (e.g.: poverty and education, food security, racism, sexism/genderism, classism, built environment, social norms)

Adapted from The extended Circle of Care Model of continuity of care, by Price M. & Lau, F. (2013). Available at https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-309

Continuity of Care Breakdowns

Many factors contribute to ineffective transitions of patient care, and these root causes often differ from one organization to another. The three breakdowns that most often lead to gaps in CoC are communication, patient education, and accountability.[67] The USBC-affiliated CoC Constellation and other invited stakeholders applied the CoC breakdown framework to breastfeeding support, based on existing research and their collective lived experience. The workgroup identified the following root causes for gaps in CoC in lactation support:

The root causes of continuity of care breakdowns in community lactation support

Communication

- Lack of warm hand-offs, specific role on communicating clarity (many providers, organizations and systems)
- Lack of buy-in on the need to communicate to other providers
- Lack of policy/procedure
- Lack of generalized awareness of available community resources and next level of care
- Staffing constraints, time constraints, system constraints of Electronic Health Records (EHR) incompatibility among providers
- Embedded institutional and systemic racism, discrimination, and bias within care systems and healthcare institutions

Patient Education

- Breastfeeding not approached as preventative model
- Lack of anticipatory guidance education and empowerment
- Patient education starting late in the pregnancy or at birth
- Lack of skilled providers and limited provider training available
- Conflicting messages with lack of consistent and evidence-based education (providers, society, online)
- Limited education provided on laws and family-friendly rights
- Provider implicit bias, and provider's own lactation experiences influencing their education provision on breastfeeding
- Aggressive infant formula marketing influencing education content and providers' priorities
- Staffing constraints, time constraints
- Family members not included in education and care plan
- Lack of community trust on provider
- Limited diversity among skilled lactation support throughout the perinatal continuum

Accountability

- No care coordination role among providers
- Lack of established partnerships to coordinate care
- No clarity of roles and responsibilities of each provider/entity in establishing CoC
- No proper handoff/warm handoff or follow up
- Limited focus on breastfeeding, as providers' attention ends after the first weeks after birth
- Weak or ill-established referrals systems, lack of follow up
- Lack of timely data transfer
- Lack of support persons around the family (such as patient navigator) to ensure appointments are made and followed through
- Reimbursement barriers

Continuity of Care

The Public Health Approach to Continuity of Care in Community Support

Using the Breastfeeding Socio-Ecological Model (SEM) to Identify Targets for Policy, System, and Environmental (PSE) Changes to Address Care Gaps

The CoC theoretical framework focuses on various aspects of clinical health service delivery and transitions among care providers, and to a lesser extent, health system infrastructure. Although these are critically important, public health involves far more than direct service care; public health works on improving the community context, which is where behaviors take place, so the healthy option can be the easy, default option.[82] Within community chest/ breastfeeding support, in addition to improving the quality of care and the care transition coordination, CoC also refers to the assurance that there is a consistent presence of enabling environments where families live, work, play, and raise children. While ensuring seamless transitions of direct lactation care needs to be approached at the individual provider level, ensuring consistent availability of supportive environments requires an upstream, community-wide approach, focusing on systemic solutions to community issues rather than individual behavior.[83,65]

The establishment of chest/ breastfeeding-supportive environments to achieve full CoC in the community are often implemented through Policies, Systems, and Environment (PSE) changes. The PSE change approach to public health interventions uses the socioecological model (SEM) to identify key stakeholders and PSE opportunities across various domains to improve systems-level factors that affect individual and community health.[84,85] PSE shifts help deconstruct barriers and build environments where the healthy choice (e.g., breastfeeding) can be the easy default option.[82,86,81,65]

Just as there are multiple stakeholders who directly support human milk feeding, there are also many interrelated factors outside of

Within community chest/ breastfeeding support, in addition to improving the quality of care and the care transition coordination, CoC also refers to the assurance that there is a consistent presence of enabling environments where families live, work, play, and raise children.

direct support that must be accounted for with CoC. Evidence shows that breastfeeding PSE solutions, such as the presence of and easy access to skilled lactation support, family-friendly policies, and supportive physical environments are strong influencing factors for families to continue breastfeeding post-discharge.[33,87,88,89] The breastfeeding SEM (**Figure 3**) illustrates the multilevel stakeholders that influence the infant feeding journey, demonstrating the need for a collective approach to improving breastfeeding rates. Each sphere represents a set of entities, systems, and environments from individual to federal levels that can either enable or undermine a family's chest/breastfeeding experiences.

The first three to four spheres closest to "Mother and Baby" within the SEM (**Figure 6**) represent stakeholders that highly influence the chest/breastfeeding journey of families in a community.[90,91,92] These are the stakeholders within the chest/breastfeeding local health system; therefore, CoC needs to exist within these spaces. For instance, education focusing only on the birthing parent leads to CoC communication breakdowns, leaving out important family members that have a direct influence on the parent's feeding decision and actions. When pregnant people's partners also receive lactation education during prenatal and postpartum periods and are engaged in peer support networks to reinforce breastfeeding and fatherhood/parenthood, their families are more likely to have higher rates of both initiation and exclusivity of breastfeeding.[93] Similarly, programs integrating grandmothers/grandparents in lactation education and support also show a positive impact on parents' breastfeeding self-efficacy, which is a positive indicator for exclusive breastfeeding.[94] Thus, one step to establishing CoC in lactation support within this sphere closest to *Birthing Parent (Mother)-Baby* must incorporate those who the parent considers to be part of their social support network through the 1,000 days or through weaning.

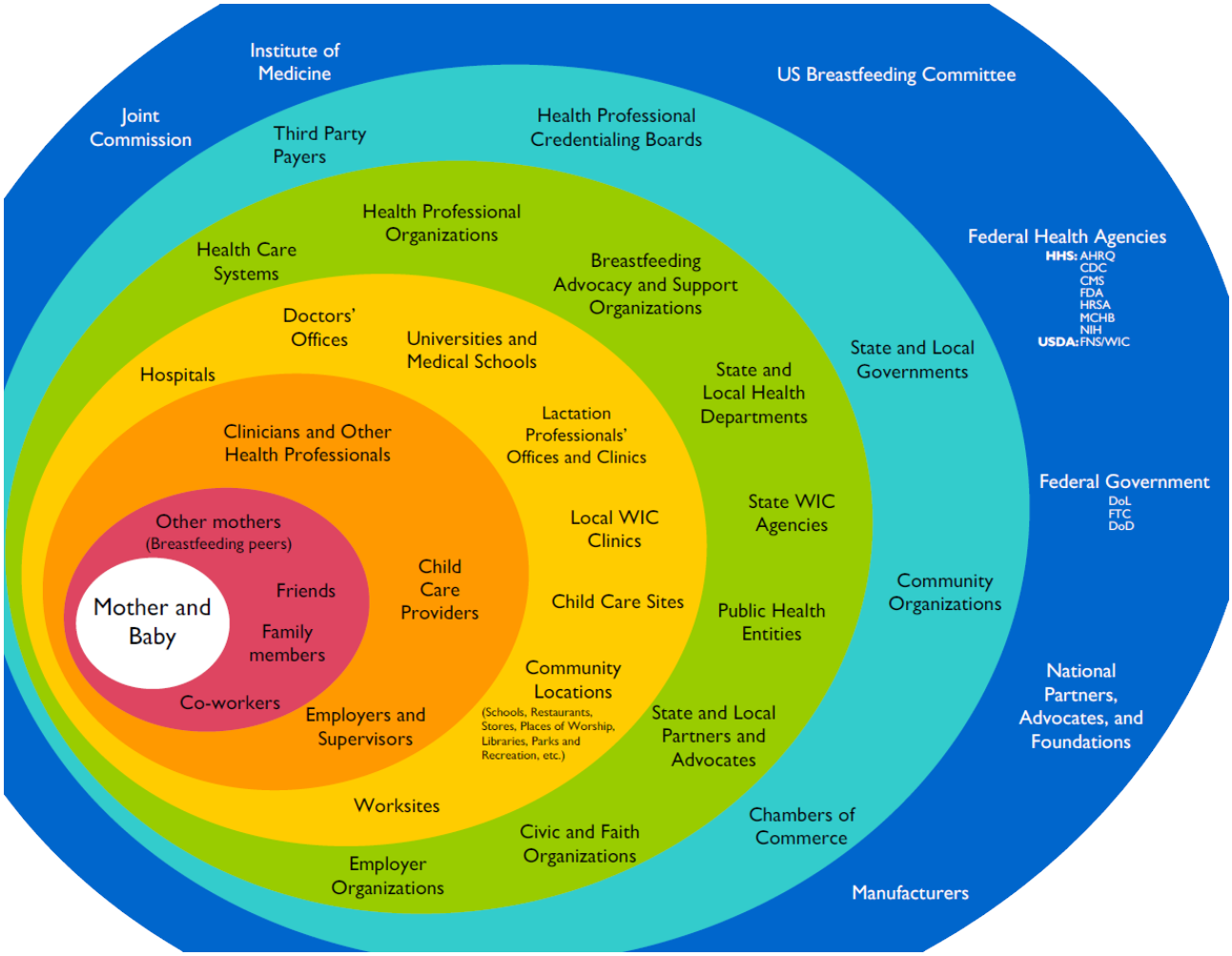


Figure 6: Breastfeeding Socio Ecological Model. Source: Grummer-Strawn, 2011.

PSE shifts help deconstruct barriers and build environments where the healthy choice (e.g., breastfeeding) can be the easy default option.

However, even if family members are supportive and educated on chest/breastfeeding, if direct care providers are not adequately trained or are biased and not fully supportive of breastfeeding, it can lead to early breastfeeding cessation due to different reasons, such as unnecessary non-medically indicated supplementation, lack of timely support, or conflicting messaging from different health professionals.[95,96,97,98] Healthcare providers caring for pregnant and postpartum families are often offering services disjointly, across different settings. Many times, one provider assumes someone else within their team or from another institution will address families' educational and lactation support needs.[80] This lack of accountability is attributed to communication/patient education breakdowns, one of the common root causes of CoC failure.[67]

Moving beyond the family, friends and individual providers' sphere, institutional support (the yellow and part of the green sphere in the SEM), especially from workplace/school, childcare settings and hospitals, is also critical for the CoC experience of employed/student parents' chest/breastfeeding journey. These stakeholders can either enable or represent a major barrier for employed parents to continue breastfeeding. While there are state and federal workplace laws, they have limited legal accountability, and there is no national standard for the support for and regulation of human milk feeding in childcare settings. There are existing childcare recommendations that differ in implementation and adherence across states.[99]

Several states and communities have developed resources and implementation programs using the breastfeeding PSE approach within workplace and childcare settings. These include establishing welcoming environments, implementing infant feeding policies, and training employees and childcare providers on the importance of breastfeeding and how to support working lactating parents.[100,101]

As discussed earlier in this document, a known example of a successful institutional-level breastfeeding PSE approach implementation that aims to establish CoC within hospital settings during the immediate before and after birth periods is the Baby-Friendly Hospital Initiative (BFHI). In addition, there are similar state-level programs that also use PSE changes within maternity care practices. The BFHI is a global effort to ensure that all facilities providing maternity and newborn services become centers of breastfeeding support by implementing the *Ten Steps to Successful Breastfeeding* within their organization, which facilitates breastfeeding initiation and exclusivity during the hospital stay. These steps include infant feeding policy and procedures, training staff, supportive environments, and other evidence-based clinical guidance. Steps 3 and 10 are related to establishing CoC to and from the hospital, as it refers to prenatal education and post-discharge support, alluding to the need to collaborate with community stakeholders for community-clinical linkages. However, it has been shown that these steps are some of the most difficult steps to achieve, reinforcing the common CoC challenges of coordinating care across varied stakeholders and settings.[102]

The application of the CoC theory to the breastfeeding SEM helps to visualize that making breastfeeding work is not only a matter of an individual parental choice, but a collective responsibility to ensure all community stakeholders, including both individuals and institutions, are committed and contributing to creating CoC in breastfeeding support for their community.

The SEM for breastfeeding illustrates the complex interplay between individual, community, and societal factors on families' chest/breastfeeding journeys. The application of the CoC theory to the breastfeeding SEM helps to visualize that making breastfeeding work is not only a matter of an individual parental choice, but a collective responsibility to ensure all community stakeholders, including both individuals and institutions, are committed and contributing to creating CoC in breastfeeding support for their community.

The additional spheres of influence within the SEM: state and federal influences in continuity of care in the community

Federal and state policies and laws that are supportive of breastfeeding are critical in creating environments that enable breastfeeding at the local level. For example, state and territorial health agencies play important roles in prioritizing breastfeeding across organizations in some communities. States can lead or support communities in shaping policy through legal statutes and regulations; act as conveners and leaders to ensure successful partnerships; fund programs at the local level; provide training and technical assistance; and connect communities in the same state working on similar CoC activities. For state and federal influences and policies, review the recently published national report: the Role of Law and Policy in Assisting Families to Reach Healthy People's Maternal, Infant, and Child Health Breastfeeding Goals in the United States.

This Blueprint focuses on strengthening local health systems, and therefore, the recommendations and strategies are tailored to feasible actions that community-level organizations and local health departments (LHDs) can take. Specifically, the recommendations and strategies in this Blueprint reflect practices to improve the interpersonal and institutional factors within the local health system for breastfeeding to establish breastfeeding CoC within their community.

For more state and federal level resources, see additional CoC resources (page 76).

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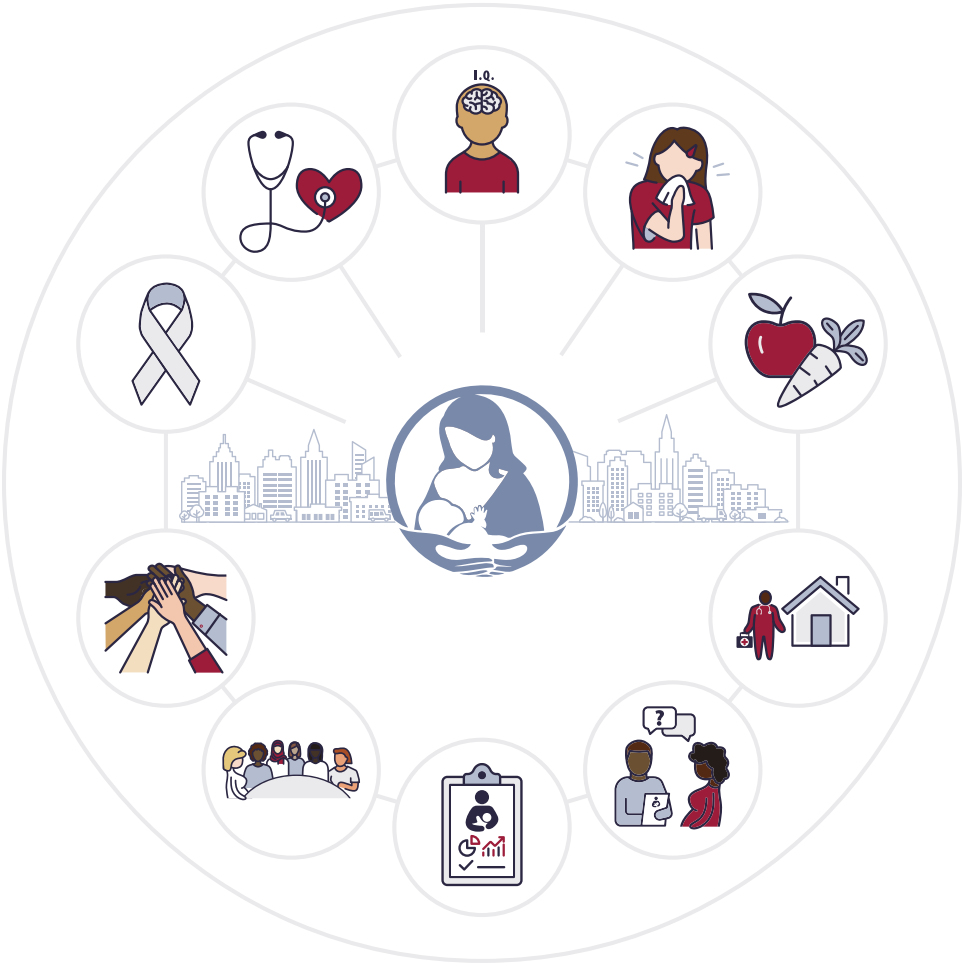
Recommendations to Establish Continuity of Care in Breastfeeding Support Within a Community

To develop the following community-level recommendations and set of accompanying strategies, NACCHO drew on research, known gaps, and relied on the expertise and field experience from the USBC CoC Constellation members and additional experts.

The recommendations are divided into two categories: **improving community health infrastructure** and **building capacity of the local lactation workforce**. Each of the seven recommendations provides its own resource package, which includes: a set of strategies with corresponding rationale, a list of practical implementation tools and other resources, and examples of successful implementations. Finally, each section includes a reference list of sources used to build evidence and develop each specific recommendation rationale.

Note that there is an abundance of existing resources for most of the recommendations below, and this resource is not exhaustive. An online CoC in chest/breastfeeding support resource repository portal (http://www.breastfeedingcontinuityofcare.org) is under development, and resources and implementation tools will continually be added. If you would like to contribute with useful tools and resources, please email breastfeeding@naccho.org.

Because each community is unique, organizations implementing the recommendations and strategies should center community members in planning efforts and partner with community members and local lactation support providers who are representative of the population as experts to lead or co-create implementation plans and programs.



1

Community Infrastructure Recommendations

Breastfeeding as a Community Health Improvement Strategy

Recommendation:

Integrate breastfeeding promotion, protection, and support goals into existing community health improvement strategies and as a component of health promotion programs.

Strategies 1

1.1

Conduct a chest/breastfeeding community needs/assets assessment to understand the local lactation support landscape. This analysis should include breastfeeding rates, availability of direct care services and agencies, social norms, structural barriers, and input from LSPs and families with lived experience to understand how they experience chest/breastfeeding CoC in their infant feeding journey.

1.2

Incorporate breastfeeding indicators and goals into community health assessments/community health needs assessments (CHAs/CHNAs). Integrate breastfeeding support as a strategy into community improvement plans (CHIPs) and other community health strategic plans.

1.3

Educate public health professionals about the connection between breastfeeding and the numerous health risk reductions across the lifecycle related to each program area (such as breastfeeding and childhood obesity, breastfeeding and chronic disease prevention, safe sleep).

1.4

Integrate the tracking of breastfeeding education and support activities into performance measures of public health initiatives, such as chronic disease prevention programs, infant and maternal mortality reduction initiatives, early childhood education, child neglect prevention, food security programs, emergency preparedness and response efforts.

1.5

Establish/enhance community partnerships among organizations implementing health promotion programs to strategically leverage resources and lactation support expertise. Ensure partners' subject matter experts are included into planning meetings and workshops. Examples of enhanced community partnerships include:

- Co-location or integration of lactation support within family health services, especially within prenatal and pediatric visits and social service appointments.
- Integration of lactation support services into programs with mandatory attendance, such as the Maternal and Infant Home Visitation programs, early Head Start, and prenatal care programs such as Centering® Pregnancy.
- Joint staff training, including multiple partners' staff to increase overall workforce capacity to promote and support breastfeeding.
- Inclusion of breastfeeding education into chronic disease prevention and other public health curricula for staff and participants.
- Engagement of interdisciplinary partners to collaborate in identifying community activities to advance CoC in breastfeeding support within the community, such as codeveloping integrated educational materials, designating spaces for those who choose to pump or chest/breastfeed in private at community events, hosting health fairs and community baby showers.

1.6

Develop a community engagement plan to continuously strengthen working relationships with partners and community members, to better plan and co-create, (or follow community's lead on) developing programs and services. Engagement should also include other influencers in the community, such as community leaders, cultural brokers, community health workers, organizers, service providers, employers, and other related experts of their community.

- Despite solid evidence from decades of infant feeding research establishing the importance of human milk and the risks of breast milk substitutes (Victora et al., 2016), there continues to be a failure to recognize the importance of breastfeeding on infant health (Campbell, 2021[83], Tomori et al., 2020[103]), during normal times and especially during public health emergencies.

- Community assessments are essential to understanding the health status and root causes that affect the local public health system and the community. The analysis of the data collected validates the need for funding and informs where priority efforts are needed. The results can inform specific community needs and wants, potential partners, awareness of community assets, and the identification of resources that can be leveraged while providing content for the development of lactation support resource guides (CDC, n.d.[104]).

- A community health improvement plan (CHIP) is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process (CDC, n.d.[103]). Without concerted efforts to collect infant feeding data during community assessments and potentially tap into lactation support as a powerful strategy to improve community health, chest/breastfeeding programs and services are often left out of community health improvement plans and the financial investment opportunities to address community health priorities.

- The inclusion of breastfeeding in the city and county overall community health improvement (CHIP) strategies is a pivotal opportunity to improve population health and tackle health inequities. Lactation promotion, protection, and support will lead to overall community health improvement, since breastfeeding has a positive effect on the health status of breastfed individuals throughout their life cycle and is also associated with long-term decrease in chronic disease risk among lactating parents (Dieterich et al., 2013[6], Victora et al., 2016[35]). CoC in breastfeeding support activities can be incorporated in CHIP priorities and many other public health programs, such as infant and maternal mortality reduction initiatives, obesity, and chronic diseases reduction strategies. Moreover, it is important to educate local partners and the public about the connection between breastfeeding and community health improvement.

- Family units have diverse and changing needs of support throughout the first 1,000 days. Not one single entity is able to meet all the needs of a family. The complex care paradigm is a framework that seeks to improve the health and wellbeing of those who cycle through healthcare, social service, and other systems. Complex care works at the systemic level by creating care ecosystems through local networks of organizations that collaborate to address health and social needs of families together (Humowiecki, 2018[105]). Partnerships with other community organizations enable leveraging multi-organizational resources, skills and policies, and systems to expand service capacity and integrate breastfeeding support into other public health programs (Reis-Reilly et al., 2018[64]). Breastfeeding services should be incorporated into or co-located within established systems and be provided around the same time as existing well-attended programs, rather than being stand-alone programs (Lilleston, et al., 2015[63]).

- Preparedness response planning efforts should include human milk feeding protocols, skilled lactation support, and the establishment of supportive environments, since human milk continues to be the optimal and safest infant and young child food source and the first line of defense during natural disasters and pandemics (USBC, 2011& 2020[29], World Health Organization, 2004[106]).

Community Lactation Landscape Assessment Examples

Brooklyn, NY. Breastfeeding Community Assessment Report: http://bit.ly/CommunityBreastfeedingAssessment

Center for Health Equity, FL. Enhancing the Breastfeeding Landscape in Gadsden County Through Education and Integration in Home Visiting: http://bit.ly/BfStories

Community Breastfeeding Assessment Guidance: http://bit.ly/NACCHOIssueBrief

Compilation of a Sample of Community Assessments and Tools Conducted by CDC REACH Recipients: http://bit.ly/REACHBFAssessments2021

Illinois Public Health Institute. Breastfeeding Focus Group Report: http://bit.ly/iphionline

Region of Waterloo, Canada. Public Health & Emergency Services. Breastfeeding Needs Assessment: https://bit.ly/2RwodT8

Texas Department of State: Community Action Kit for Protecting, Promoting, and Supporting Breastfeeding: http://bit.ly/wibreastfeeding

General Community Assessment Resources

Frieden, Thomas R. (2010). A framework for public health action: the health impact pyramid. *American Journal of Public Health, 100*(4), 590–595.

Gutilla, M.J., et. al (2017). Making the most of our community health assessment by developing a framework for evaluation. *Journal of Public Health Management and Practice, 23*(4), S34–S38.

NACCHO. Community Health Assessment and Improvement Plans - http://bit.ly/NACCHOHealthAssessment

Strengthening Nonprofits: Capacity Builders Resource Library. Conducting a Community Assessment http://bit.ly/ananlcc

Breastfeeding Indicators in Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) Examples

Contra Costa Health Services, CA

- Breastfeeding Indicators in the Community Health Assessment: http://bit.ly/BreastfeedinginCommunityHealthAssessment
- Pioneering the Change for Breastfeeding Continuity of Care through Leveraging Public and Private Partnerships (page 6): https://bit.ly/NACCHOExchange

Erie County Department of Health, NY:

- CHA/CHIP, including breastfeeding logic model and indicators (page 2) and breastfeeding and obesity prevention (page 47): http://bit.ly/ErieNYbreastfeedingintheCHACHIP

Florida Department of Health /Community Health Assessment (page 52): http://bit.ly/FLCHIPSHIPbreastfeeding

Breastfeeding Support/Continuity of Care as a Strategy to Health Promotion and Chronic Disease Prevention

Breastfeeding and Breast Cancer Prevention Programs:

- Promoting Breastfeeding to Help Reduce Breast Cancer Risk in African-American Women | Roswell Park Comprehensive Cancer Center
- African-American Women and Risk Reduction of Breast Cancer By Breastfeeding http://bit.ly/breastCAreductionbreastfeed

Breastfeeding as an Obesity Prevention Strategy - Increasing Support for Rural Mothers in the Finger Lakes Region, page 14: https://bit.ly/NACCHOExchange

CDC REACH: Integrates Continuity of Care/Breastfeeding Support as a Strategy for Chronic Disease Prevention: https://www.cdc.gov/nccdphp/dnpao/state-local-programs/pdf/REACH-Implementation-Guide-508.pdf

Campbell, S. (2021). *Lactation: A foundational strategy for health promotion.* Jones & Bartlett Learning, LLC.

NY Evidence Based Approaches to Preventing Chronic Disease through Breastfeeding Promotion: https://www.albany.edu/cphce/prevention_agenda/bf_web_sllides.pdf

Resources, Tools and Examples From the Field

1

Infant and Young Child Feeding in Emergencies

Alimentacion Segura – Infant and Young Child Feeding: https://asi-iycf.org

American Academy of Pediatrics – Infant Feeding in Disasters and Emergencies: http://bit.ly/AAPDisasterFactSheet

Carolina Global Breastfeeding Institute: Lactation and Infant Feeding in Emergencies (L.I.F.E.): http://bit.ly/cgbilife

COVID Constellation Joint Statement: http://www.usbreastfeeding.org/d/do/3679

Jefferson County Health Department, CO Model Practice Award: infant feeding services and training included in county's emergency preparedness plan: http://bit.ly/LactEmergTrainLHD

New Orleans Breastfeeding Center. Infant Ready Emergency Feeding program: https://www.nolabreastfeedingcenter.org/infant-ready

United States Breastfeeding Committee: http://www.usbreastfeeding.org/emergencies

Community Partnerships

Agency for Healthcare Research & Quality (AHRQ). Linkages between clinical Practices and Community Organizations for Prevention - Final Report: https://ajph.aphapublications.org/doi/10.2105/AJPH.2012.300692

Creating Community Partnerships with WIC for Breastfeeding Success: http://bit.ly/WICPartnerships

Integrating Breastfeeding into Home Visiting: http://bit.ly/NACCHOHVP

Leveraging FQHC-WIC Partnerships to Address Social Determinants of Health. *CPCA Annual Conference*, 2018: http://bit.ly/CPCAnnual

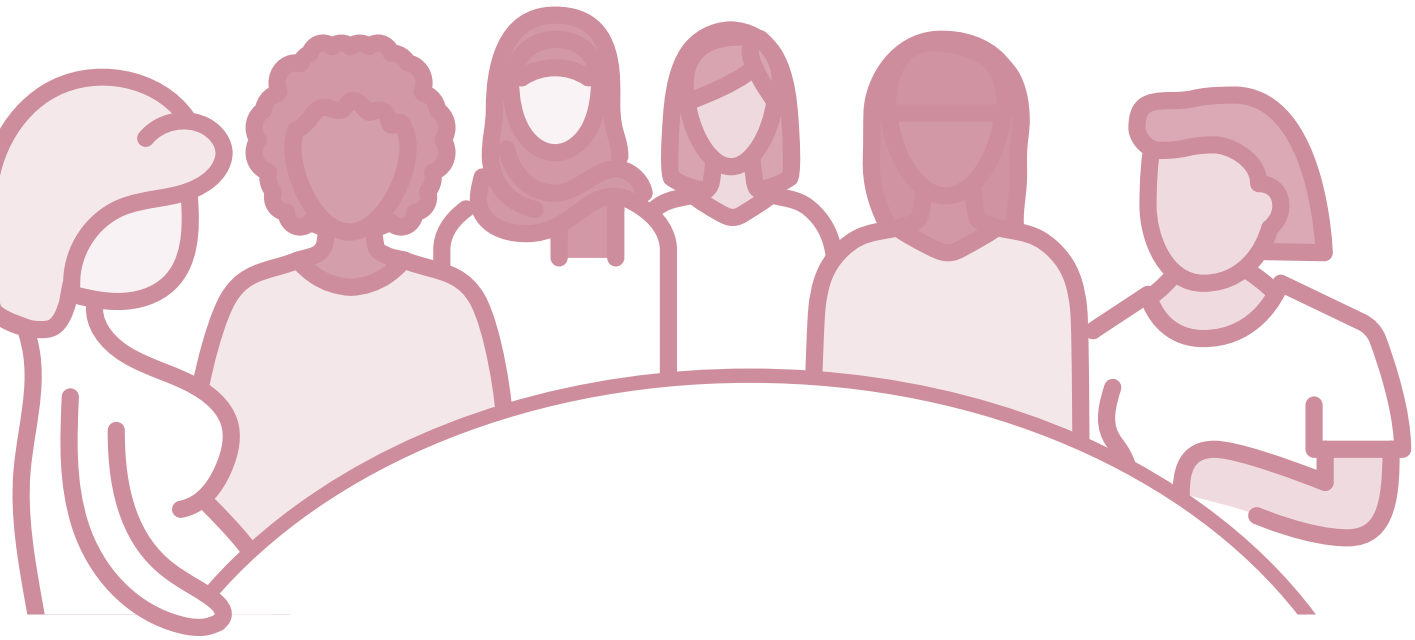
NACCHO Webinar: Leveraging Funds and Partnership for Sustainability of Breastfeeding Services: http://bit.ly/leveragingbfpartnerships

NACCHO Breastfeeding Series: Community Partnerships Webinar: http://bit.ly/MarshalingCommResources

Porterfield, D et al. (2012). Linkages between clinical practices and community organizations for prevention: a literature review and environmental scan. *American Journal of Public Health, 102*(3), S375–S382.

Power building partnerships for health: http://bit.ly/humanimpactcapacity

Prevention Institute. The Spectrum of Prevention: https://www.preventioninstitute.org/tools/spectrum-prevention-0



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Dieterich, C. M., et al. (2013). Breastfeeding and health outcomes for the mother-infant dyad. *Pediatric Clinics of North America, 60*(1), 31–48.

Humowiecki M., et al. (2018). *Blueprint for complex care: advancing the field of care for individuals with complex health and social needs*. The national center for complex health and social needs. www.nationalcomplex.care/blueprint

Lilleston, P., et al. (2015). An evaluation of the CDC's community-based breastfeeding supplemental cooperative agreement: reach, strategies, barriers, facilitators, and lessons learned. *Journal of Human Lactation: Official Journal of International Lactation Consultant Association, 31*(4), 614–622.

Tomori, C., et al. (2020). When separation is not the answer: Breastfeeding mothers and infants affected by COVID-19. *Maternal & Child Nutrition, 16*(4), e13033.

Victora, C. G., et al. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet, 387*(10017), 475–490.

United States Breastfeeding Committee. (2020). *Covid-19 infant and young child feeding constellation joint statement*. http://www.usbreastfeeding.org/page/covid-19-constellation

World Health Organization. (2004). *Guiding principles for feeding infants and young children during emergencies*. https://www.who.int/publications/i/item/9241546069

2

Community Infrastructure Recommendations

Breastfeeding Policies, Systems and Environmental Changes

Recommendation:

Create environments that proactively promote, protect, and support chest/breastfeeding throughout the community in spaces where families live, work, play, worship, shop, travel, receive services, and raise children.

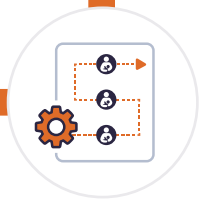
2.1

Implement family-friendly policies in all spaces pregnant and postpartum families usually are. Policy examples may include but are not limited to employee/student break time for expressing human milk, designation of spaces as lactation rooms, positive messaging, paid parental leave, flexible work schedules, and infant-at-work/school policies.

Strategies 2.2 to 2.5 *are specifically tailored to organizations serving pregnant and postpartum families, such as local health departments, health centers, outpatient providers, and other service delivery spaces. Due to their direct service roles, these organizations should go beyond strategy 2.1.*

2.2

Conduct a comprehensive analysis of internal operations to understand limitations to continuously protect, promote, support chest/breastfeeding, such as potential institutional mistrusts, and timing and locations of services offered. Identify organizational levers for change to advance CoC and incorporate breastfeeding goals into the organization's programmatic strategic plans and as part of quality improvement efforts.



2.3

Eliminate all formula marketing practices, such as accepting free or discounted formula supplies and promotional materials from manufacturers, and designate storage for formula products away from clients' view. Commit to following the guidelines of the International Code of Marketing of Breast Milk Substitutes and educate staff about the risks of aggressive formula marketing to chest/breastfeeding families.

2.4

Provide proactive, consistent education and support by implementing both policy and workflow procedures that contain scheduled, mandatory touchpoints for breastfeeding education and/or support, which includes at least four to eight encounters to continuously serve pregnant and postpartum families within the clinic.

2.5

Provide required initial and ongoing competency-based education and training to all direct service staff to improve their lactation support skills. Training should include an overview of organizational policies, protocols, and workflows to support families and employees, the scope of work for each position and the internal/external referral procedure to other types of care across the spectrum of LSPs.

2.6

Identify chest/breastfeeding champions within organizations to lead and support organizational PSE changes.

2.7

Develop social marketing campaigns in collaboration with community members and coalitions to normalize human milk feeding. Campaigns should display culturally responsive chest/breastfeeding images, ideally with pictures of real families from the community, share supportive educational messages, and promote lactation services around the organization's physical and virtual environments.

2.8

Collaborate with breastfeeding/health coalitions and local/state health departments to develop designation and/or recognition programs to award lactation-supportive spaces, employers, and outpatient clinic settings. These programs should include technical assistance or coaching and focus on communities and sectors experiencing the greatest breastfeeding inequities. In addition, recognize and award whole communities that have achieved a multi-faceted, cross-sector approach to chest/breastfeeding.

2.9

Establish community donor human milk programs to increase access of pasteurized donor human milk and to facilitate the donation process (milk depots, outreach and collection centers, dispensary sites). Furthermore, assess the need and feasibility of implementing an independent, nonprofit human milk bank in the community.

- Establishing CoC in chest/breastfeeding support includes improving the built environment by increasing the availability of supportive environments throughout the community. Built environment includes all the physical parts of where people live, work, play, worship, and travel (such as homes, buildings, streets, open spaces) because these environments influence a person's level of engagement in healthy behaviors (CDC, 2011[107]).

- The process of improving the community context (built environment) and establishing CoC within a community requires an integrated, upstream, community-wide approach to improving the local built environment (Crosby et al., 2013[108]; Frieden, 2010[81]). For example, inaccessible or nonexistent sidewalks contribute to sedentary habits. Within infant feeding, an example of a supportive built environment is the designation of spaces for chest/breastfeeding or human milk expression areas (lactation/pumping rooms) for those who choose to do it in private, and comfortable chairs and welcoming lactation signs in malls, places of worship, and at community events.

- Breastfeeding PSE changes seek to improve the built environments where families are, therefore, enhancing CoC in breastfeeding support. The specific PSE changes needed in a community depend on the families' particular needs and each organizational capacity (McKenzie et al., 2013[109], Bradford et al., 2017[87], Reis-Reilly et al., 2018[64]). For instance, organizational PSE changes for those serving pregnant and postpartum families may include activities that build internal CoC, such as lactation support policies for employees and clients, all staff training, patient education/support internal protocols, and implementing internal referral procedures (Johnson, et al., 2015[110], Vanguri, et al., 2021[111]). For workplace settings, key PSE changes to improve the environment include family-friendly policies related to pumping breaks, a designated private and sanitary space to pump and store milk, a flexible work schedule, and positive attitudes from supervisors and coworkers (Johnston and Esposito, 2007[112]).

- Community culture and social norms may shape breastfeeding beliefs and behavior and influence infant feeding choice and chest/breastfeeding practices (Dunn et al., 2015[113], Kawachi & Berkman, 2003[114]; Rollins, 2016[10]; Yourkavitch, et al., 2018[115]). Supportive attitudes from parents' immediate social network, other community members, and community settings are critical for a successful breastfeeding journey (Jones et al., 2015[42]; Johnson, A., et al. 2015[116]). Social marketing has been established as an effective behavioral change model for several public health issues (Evans et al, 2010[117]; Shams, 2018[118]; Storey et al., 2015[119]). Normalizing chest/breastfeeding with positive and educational messages is a type of environmental change approach and is usually done through multi-media campaigns. These are interventions that, when implemented alongside other lactation support activities, can be successful in normalizing and increasing community acceptance of and support for breastfeeding. Social marketing channels may include billboard ads, TV or radio Public Service Announcements (PSA), social media messaging, or the simple placement of culturally responsive chest/breastfeeding images on posters within a clinic or organizational setting (Perez-Escamilla, 2012[120]; Schmidt, 2013[121]; USDHHS, 2011[3]; CDC, 2013[22]; Jones, 2015[42]).

- The infant formula industry has contributed to low breastfeeding rates through various marketing methods of advertising infant formula (Kaplan & Graff, 2008[122]). Aggressive commercial formula marketing, especially in communities of color, is one key factor undermining families' chest/breastfeeding journeys. Infant formula meets nutritional standards for infant feeding, but it lacks bioactive components, thus does not confer immunity, and does not promote neurological development as human milk does (Martin et al., 2016, Ballard & Morrow, 2013[123]). Unethical predatory marketing tactics include promoting infant formula as similar to or more convenient than human milk through powerful emotional messages on digital platforms and via other channels targeted to parents. Marketing techniques also include delivering unsolicited formula samples and gift bags at their homes (Hastings et al., 2020[124]; Wilking, et al., 2020[125]; Public Citizen, n.d.[126]; Waite & Chirstakis, 2016[127]) while engaging healthcare providers to promote their free samples and marketing materials (Vanguri, S. et al., 2021[108]). This aggressive marketing usually happens because of the inadequate implementation and enforcement of The International Code of Marketing of Breast Milk Substitutes, also known as *The Code* (WHO, 1981[128]).

- Interventions to eliminate formula marketing from clinical environments ensure that chest/breastfeeding promotion opportunities are not undermined (New York State's Obesity Prevention Coalition and Policy Center). Organizational policy around infant feeding should include guidance on providing unbiased, evidence-based formula information and support to parents who may (also) formula feed in ways that do not undermine breastfeeding promotion (Appleton et al., 2018[129]).

- Donor milk and human milk banks (HMBs) also play an important role in supporting breastfeeding and thus increasing breastfeeding rates. Access to affordable donor milk outside the hospital is limited in many communities. This has a particular impact on families that are unable to provide human milk to their infants and that are already at a higher risk of poor health outcomes. Food pantries, neighborhood clinics, or other familiar community spaces are well situated to also function as collection depots and dispensary sites of donor milk to help increase the access to donor milk and normalize donor milk usage, while also easing the human milk donation process.

Resources, Tools and Examples From the Field

2

Breastfeeding PSE Definitions and Implementation Examples

Breastfeeding in the Community: Addressing Disparities Through Policy, Systems, and Environmental Changes Interventions: bit.ly/BreastfeedingPSE

Improvements in EHR Forms and other PSE Changes in a Health Center, HealthNet, IN: http://bit.ly/EHRforms

NACCHO Voice. Shifting Internal Policies and Systems to Create Breastfeeding Continuity of Care: https://www.naccho.org/blog/articles/shifting-internal-policies-and-systems-to-create-breastfeeding-continuity-of-care

NACCHO Webinar: Weaving a Lactation Care Safety Net: Navigating Organizational Change for Breastfeeding Success: http://bit.ly/BreastfeedingOrgChange

Public Health Breastfeeding Webinar Series: Breastfeeding in the Community: Building Sustainable Lactation Support Projects through PSE Changes, 2017: http://bit.ly/LactationPSE

Coffective, Resources for Building CoC: coffective.com/about/what-we-do/

Breastfeeding-Friendly Child Care

Carolina Global Breastfeeding Institute: www.sph.unc.edu/cgbi/bfcc-toolkit

Colorado Breastfeeding Coalition: http://bit.ly/CBCoalition

Colorado Department of Health: https://cdphe.colorado.gov/nutrition-services-menu/breastfeeding-friendly-child-care-professionals

San Diego Breastfeeding Coalition: www.breastfeeding.org/breastfeeding-friendly-child-care

Breastfeeding-Friendly Workplace

Infant at Work Policy: http://bit.ly/infantatwork

NYCDHMH, Breastfeeding Business Toolkit: http://bit.ly/BFBusinesstools

Office on Woman's Health Business Case for Breastfeeding: http://bit.ly/womenshealthcase

Sample Policies for Supporting Pregnant and Breastfeeding Employees: http://bit.ly/supportingpolicies

Supporting Nursing Moms at Work: www.womenshealth.gov/supporting-nursing-moms-work

Breastfeeding-Friendly Outpatient Settings

California Department of Public Health. 9 Steps to Breastfeeding-Friendly: https://bit.ly/3tCLsbi

Dakota County Public Health. Breastfeeding-Friendly Health Department: https://bit.ly/3xZyU1b

NACCHO Community Health Centers Report: http://bit.ly/NACCHOCHC

New York Ten Steps to Breastfeeding-Friendly Practice Implementation Guide: https://on.ny.gov/3ezCSFX

Rosen-Carole C., et al. (2016). Assessing the efficacy of a breastfeeding-friendly quality improvement project in a large federally qualified health center network. *Journal of Human Lactation, 32*(3), 489–497.

Schwartz R., et al. (2015). Washington 'steps' up: A 10-step quality improvement initiative to optimize breastfeeding support in community health centers. *Journal of Human Lactation, 31*(4), 651–659.

WA Breastfeeding-Friendly Clinics: https://bit.ly/3uEuF94

Faith-based Resources

Health Community Capacity Collaboration. Supporting Breastfeeding Interventions for Faith-based Organizations: http://bit.ly/Breastfeedingfaithbased

Health Ministers Guide: http://bit.ly/healthministersks

South Carolina Obesity Action Plan. Creating a Mother-Friendly Environment for your Faith-based Organization: http://bit.ly/MotherFriendlyFaithToolkit

Breastfeeding-Friendly Schools and Universities

Breastfeeding Laws in Schools. *BreastfeedLA*: www.breastfeedla.org/breastfeeding-laws-in-schools/

California Breastfeeding Coalition, Laws That Protect Lactating Students in College. *Breastfeeding Rights*: http://bit.ly/CaliBFC

Community Human Milk Donor Programs Resources

Donor Milk Drive Toolkit. *American Academy of Pediatrics*, AAP Section on Breastfeeding, 2019: http://bit.ly/donormilktoolkit

Human Milk Banking Association of North America: https://www.hmbana.org/our-work/establish-a-milk-bank.html

Breastfeeding-Friendly Community-Wide Approach & Recognition Programs Resources

Breastfeeding-friendly San Diego: https://ucsdcommunityhealth.org/work/breastfeeding/child-care/building-blocks/

Brooklyn Breastfeeding Empowerment Zone: http://bit.ly/brooklynBFzone

Colorado Department of Public Health breastfeeding-friendly recognition programs: https://cdphe.colorado.gov/prevention-and-wellness/healthy-eating-and-active-living/breastfeeding/colorado-breastfeeding

Creating Breastfeeding-Friendly Communities: https://www.health.ny.gov/prevention/obesity/prevention_activities/cbfc.htm

Gregg D.J., et al. (2015). Breastfeeding-Friendly Erie County: Establishing a Baby Café Network. *Journal of Human Lactation, 31*(4), 592–594.

Kansas Breastfeeding Coalition. Communities supporting breastfeeding: http://bit.ly/KSBFcoalition

Ramsey County Public Health, MN. Breastfeeding-Friendly public spaces: http://bit.ly/BfFriendlypublicspaceguide

Other Community Breastfeeding-Friendly Spaces

Correctional Settings: Breastfeeding in Correctional Settings (ncchc.org)

Food pantries: https://breastfeedingcommunities.org/breastfeeding-family-friendly-food-pantries/

Michigan Breastfeeding Network. Guide to Breastfeeding and Incarceration: http://bit.ly/miBFnetwork

Shelters: Ernst et al. (2020). Building a policy: Ten steps to a breastfeeding-friendly shelter. *Journal of Human Lactation, 36*(4), 795–802.

Sutter County Public Health Division, CA. Model Practice: http://bit.ly/BreastfeedingInJail

Aggressive Commercial Infant Formula Marketing

American Academy of Pediatrics, American College of Obstetricians and Gynecologists. (2013). *Breastfeeding handbook for physicians*. 2nd edition. Elk Grove Village (IL).

Freeman, Andrea. Skimmed: Breastfeeding, Race, and Injustice. Stanford University Press, 2019.

Piwoz, E. G., & Huffman, S. L. (2015). The impact of marketing of breast-milk substitutes on who-recommended breastfeeding practices. *Food and Nutrition Bulletin, 36*(4), 373–386.

Walker, M. (2013). Countering Infant Formula Marketing Messages: http://bit.ly/counteringformula

McFadden A., et al. (2016). Spotlight on infant formula: coordinated global action needed. *Lancet*, 387(10017), 413–5.

Social Marketing Examples

Asiodu, I., et al. (2015). Breastfeeding and use of social media among first-time African American mothers. *Journal Of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN, 44*(2), 268–278.

Beard, M. (2014). "Bfed" Texting program and "breastfeeding: a smart choice" class: using cell phones to reach gen y mothers. *Clinical Lactation, 5*, 123–127.

Billboard to normalize breastfeeding by CDC REACH recipient (CA): http://bit.ly/CDCREACHrecipient

Centers for Disease Control and Prevention. Communication at CDC, Practice Areas: Social Marketing. 2005

Office on Women's Health. It's only natural: https://www.womenshealth.gov/its-only-natural

University of Kansas. Social Marketing of Successful Components of the Initiative | Community Tool Box (ku.edu). Chapter 45.

WIC Breastfeeding Support Learn Together. Grow Together: https://wicbreastfeeding.fns.usda.gov/about

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3

Community Infrastructure Recommendations

Transfer of Care Accountability and Referral Systems

Recommendation:

Implement a care coordination system across the prenatal through weaning stages, including the development of formal referral systems, follow-up accountability, and hand-off protocols during transitions of lactation care from one provider or setting to another.

Strategies 3

3.1

Improve consistency of chest/breastfeeding messaging by using evidence-based information and co-creating educational materials among lactation support providers and institutions within the community to avoid the provision of conflicting information to breastfeeding parents.

3.2

Develop and continuously update an easily accessible lactation support resource guide, including an inclusive compilation of services and LSPs available in a community, such as support groups, individual counseling, virtual options, and hot/warmlines. This resource guide should be disseminated in multiple, easily accessible formats (e.g., via text, social media), given to all new families, and used by organizations.

3.3

Establish community-clinical linkages among healthcare providers, community-based organizations (CBOs), and other LSPs through networking and relationship building, leading to a memorandum of understanding (MOU) or other formal/informal agreements outlining each party's responsibility to ensure a seamless transition of care. Support hospitals to strengthen evidence-based maternity care practices (such as BFHI steps 3 and 10) by outlining clear procedures for connecting to the appropriate level of care in the community.

3.4

Develop systems that allow safe sharing of breastfeeding-protected health information (PHI) across institutions, such as WIC, public health programs, CBOs, and healthcare systems.

3.5

Develop workflows with a bi-directional referral system that emphasize warm hand-offs or hand-off accountability protocols to ensure recognition of the transfer of care responsibility, transfer of pertinent family information, and potential risks for lactation discontinuation. Ensure that the family actively participates in and fully understands the hand-off plan process, voicing goals and personal preferences on selecting the next provider for continuity of care. Health agencies should leverage electronic health record (EHR) capabilities and other technologies including apps, patient portals, and telehealth, to enhance inter-professional care communication and generate e-referrals, internally and externally, and enhance timely hand-offs between senders and receivers to reduce the burden on families of having to seek help and repeat relevant personal information multiple times across care providers.

3.6

Designate a community lactation care coordination role to assist pregnant and postpartum families in navigating and accessing, in a timely manner, appropriate community services that primarily serve families experiencing the greatest breastfeeding inequities in the community. This coordinator should ensure that follow-up care is established and received. This role could be integrated into an existing staff responsibility, such as community health worker, perinatal coordinator, case manager, or patient navigator.

3.7

Facilitate an understanding of reimbursable services for lactation support at the community level and identify pathways to increasing reimbursement for all types of lactation support providers and care coordination roles.

3.8

Organizations serving pregnant and postpartum families should collaborate to establish a screening tool or triage system for lactation-related concerns that includes timely referrals to the appropriate level of care. It should also include options for rapid remote response outside of business hours, such as telehealth, texting platforms, or hot/warmline services. Whenever possible, refer to services and LSPs that are congruent and responsive to the family's culture, language, values, individual needs, and ensure families' ability to access the services they are being referred to.

- Common CoC breakdowns often include inadequate hand-off communication problems during transitions of care. The process of intentionally clarifying the sending and receiving roles plays a critical role in decreasing gaps in care. The *sender* is responsible for sending patient information to all relevant providers and/or agencies, and releasing the care to *receivers*, and the *receiver* is responsible for obtaining patient information and acknowledging accepting care of the patient (Solet et al., 2005[130]). Simple tactics to reduce errors in communication include adopting protocols for proper hand-off/warm hand-off, enabling electronic health records to generate and send referrals to the next appropriate level of care, or simply using a referral form from sender to receiver (Joint Commission, 2012[67]).

- Care coordination is a critical component of effective intervention for those at risk and has been successfully integrated in primary care settings (Falletta et al., 2020[131]). However, upon hospital/birth center discharge families are often only provided with general information about lactation support sources available in the community. Effective referrals for outpatient support with contact information of those who can manage lactation problems is paramount (Feldman-Winter et al., 2020). It is less common for an entity (provider or agency) to ensure that the lactation follow-up care is culturally congruent, that appointments are scheduled and indeed received, and that care is coordinated and supported across settings when a transition or multiple levels of care are involved (Cohen, 2013[132]).

- These CoC accountability breakdowns may cause confusion about next steps of care plans, overwhelm families, leave out most appropriate LSP options, and ultimately result in negative lactation outcomes such as non-medically indicated artificial formula supplementation or unintended weaning.

- Timely referral to appropriate level and type of care is key to seamless CoC (Pounds et al., 2017[133]). There are some lactation issues that can be easily solved with the counseling and support provided by a LSP with basic training. Other issues would be better managed by someone who has additional clinical lactation management experience and expertise. There are also complex medical issues that need the attention of a healthcare provider with breastfeeding medicine specialization or another professional specialty, such as ear nose and throat (ENT) medical doctors, pediatric dentists, speech-language and occupational therapists, child nutritionists, social services, craniosacral fascial, and orofacial myofunctional therapists. Ideally, each LSP would work from a clearly defined role and scope of work and have in place a referral system to the additional level of support when needed. Such a system will be reached only if every tier of the profession is appropriately valued and compensated, and barriers that have kept LSPs of color from reaching the top tiers are properly addressed (Long, 2015[134]). See LSP descriptor chart in the Appendix, page 74.

- Strategic community partnerships enhance the infrastructure to strengthen linkages among LSPs, community organizations, and other medical providers and improve the CoC. Without these kinds of collaborations for coordinated interventions, services are often provided in a siloed and fragmented fashion, which can be both ineffective and inefficient (Stange, 2009[135]). Formal agreements, such as MOUs, clarify the roles and responsibilities of each organization and staff to reduce the communication breakdowns within CoC and ensure policies and protocols exist to ensure seamless transitions for each family, when needed. Informal agreements can also be beneficial when created as part of a collective impact initiative as a starting point towards more formalized referral systems that may be needed but can be time and resource consuming.

- Currently, each care episode is distinct and disconnected from past and future events. Attention and investment are needed to strengthen the infrastructure for patient information systems, such as interoperable electronic health records, enabling electronic health information (EHI) to securely follow the patient when and where it is needed across providers within the continuum (The Office of the National Coordinator for Health Information Technology, 2019[136]) and generating bidirectional referrals with proper exchange of information and care acceptance. While these systems do not guarantee strong informational continuity, they can help connect individual's records across settings as families are referred or migrate between locations (Schwarz, 2019[65]).

Hand-offs/Warm Hand-offs

Agency for Healthcare Research and Quality (AHRQ). Warm Hand off Intervention: http://bit.ly/WarmHandoffIntervention

Breastfeeding Support Referral Form (template): https://www1.nyc.gov/assets/doh/downloads/pdf/csi/csi-breastfeeding-hosp-referral.pdf

Broward County, Florida Department of Health (DOH): Integrating WIC Peer Breastfeeding Support into the Hospital and Community: http://bit.ly/BreastfeedingStories

Centers for Disease Control and Prevention (2011). Healthy Community Design Fact Sheet Series, Impact of the Built Environment on Health, National Center for Environmental Health: https://www.cdc.gov/nceh/publications/factsheets/impactofthebuiltenvironmentonhealth.pdf

Colchamiro R., et al. (2015). Mobilizing community resources to enhance post discharge support for breastfeeding in Massachusetts (USA): results of a catalyst grant approach. *Journal of Human Lactation, 31*(4), 631–640.

Dakota County Public Health Department, MN: Rapid Referral System: http://bit.ly/RapidReferralSystem

Garner, C.D. (2016). Discontinuity of breastfeeding care: "There's no captain of the ship." *Breastfeeding Medicine, 11*(1), 32–9.

Hillsborough County Florida DOH: Model Practice Women Infant Resource Specialist Position, see at NACCHO webinar: http://bit.ly/MarshalingCommResources

2020 NBCC Conference Innovations in Continuity of Care: https://www.lactationtraining.com/nbcc#three, features:

- Cincinnati Children's Hospital. Addressing Gaps in Breastfeeding: from Hospital to First Visit (Quality Improvement Process)
- Hawaii Breastfeeding Workgroup. The Breastfeeding Toolkit: Rapid Innovative Process to Expand Lactation Support in Hawaii
- Plains Montana Breastfeeding Taskforce: The Virtual Baby-Bistro & Increasing Rural Access to Breastfeeding Support

NACCHO Transitions of Breastfeeding Care Stories: https://www.naccho.org/uploads/downloadable-resources/Breastfeeding-Continuity-Care.pdf

NACCHO Webinar: Community-Clinic Linkages in Breastfeeding: http://bit.ly/CCLinbreastfeeding

Re-engineering Discharge Toolkit: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html

The Joint Commission Center for Transforming Healthcare. Hand-off communications: http://bit.ly/HandOffCommunications

United States Breastfeeding Committee, Lactation Support Providers (LSP) Constellation: http://www.usbreastfeeding.org/lsp-const.

Resources, Tools and Examples From the Field

3

Telehealth Resources

Demirci, J. R., et al. (2020). The development and evaluation of a text message program to prevent perceived insufficient milk among first-time mothers: retrospective analysis of a randomized controlled trial. *JMIR mHealth and uHealth, 8*(4), e17328.

Dos Santos, Laura, et al. (2020). Telehealth and breastfeeding: an integrative review. *Telemedicine and E-Health, 26*(7), 837–46.

Kapinos, K. et al. (2019). The use of and experiences with telelactation among rural breastfeeding mothers: secondary analysis of a randomized controlled trial. *Journal of Medical Internet Research, 21*(9), e13967.3.

Maternal Health Learning and Innovation Center (MHLIC). Maternal Telehealth Access Project: https://maternalhealthlearning.org/telehealth/

Plains Montana Breastfeeding Taskforce: The Virtual Baby-Bistro & Increasing Rural Access to Breastfeeding Support: https://www.lactationtraining.com/nbcc#three

Reaching our Sisters Everywhere. (2020). How ROSE transitioned to a Virtual Baby Café: www.breastfeedingrose.org/vbc

The Joint Commission (2013). Transitions of Care The Need for Collaboration across Entire Care Continuum: http://bit.ly/TransitionsCareContinuum

Uscher-Pines, L. et al. (2020). Feasibility and Effectiveness of Telelactation Among Rural Breastfeeding Women. *Academic Pediatrics, 20*(5), 652–659.

4TH Trimester Project. Telehealth Resources: https://newmomhealth.com/telehealth

Transitions of Care in Breastfeeding Stories

Broward County Florida Department of Health In-Hospital Peer Counselor Connecting to WIC Breastfeeding Support: http://bit.ly/BreastfeedingStories

Community-Clinical Linkages in Breastfeeding Webinar and CoC Stories: bit.ly/BreastfeedingCCL

Linking Peer Counselors to Hospitals and Pediatricians: Monroe County DOH

Post-discharge Referral Systems: Parkland Health, Hospital Center and City of Dallas Lactation Care Center

Written Agreements and Memorandum of Understanding for Steps 3 & 10 and Referral System: Mississippi State DOH

Dakota County Public Health (MN) Rapid Referral System: http://bit.ly/RapidReferralSystem

Florida Department of Health in Hillsborough County. Model Practice. Care Coordinator Role: http://bit.ly/FLDOHCareCoordinator

NACCHO. Closing the Breastfeeding Care Gap: http://bit.ly/BFCareGap

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The Joint Commission (2012). *Transitions of Care: The need for a more effective approach to continuing patient care*. http://bit.ly/TransitionsofCare

The Office of the National Coordinator for Health Information Technology (2019). *Trusted exchange framework and common agreement (TEFCA) draft 2*. http://bit.ly/TrustedEF

4

Community Infrastructure Recommendations

Community-Driven Chest/ Breastfeeding Data System

Recommendation:

Develop a shared community breastfeeding database system to track infant feeding consistently for community health collective impact efforts.

Strategies 4

4.1

Assess availability and accessibility of existing community-level breastfeeding data collection systems among local healthcare systems, WIC, and local and state health departments to leverage a shared system.

4.2

Standardize and share indicators among community stakeholders to facilitate shared community-relevant breastfeeding surveillance data collection and reporting systems. Indicators may include breastfeeding initiation and exclusivity at established milestones, birthing outcome data, local lactation support resources with geospatial information, family demographics, and barriers to breastfeeding.

4.3

Develop a data sharing agreement (DSA) outlining what data users should report and can access, and other data users' rights and responsibilities. The DSA also states that users can use such data only to improve programs and services that ultimately eliminate disparities and benefit the community's health equitably.

4.4

Designate a backbone organization to support others in using health data to prioritize and gauge stakeholder efforts' success.

4.5

Healthcare organizations should assess EHR/EMR capabilities and update templates to query and collect appropriate breastfeeding data accurately and inclusively.

- Data should tell a story of where the CoC gaps exist. Population-level data is necessary to understand needs, drive investments, inform efforts, and support models of care that provide best-matched services for infants and their families in the context of their needs and resources (Reuland et al., 2020[137]). The availability of quality county or community-level infant feeding data that is stratified by race and ethnicity, geography, and socioeconomic status is essential to understanding how to better inform priority efforts and resources to equitably improve CoC. However, these types of data are not often easily available. In fact, they are not commonly tracked outside of the WIC program and a few other maternal-child programs in the community. Most of the available breastfeeding data exists at national, state, and hospital levels, accessible from the CDC. There also may be relevant data from the National Health and Nutrition Examination Survey (NHANES) or the Pregnancy Risk Assessment Monitoring System (PRAMS).

- Breastfeeding data is consistently collected by the WIC program, which includes breastfeeding performance measures. However, this data is not always easily accessible by other community agencies. Each local agency tracks participants' breastfeeding data and reports to their state, which then reports the data to USDA. WIC data is then aggregated on a regional level, often resulting in the loss of important information related to barriers and successes (Berkowitz, 2019[138]), and the data compilation is reported by USDA with no additional socioeconomic status, race/ethnicity, and milestone information. Moreover, WIC data reflects only a subset of the community; only using one local dataset is limiting and does not depict the true picture of breastfeeding rates in a given community.

- Other maternal child health programs in the community, such as Early Head Start, Nurse Family Partnership, and Healthy Start, may also collect some breastfeeding data, but the type of data collected and indicators may not align with each other. In fact, there is a lack of nationally standardized breastfeeding-related definitions, corresponding measures, and mandated collection such as a Healthcare Effectiveness Data and Information Set (HEDIS) measure, that helps to identify opportunities for improvement, monitor quality improvement, and provide a set of measurement standards (Centers for Medicare & Medicaid Services, n.d.[139]).

- Health centers, healthcare provider offices, LSP private practices, and other outpatient settings may also collect some type of infant feeding data through their electronic medical records/ electronic health records (EMR/EHR) systems. Although for decades, healthcare providers have sought a system that enables a patient's Electronic Health Information (EHI) to flow, data sharing is rare. Connectivity across systems and networks remains fragmented and interoperable uses of EHI vary (The Office of the National Coordinator for Health Information Technology, 2019[140]). An area of opportunity is to explore interoperability among systems that can allow all in the CoC spectrum to have a more complete view of the family's infant feeding journey by incorporating information from various clinical settings and systems, and facilitating the linkage of maternal health records with infant health records.

- The collective impact framework uses shared data measurement as an essential component of any collaborative and can be tailored to improving CoC for community breastfeeding support. There are several related resources that outline steps in the process of building streamlined community data systems, such as guidance for protecting data, collaborative use agreements, and other important tools and templates (Cooper & Schumate, 2015[141]). Ideally, community stakeholders, such as agencies serving pregnant and postpartum families, should together determine which qualitative/quantitative local data is relevant to track, and define common metrics, indicators, and benchmarks to ensure comparability, and data collection forms. Finally, they could identify a streamlined method for data reporting and sharing, such as a community data dashboard and other data visualization tools.

Resources, Tools and Examples From the Field

4

Community Example: Healthy Lincoln: https://www.healthylincoln.org/welcome.html

Guide to Evaluating Collective Impact: http://bit.ly/collectiveimpactguide

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Page 53: https://www.naccho.org/uploads/downloadable-resources/2018-Forces-of-Change-Main-Report.pdf

Opportunities in Electronic Health Record: http://bit.ly/EHrecord

United Way of Erie and Buffalo County. Local breastfeeding database planning. Presentation slides and Process map: http://bit.ly/LocalBfDatabase

Selecting a Technology Provider: http://bit.ly/technologyprovider

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The Office of the National Coordinator for Health Information Technology (2019). *Interoperability: trusted exchange framework and common agreement:* http://bit.ly/exchangeframework

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5

Lactation Workforce Recommendations

Public Health, Allied Health and Healthcare Workforce Education

Recommendation:

Increase community capacity to provide consistent, tailored, evidence-based lactation education and support by regularly training all individuals who provide services to the family unit.

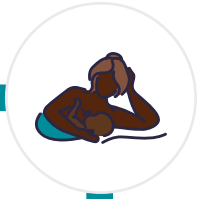
Strategies 5

5.1

Incorporate a minimum competency requirement in lactation management education for health professionals in organizations serving pregnant and postpartum families.

5.2

Increase community access to multi-level lactation support training opportunities with continuing education credits to support maintenance of minimum competencies and skills and to train and build the local LSP workforce. Consider building community capacity to design and deliver training to others in the community, such as securing train-the-trainer certifications that certify individuals as lactation trainers.



5.3

Integrate lactation education and support curriculum into health-related vocational programs, skilled trade technical programs, and undergraduate and graduate education for health professionals within the community.

5.4

Improve access to training and mentors and create equitable paths to career advancement opportunities to build up community-based leadership, especially for LSPs of color to better serve families of color and diversify the lactation workforce.

5.5

Establish consistent breastfeeding messaging across agencies and within the lactation workforce (LSPs and others interacting with pregnant and postpartum families) to ensure families hear the same message at every interaction, regardless of the setting. Partner with peer organizations to identify existing suitable training curricula, common educational materials, or co-create resources, as identified and needed.

- Families will interact with various entities and health professionals throughout their pregnancy and into toddlerhood. Health professionals are strong influencers on parents' decisions and ability to breastfeed and have a unique role in ensuring seamless CoC for families (Debevec, A., 2016[142], Pérez-Escamilla et al. 2012[116]).

- Consistency in educational content and chest/breastfeeding messaging provided to families across professions can reduce confusion and prevent the negative outcomes that come from CoC communication breakdowns.

- Including breastfeeding education in medical schools and continuing medical education opportunities can improve healthcare providers' confidence and improve care and lactation outcomes. However, there is limited training among healthcare providers. More recently, the American Academy of Pediatrics has developed a breastfeeding residency curriculum and has been working on other educational efforts.

- Each individual interacting with families has different opportunities and influences to educate, encourage, and provide direct clinical services to pregnant and postpartum parents. Adequate training, consistent communication among healthcare providers, and respect for different scopes of healthcare disciplines are indispensable for integrating care toward a patient-centered focus, optimizing cost-efficiency, and patient satisfaction and health outcomes (Chao et al., 2016[143]; McFadden et al., 2017[19]; Ramakrishnan et al., 2014[144]; Rosin, 2016[69]). The level of training — such as peer encouragement, basic lactation education, intermediate hands-on support, or advanced clinical management — needed depends on each individual role, capacity and skills required. The respect of different scopes within the LSP spectrum and other healthcare disciplines are indispensable for integrating care and optimizing cost, as it helps everyone involved in lactation care to understand the appropriate level of care needed to match families' specific needs at a given time.

- The Surgeon General's Call to Action to Support Breastfeeding (2011) recommended establishing and incorporating minimum requirements for lactation care competency into health professional credentialing, licensing, and certification processes. This Blueprint recommendation adds that organizations providing services to pregnant and postpartum families should incorporate a minimum set of lactation care competencies into job requirements and provide these trainings, or collaborate with others, to achieve this strategy.

- Since pregnancy and lactation are biological parts of the human life course, it is essential that individuals interacting with pregnant and postpartum families (not only clinical providers, but also allied and support staff such as front desk, medical assistants, patient navigators, community health workers, and others) have training to develop a solid base of information to support the health of parents and children, including the positive outcomes of human milk feeding, basic lactation management, where to refer families in need of additional support, and their unique role in helping establish CoC.

- Overall, there are limited lactation training opportunities tailored for outpatient staff working with postpartum families. Most lactation trainings are tailored and provided as a requirement of the BFHI and aimed at lactation management in the immediate postpartum period. Given the recommendations to continue breastfeeding for one or two years and beyond, it is expected that family units will use various health services over several years from pregnancy to toddlerhood, which makes lactation training focused on issues beyond birthing and the first weeks at home critical to achieve CoC.

- It is critical that the LSP workforce reflects the diverse communities they serve. However, there are several barriers to entrance into and maintenance of the LSP profession, and limited opportunities to generate revenue to make a living, without additional sources of income, particularly for BIPOC, LGBTQIA+ individuals and persons with disabilities. Each community should identify and create or enhance access to opportunities for both training and mentorship to build capacity in a sustainable and equitable manner.

Resources, Tools and Examples From the Field

5

Breastfeeding Competencies for Health Care Professionals: http://www.usbreastfeeding.org/core-competencies

Community Health Workers as Infant feeding advisors training: https://mnbreastfeedingcoalition.org/chws-as-infant-feeding-advisors/

Equity in Breastfeeding Report: http://bit.ly/EquityinBF

Gary, A., et al. (2017). Improving breastfeeding medicine in undergraduate medical education: A student survey and extensive curriculum review with suggestions for improvement. *Education for Health, 30*(2), 163–168.

Holmes, A., et al. (2012). Physician breastfeeding education leads to practice changes and improved clinical outcomes. *Breastfeeding Medicine: The Official Journal of the Academy Of Breastfeeding Medicine.*

Indigenous Breastfeeding Counselor: https://www.facebook.com/IndigenousBreastfeedingCounselor/

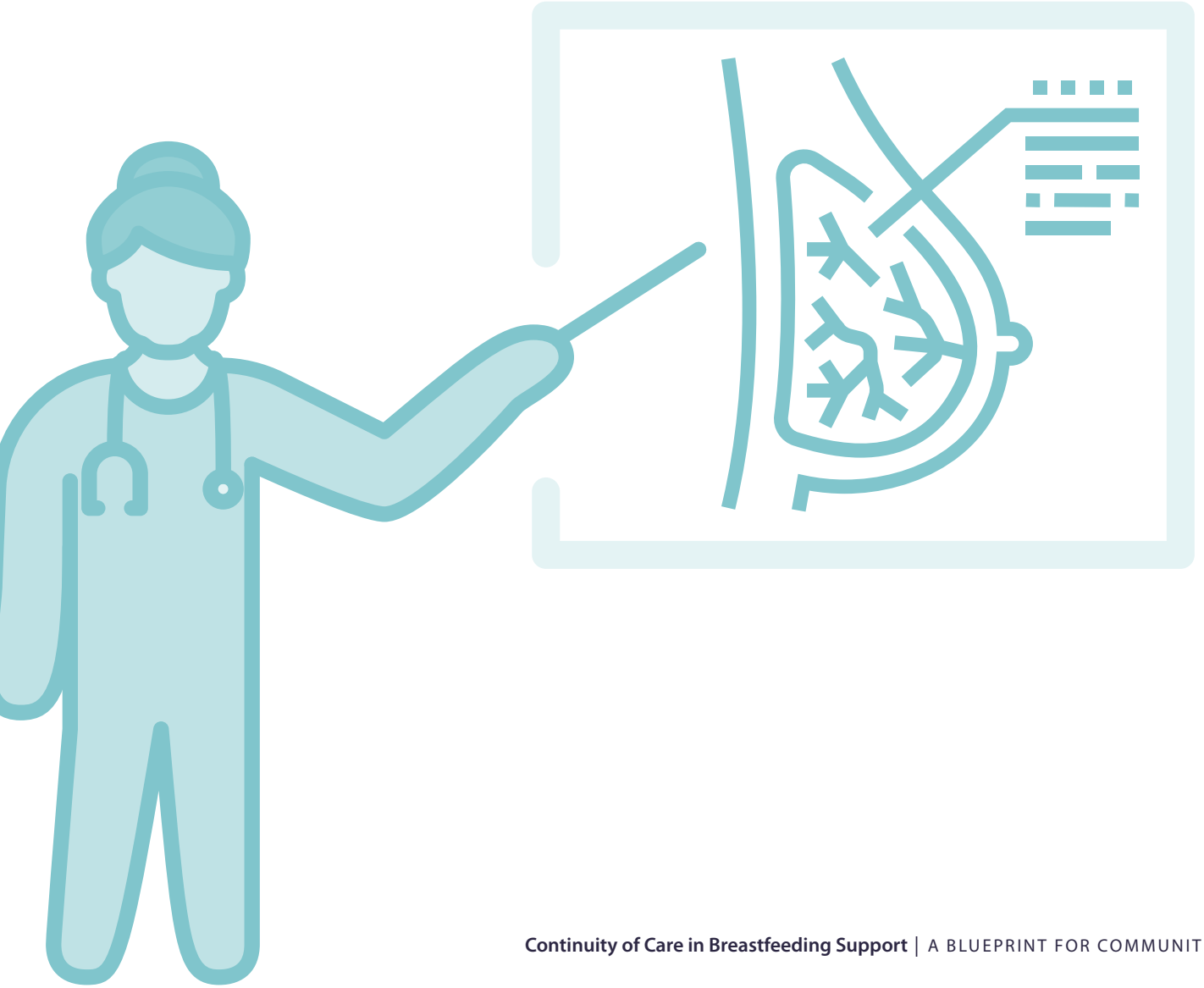
Lactation Education Accreditation and Approval Review Committee courses: https://leaarc.org/

Physician Breastfeeding Training Curriculum: http://bit.ly/physicianBF

Szucs, K.A., et al. (2009). Breastfeeding knowledge, attitudes, and practices among providers in a medical home. *Breastfeeding Medicine, 4,* 31–42.

The B.L.A.C.K course: The B.L.A.C.K. Course

The Institute for Breastfeeding and Lactation Education (IABLE): https://lacted.org/



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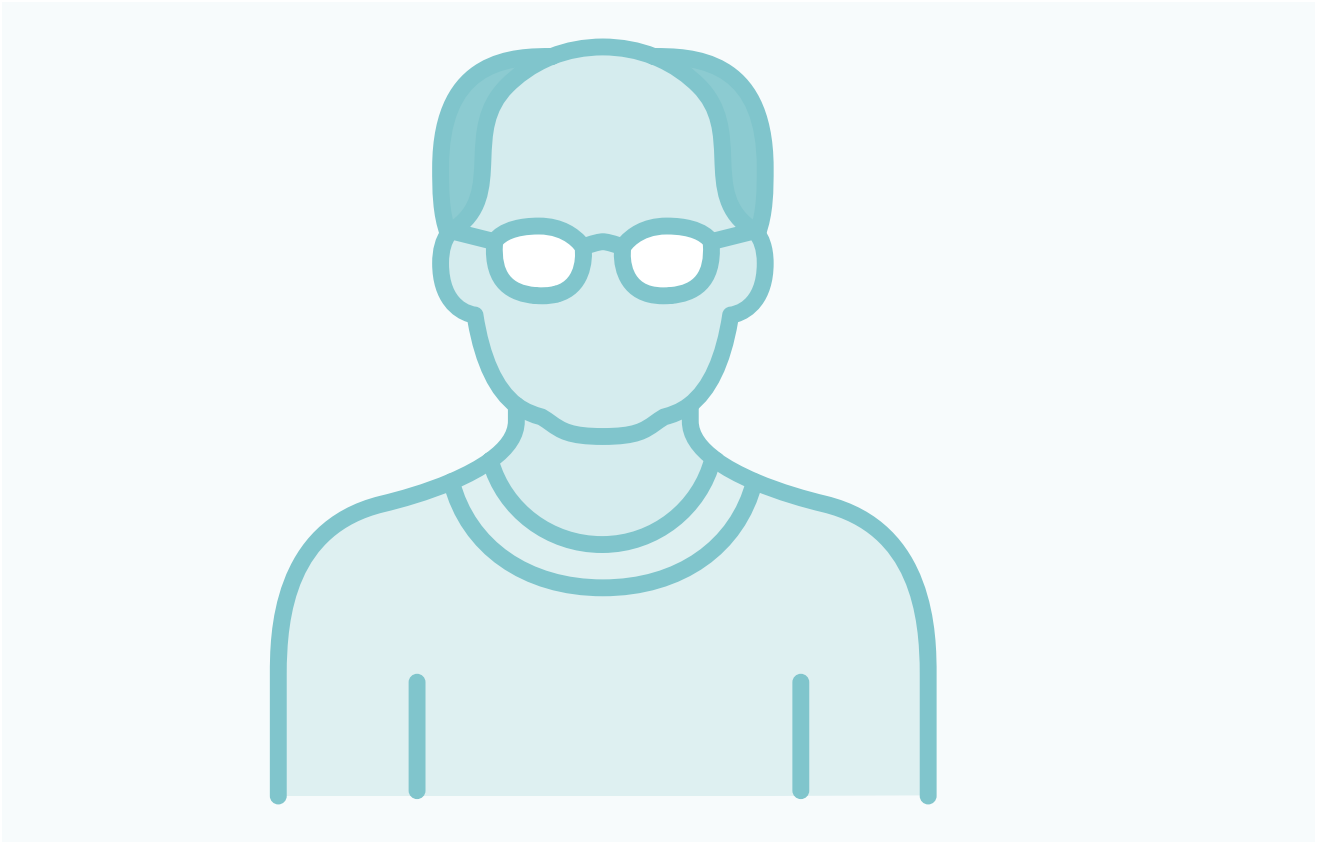

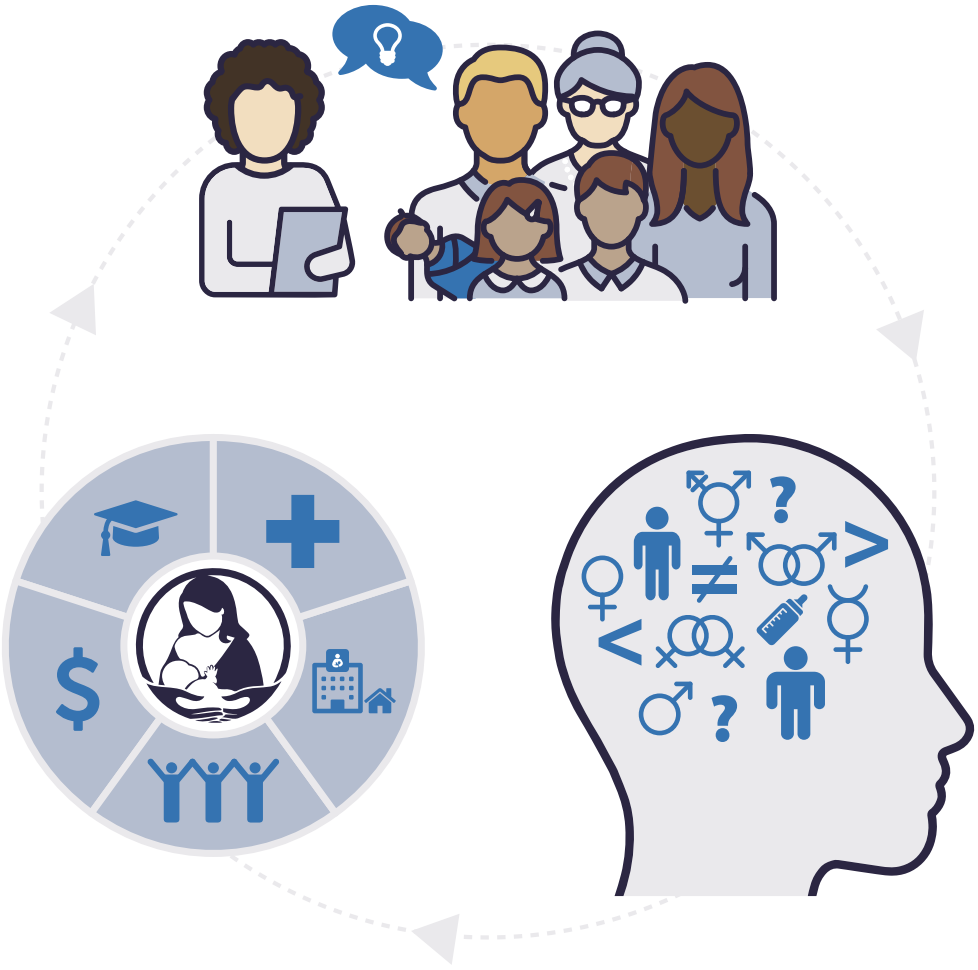

6

Lactation Workforce Recommendations

Family-Centered Care, Implicit Bias Awareness & Cultural Humility Approach

Recommendation:

Provide family-centered lactation care that is responsive to the intersectionality of families' multiple identities, their social determinants of health, and other factors impacting their infant feeding journey.

Strategies 6

6.1

Utilize the cultural humility (CH) approach and motivational interviewing techniques to learn about a family's culture, values, and needs and to fix provider-client power imbalances while building trust and authentic relationships.

6.2

Actively engage in trainings to understand and recognize one's own implicit biases to avoid prejudice and stereotyping. Individuals providing education and support to families should distinguish their personal infant feeding experiences from current research to ensure only evidence-based information is conveyed to families.

6.3

Include and engage other individuals within the family's support system, such as spouses, significant others, siblings, and grandparents, in screening, education, care planning, counseling, and other support services.

6.4

Incorporate a shared decision-making tool to help inform a plan for lactation care (similar to a birth plan), honoring families' preferences and values.

6.5

Integrate universal screening for social determinants of health that may impact infant feeding practices to identify families at-risk for suboptimal breastfeeding as part of routine prenatal and postpartum appointments, and collaborate with community partners to address these factors through referrals to appropriate services.

6.6

Increase access to congruent lactation care that matches families' needs and preferences, while also creating financially compensated opportunities for BIPOC, LGBTQ+, and other persons routinely underrepresented to lead, manage, and collaborate with community programs, develop lactation-related resources, deliver trainings, and other career advancement opportunities.

- Relational continuity is one of the three dimensions of CoC and refers to the provider-patient relationship. Research has shown that these relationships are integral to quality healthcare (Price & Lau, 2013[78]; Reid et al., 2016[79]). Mutually respectful and trusting healthcare relationships influence satisfaction with care and health outcomes (Robinson et al., 2016[145]).

- Evidence suggests that disparities in breastfeeding exist in part due to institutional racism, biased practices, or unconsciously prejudiced care on the part of professional breastfeeding support (Johnson et al., 2015[47]; Mojab, 2015[146]). Implicit or unconscious bias describes subconscious attitudes and stereotypes that affect understanding and actions. Recognizing that everyone brings bias to interactions with others and that stereotypes often influence the quality of care delivered, it is key that individuals and the various stakeholders from across the socio-ecological model of breastfeeding examine their own bias and prejudices and take steps to prevent them from impacting their ability to provide the best care possible for families.

- Treating everyone the same is not one of these steps. Each family has a different background, resources, access, and personal culture. Achieving chest/breastfeeding equity includes achieving the same optimal infant feeding outcomes for all families, in alignment with their goals and preferences. The CH approach in lactation care can be used to counteract biased care and stereotyping and help fix provider-patient power dynamics. CH is a lifelong commitment to self-evaluation and critique, redressing power imbalances, and developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations (Tervalon & Murray-Garcia, 1998[147]). CH aims to develop a self-ability to maintain an interpersonal stance that is other-oriented in relation to aspects of cultural identity that are most important to the family served.

- Family-centered care and motivational interviewing are some of the counseling methods that are in line with cultural humility principles and are appropriate to develop a strong working relationship and conduct effective counseling, where the provider must be able to overcome the natural tendency to view one's own beliefs, values, and worldview as superior, and instead be open to the beliefs, values, and worldview of the diverse client.

- Family-centered care is grounded in mutually beneficial partnerships among healthcare professionals, patients, and families. This collaboration assures that care is responsive to priorities, preferences, and values of patients and their families. In family-centered lactation care, the birthing person defines their "family" and determines how they will participate in care and decision-making as a part of their support network. This perspective is based on the recognition that patients and families are essential allies for healthcare quality and safety — not only in direct care encounters but also in efforts to improve healthcare for all (Johnson, 2016[148]; The Institute for Patient and Family-Centered Care, n.d.[149]).

- Social determinants of health (SDOH) — the conditions in which people are born, grow, work, live, and age that affect health and quality of life, and the degree to which people can access affordable, safe housing, nutritious food, (U.S. Department of Health and Human Services, 2019[150]) — are strongly associated with inequities in breastfeeding (Renfrew, 2012[18]; ASTHO, 2017[151]). LSPs and others providing direct services that do not consider SDOH's impact on infant feeding fall short of being family/patient-centered, which may lead to negative health outcomes.

- Screening for SDOHs and the impact of the family's intersectionality in their infant feeding journey and engaging in cross-sector collaboration to build partnerships to address complex social needs and link families to needed resources is key to advancing equity (Lynn, 2020[152]; Crear-Perry et al., 2021[153]). Given the siloing of SDOH from clinical care, a screening for SDOH helps inform adjustments in services and referrals needed to tailor services to better meet the individual needs of families served. This approach is useful not only for understanding a specific family unit context, but also in moving farther upstream toward identifying community-specific structural determinants of health: cultural norms, policies, institutions (Crear-Perry et al., 2021[149]) and practices that may impact infant feeding and access to (lactation) care.

- Shared decision-making is a form of nondirective counselling in which the provider and patient come together as experts, in clinical evidence and lived experience respectively, to help families navigate complex feeding decisions, evidence-based recommendations, their personal goals, potential complex feeding issues, and clarify the value they place on the different options to feed and care for their infant or young child. The ideal outcome of a shared decision-making process is a parental decision that is informed, consistent with their preferences and values, and respected and supported by all professionals caring for the family (Haiek, L, 2021[154]; Unger, 2020; Munro et al., 2019[155]).

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Cultural Humility and Cultural-specific Resources

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Association of Women's Health, Obstetric and Neonatal Nurses (2015). Breastfeeding support: preconception care through the first year. Evidence-based clinical practices guidelines. *Journal of Obstetric Geology and Neonatal Nursing, 44*(1), 145-150. https://doi.org/10.1111/1552-6909.12530

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NACCHO Cultural Humility Factsheet: http://bit.ly/CulturalHumilityFactsheet

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African American Breastfeeding Network: http://aabnetwork.org/

Reaching Our Sisters Everywhere: http://www.breastfeedingrose.org/

Native American Breastfeeding Coalition of Wisconsin: https://www.glitc.org/NativeBFCoalition

Adelante. The Latino Network for Health and Education.

Asian Pacific Islander Breastfeeding Taskforce: http://bit.ly/APIBftaskforce

Cultural breastfeeding coalitions directory: http://www.usbreastfeeding.org/coalitions-directory

Resources, Tools and Examples From the Field

6

Family-Centered Care Resources

Cultural and Linguistically Appropriate Services (CLAS) in Maternal Health Care: http://bit.ly/CLASinMCH

Eagen-Torkko M. (2019). Concordance as a Person-Centered Measure of Breastfeeding Success: From Adequacy to Agency. *Journal of Midwifery & Women's Health*, 64(6), 753–757.

Family-centered Care Initiative Guide: http://bit.ly/familycenteredguide

Papautsky E. L. (2019). Adjusting for patient context in inpatient breastfeeding education: a human factors perspective. *Journal of Midwifery & Women's Health*, 64(6), 699–702.

Grandmothers, Spouses and other Family Members Resources

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Social Determinants of Health

Social Needs Screening Tool: http://bit.ly/AAFPSocialNeeds

National Association of Community Health Centers: Protocol for Responding to and Assessing Patient Assets, Risks, and Experience (PRAPARE): http://bit.ly/NACHCPRAPARE

Centers for Medicare and Medicaid Services: The Accountable Health Communities Health-Related Social Needs Screening Tool: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

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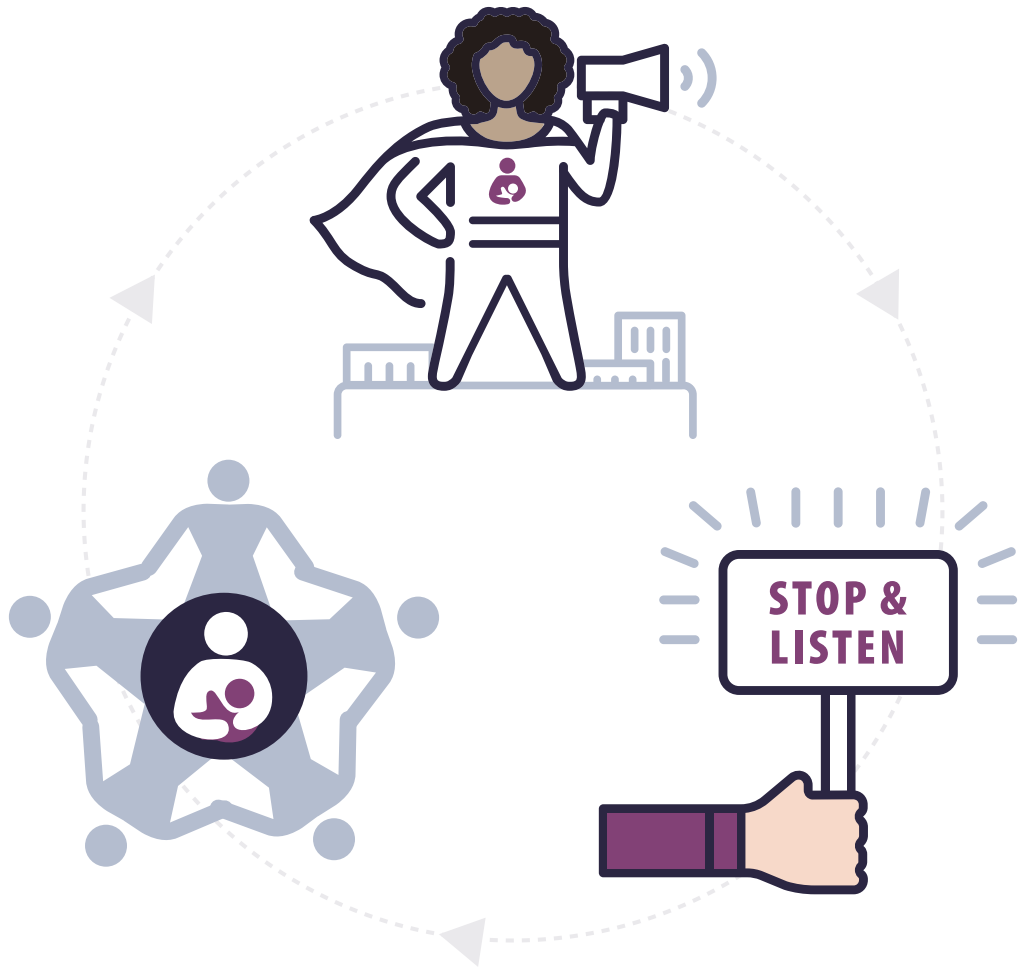

7

Lactation Workforce Recommendations

Health Advocacy and the Local Breastfeeding Champion Role

Recommendation:

Assume a community champion role, beyond the provision of direct services, by identifying and engaging key stakeholders to identify and help remove structural barriers to chest/breastfeeding within systems, organizations, and the community.

7.1

Intentionally build or engage with an existing multi-sectoral coalition that represents lactation support touchpoints throughout the community and includes all voices and perspectives within the coalition to properly identify and leverage opportunities for the advancement of an equitable CoC in breastfeeding support system. Distribute leadership across the coalition to maximize the strengths of each partner for maximum effect. Adopt diversity, equity, and inclusion statements and establish practices with concrete goals for creating both safe and brave spaces within coalitions, embracing values of mutual respect for the many voices expressed. Recognize and welcome that exploratory conversations, identified levers for change, and priority strategy selections will all change fundamentally when and as new voices come to the table.

7.2

Once a diverse, multi-sectoral coalition is developed and centered, explore the gaps within CoC using a root cause analysis (equity) lens to understand what people and groups are most impacted, and which existing institutions, policies, or laws are perpetuating those gaps or present barriers to ending community breastfeeding disparities. Identify high-level levers for change that require collaborative action to build continuity of care for lactating families, and together, choose the priority strategies to tackle as a coalition. An example may include amplifying community access to pasteurized donor human milk.

7.3

Recognizing each person's capacity for allyship (being an ally), identify and use one's own privilege to advocate for local services and amplify the voices of other people in the field who do not hold the same privilege. Disseminate and promote best and promising practices, tools, resources, financial sustainability, and lessons learned from successful implementations at regional, state, and national spaces. Share useful resources with other coalitions within the state and across the nation and to those in the community providing direct services to families.

7.4

Connect breastfeeding coalitions to countywide health initiatives, usually led by LHDs and CBOs to better understand overall community experience, identify leveraging opportunities, disseminate lactation support resources, and engage with other health and non-health specialties, such as community organizers, social services, emergency preparedness, housing and transportation, community designers, etc.

- Tribal, cultural, local/community or state multi-sectoral breastfeeding coalitions have a wide net of representation and capacity to collectively identify and work on levers for change that can have significant impact within a community.

- Provision of ongoing, high-quality, and coordinated lactation care alone is not enough to establish CoC in breastfeeding support within a community. Direct service does not address all the causes of suboptimal rates of breastfeeding. Therefore, LSPs and other individuals interacting with families may go beyond provision of lactation care for families and join community efforts to advocate for improvement in the broader conditions that affect chest/breastfeeding.

- Activities related to ensuring access to care, navigating systems, mobilizing resources, addressing health inequities, influencing health policy, and creating system changes are known as health advocacy. Evidence-based public health advocacy is key to addressing the root causes of community suboptimal breastfeeding rates of diverse communities. Everyone involved in lactation support can play a *champion* role to creating local societal and policy changes needed to create a community where health and breastfeeding equity is a reality. Advocacy skills, however, need to be taught. Being an advocate requires that an individual believes they can effect change, is motivated to do so, and is able to envision what improvements are needed and how they can be instituted. Embracing coalition building is a method to address complex health issues such as community support for breastfeeding (Campbell, 2021). LSPs and other individuals interested in advancing CoC in breastfeeding outside of their regular scope of work can work collaboratively with other like-minded people in the community by engaging with breastfeeding coalitions.

- Collective impact (CI) has been widely adopted as an effective form of cross-sector collaboration to address complex social and environmental challenges. CI has proven to be a powerful approach in tackling a wide range of issues in communities (Tamarack Institute, n.d., Collective Impact Forum, n.d.). Coalition members and the organizations they may represent usually share a common agenda and are working together for collective impact. Ideally, coalitions include a diverse range of individuals and CBOs providing direct support services, other local and state-level organizations advocating for change, individuals with lived experience, and community leaders and organizers.

- Eliminating inequity in the field of breastfeeding requires that we understand that racism and all other systems of privilege/oppression exist at various levels: personally mediated, internalized, institutional, and systemic (Mojab, 2015[142]; Jones, 2000[156]).

- An ally is someone who is not a member or is not representative of an oppressed community, but who recognizes their own privileges, spaces of power and influences, and uses it to amplify underrepresented voices, and proactively support the work and leadership from these communities.[157] Practicing critical allyship includes guiding people in positions of privilege to recognize their position of privilege and spaces of influence, and proactively effecting change to the unjust structures that produce health inequities, while working in solidarity and collective action to dismantle systems of inequity (Nixon, 2019[158]). All LSPs should identify their own privileges and opportunities to be active allies to other LSPs and families with less access and fewer resources. LSPs and others individuals who provide direct care to families may help center chest/breastfeeding into every conversation, amplify local successes, help to build practice-based evidence, and attract potential funding and investors through dissemination of local evidence-based approaches to protect, promote, and support breastfeeding wherever they are, including in multidisciplinary meetings, and regional, or national conferences.

U.S. Breastfeeding Committee http://www.usbreastfeeding.org for resources to support coalitions and organizations in the human milk feeding support community including:

- Coalitions Support: http://www.usbreastfeeding.org/coalitions-support
- Breastfeeding Coalition Directory: http://www.usbreastfeeding.org/coalitions-directory
- The Coalitions Technical Assistance Webinar Series: http://www.usbreastfeeding.org/coalition-ta
- A Diversity, Equity, and Inclusion Reading List and Resources: http://www.usbreastfeeding.org/equity
- Collective Impact Webinar Series Archive: http://www.usbreastfeeding.org/collectiveimpactwebinars
- Membership in the USBC: http://www.usbreastfeeding.org/join-usbc
- Subscription to News & Action Alerts: http://www.usbreastfeeding.org/subscribe

Prevention Institute. Developing effective coalitions: http://bit.ly/PreventionInstitute8

Kansas Breastfeeding Coalition: https://ksbreastfeeding.org/about-kansas-breastfeeding-coalition/

Community Partners Engagement: http://bit.ly/communitypartnersengagement

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Tamarack Institute. Community Engagement is the process by which citizens are engaged to work and learn together on behalf of their communities to create and realize bold visions for the future: https://www.tamarackcommunity.ca/communityengagement

CoalitionsWork for resources and tools: http://coalitionswork.com/resources/tools/

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Tamarack Institute: Collective Impact: https://www.tamarackcommunity.ca/collectiveimpact

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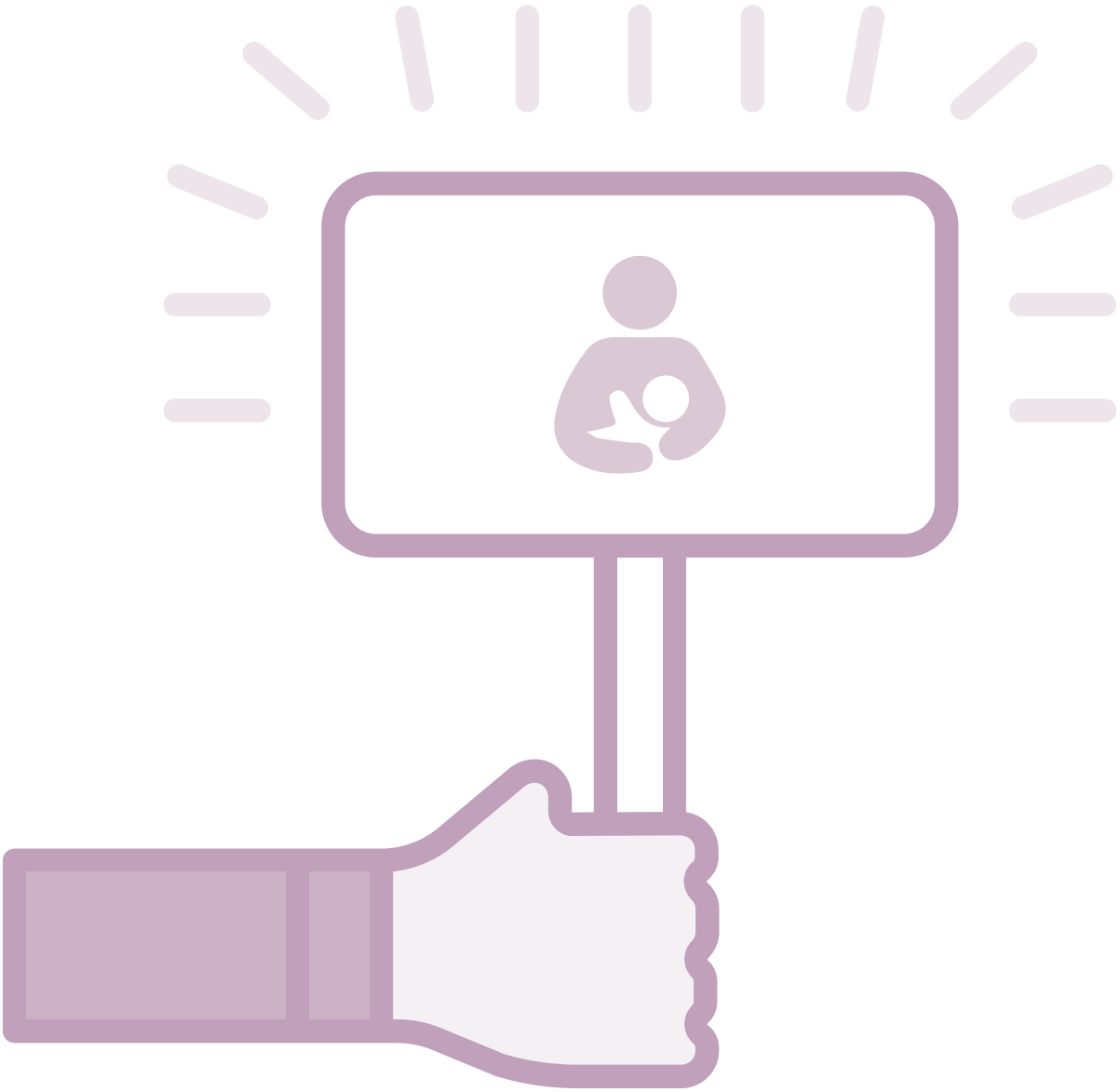

Conclusion

Summary

CoC implementation is intended to increase breastfeeding exclusivity and duration rates in all populations, particularly in oppressed communities with historically low breastfeeding rates. Achieving CoC in a community will not just improve the short- and long-term health of community members, but will also reflect sustained, collaborative efforts among stakeholders and the implementation of breastfeeding PSE solutions.

These recommendations are not intended to be one-size-fits-all prescriptions. Each community is unique, and the process of advancing the local chest/breastfeeding CoC framework will look different within each.

It is the hope that through this decade, CoC implementations will help to increase breastfeeding exclusivity and duration rates in all subsets of populations, especially in communities with disparate health inequities, thereby achieving Healthy People 2030 breastfeeding goals and improving the overall health of many communities in both the short- and long-term.

Additional resources, such as specific stakeholders' roles and unique spectrum of opportunities, community lactation assessment tools, and other supporting resources to implement these recommendations above will be co-created with communities and be available on the Continuity of Care in Breastfeeding Support national repository website: http://www.breastfeedingcontinuityofcare.org

Appendix

Public Health Lactation Equity Language: Challenging Stigma and Changing Narratives

Using inclusive language is essential within public health and for the lactation workforce as it contributes to safe and supportive environments for patients, clients, and communities, and ensures that programs and services are delivered with respect and meet the needs of all people. A key component of continuity of care is consistent messaging in breastfeeding education and support in printed materials and verbal communication; no matter how established continuity of care is, a community cannot be fully supportive of breastfeeding for all families unless it reflects all families. Through this document, we have used language to be inclusive. While we are not attempting to dictate any specific wording choice through this document, we recognize the importance of language in promoting and implementing inclusive and equitable continuity of care systems.

Chest/breastfeeding, breastfeeding, human milk feeding, lactating, and nursing will be used interchangeably to describe human milk (from donor or birth parent) feeding through a bottle, cup, spoon, syringe, or at the breast/chest.

Breast pumps/pumping also indicates chest pumps and expressing human milk.

Lactating people refers to all people who are lactating, chest/breastfeeding and expressing human milk, including those exclusively pumping.

Pregnant people/birthing people will be used interchangeably to recognize that people of many gender identities have babies and receive maternity care.

Parents will be used to refer to pregnant people, mothers, fathers, parents, adoptive parents, birthing people, and primary caregivers. It will be used to recognize that people of many gender identities — transgender, non-binary, and cisgender alike — have babies and receive maternity care. By using "parents," we also recognize the critical role of the non-birthing parent or other support person to support and enable the breastfeeding journey.

Family unit designates baby, parents and siblings, instead of mother-baby dyad, recognizing that the non-birthing parent has an equal role in supporting and enabling breastfeeding and should be included in any education, support, and care plan, and that individuals of any gender can be parents and primary caregivers.

Lactation Support Providers (LSPs) will be used throughout the document to indicate the spectrum of skilled lactation support within a community. LSPs are individuals who have received training specific to supporting breastfeeding. LSPs include: **Lactation educators** (with 20 hours of training); **breastfeeding peer counselors** (with personal experience plus at least 20 hours of training); **breastfeeding counselors** (with 45-54.5 hours of classroom training and an exam); and **lactation consultants** (with 90-95 hours didactic training hours, exam, and additional specific criteria depending on certification program). The U.S. Breastfeeding Committee (USBC)-Affiliated LSP Constellation includes national lactation training, mentoring, and accreditation organizations, plus aligned public health partners. Constellation members have created the Lactation Support Providers Descriptors Table, which reflects their consensus descriptions about the First Food field. The document was created in collaboration with the USBC-Affiliated Physician Education and Training Constellation, including ACOG, AAFP, and AAP. Physicians with lactation training are called **Breastfeeding Medicine Specialists.**

Note: *all types of lactation support providers are seen as valuable contributors in the field of lactation support. Each type of supporter provides a unique level of support that improves breastfeeding initiation, duration, and exclusivity (National First Food Cohort, 2016).*

Lactation workforce will encompass anyone who may interact with new parents and could provide education, referrals, support, and encouragement related to human milk feeding. It includes lactation support providers, breastfeeding medicine specialists, allied health, and public health personnel. Examples include but are not limited to a licensed vocational nurse in a community health clinic, front desk staff at a local health department, or human resources professionals for employers.

Community Lactation/Breastfeeding Support/ Community Support designates the provision of direct support services and supportive environments from community settings that enable chest/breastfeeding.

Cultural Humility will encompass and may be used interchangeably with culturally responsive, culturally appropriate, culturally tailored, and culturally attuned, but NOT culturally competent, to indicate a posture of constant learning and not making assumptions about a family's background, experiences, and/or choices related to maternity care and infant feeding.

Local health system for chest/breastfeeding includes community-based organizations (CBOs), local health departments, Women Infant and Children (WIC) offices, Community Health Clinics (CHC) or Federally Qualified Health Centers (FQHC), healthcare providers' offices, hospitals, pharmacies, breastfeeding coalitions, and other health and non-health settings with influence on human milk feeding within a community.

BIPOC families are family units composed of one or more parent(s) that identify as Black, Indigenous, and other People of Color. BIPOC is a newer term and is not reflected in breastfeeding research. Where research pertains to a specific population group, we will name that population group, but also recognize that BIPOC families have been historically oppressed and are likely to benefit from increased support, even if not specifically indicated by the research. **Although immigrant families are not always BIPOC, they will also be considered under this term throughout this document.**

Additional lactation inclusive language resources:

Bamberger ET, Farrow A. (2021). Language for Sex and Gender Inclusiveness in Writing. Journal of Human Lactation, February 2021.

Duckett LJ & Ruud M. (2019). Affirming Language Use When Providing Health Care for and Writing About Childbearing Families Who Identify as LGBTQI+. Journal of Human Lactation, 35(2):227–232.

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Blueprint Development Process Background

September 2018

Through funding from a cooperative agreement with the Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity and Obesity (DNPAO), and in partnership with the U.S. Breastfeeding Committee (USBC), the Continuity of Care (CoC) Constellation was reconvened under the National Association of County and City Health Officials' (NACCHO) stewardship in September 2018.

The Constellation Model is USBC's approach to implementing Collective Impact principles. This model distributes leadership to steward organizations, which lead and coordinate the efforts of aligned stakeholders, each of which leverages their capacity toward collective goals. In addition to centering equity at every stage of the collaborative process, the model also places a premium on the participants' determination of the strategic priorities and activities to be achieved, with the steward organization facilitating the identification and realization of the group's collective will. The goal of this working group was to bring together key stakeholders at the local, state, and national levels to:

advance the understanding, importance of and application of tools and best available evidence-based and evidence-informed practices to reduce missed opportunities to connect; support those in need of breastfeeding support and/or education where families live, work and play (and give birth and raise children), thereby reducing those who fall through the cracks due to transitions across the healthcare and community environments.

Throughout 2019

The CoC Constellation met monthly throughout 2019. During the first months, **the Constellation developed the following charter statement to set the context for the work:**

The Continuity of Care in breastfeeding Constellation recognizes that protecting, promoting, and supporting breastfeeding requires the involvement of many individuals, community organizations and spaces, as well as providers that enable families to have a feasible and supported breastfeeding experience. We recognize that the breastfeeding unit is more than just a mother and child, and that all involved must be given consistent messaging and support through an integrated referral system, to the appropriate level of support, throughout the entire breastfeeding experience.

The Constellation conducted two information gathering surveys to identify additional resources, stakeholders, and language to finalize the development of the CoC concept. A total of 111 survey answers were collected.

May 2019

Around May 2019, the Constellation developed a definition of continuity of care for breastfeeding:

Continuity of Care for breastfeeding removes the burden from families to be supported when it is coordinated with warm hand-offs through the various individuals, community organizations, and spaces.

Continuity of Care for breastfeeding brings equity to education and support by reducing instances of breastfeeding families "falling through the cracks" during transitions along the continuum of care and between healthcare and community environments.

The Constellation was then divided into five subgroups that reflect the first 1,000 days and beyond. This process allowed the group to identify and welcome additional experts from each field. The Constellation, originally with 21 members grew temporarily, for this specific Blueprint development task. The five subgroup themes were: Preconception & Prenatal period, Birth and Discharge, First Few Weeks, Return to Work/School, and Baby's 4+ Months.

The subgroups discussed the landscape of breastfeeding support and transitions of care for each of these lactation journey periods. They identified both barriers and facilitators to establish CoC and relevant resources, such as useful tools and successful examples from the field. These findings are translated into this Blueprint's strategies and recommendations.

June & July 2020

During June and July 2020, all subgroup participants and additional experts (71 participants in the first meeting, 58 in the second meeting) participated in an interactive virtual workshop (originally planned as an in-person meeting and canceled due to the COVID-19 pandemic) to identify specific roles of key stakeholders responsible for establishing breastfeeding support within a community. Additionally, participants provided input regarding resources needed by stakeholders to establish continuity of care.

Data were analyzed and categorized in themes, resulting in the seven core CoC recommendations. These recommendations and strategies were sent for final review and feedback to all who participated in any of the Blueprint development meetings, and a final feedback call was hosted. Overall, the majority of participants approved the recommendations and suggested some additional resources and comments.

USBC-Affiliated Lactation Support Provider Descriptor Chart

http://www.usbreastfeeding.org/p/cm/ld/fid=910

Lactation Support Provider (LSP) Descriptors

Category	Descriptions	Training	Credentials & Programs
Lactation Consultants	Referral to these health professionals is appropriate for the full range of breastfeeding care, particularly involving high acuity breastfeeding situations.	**90-95 didactic hours**, and additional training requirements and exam for each title. Often work clinically as part of the healthcare team in both inpatient and outpatient settings; may also work in private practice.	**International Board Certified Lactation Consultant® (IBCLC®)** Program accreditation by Nat'l Commission for Certifying Agencies (NCCA) ○ Health professionals and individuals with 14 college level health science courses (6 can be continuing education) ○ 95 lactation-specific didactic hours ○ 300 to 1000+ hours of clinical practice, depending on pathway **Advanced Lactation Consultants (ALC®)** ○ Certification as a CLC® or IBCLC® ○ Plus 2 college credits in *Maternal and Infant Assessment* and 3 college credits in *Advanced Issues in Lactation Practice* **Advanced Nurse Lactation Consultants (ANLC®)** ○ Current RN license and certification as a CLC® or IBCLC® ○ Plus 3 college credits in *Advanced Issues in Lactation Practice*
Breastfeeding Counselors	Individuals who hold these certifications or similar have the skills to provide breastfeeding counseling, address normal breastfeeding in healthy term infants, and to conduct maternal and infant assessments of anatomy, latch, and positioning, while providing support.	**45-54.5 hours** of classroom training and exam. Often provide support to families in the hospital and community settings. Counselors may have additional competencies to assist families with breastfeeding difficulties.	**Certified Breastfeeding Specialists (CBS®)** ○ 54.5 didactic hours earning 3 college credits **Certified Lactation Counselors (CLC®)** Program accreditation by American Nat'l Standards Institute (ANSI) ○ 52 didactic hours; ANSI accredited exam earning 3 college credits **Certified Lactation Educators (CLE®)** ○ 45 didactic hours and exam
Breastfeeding Peer Counselors	Breastfeeding peer support organizations equip these LSPs to meet the needs of the families they serve, focusing primarily on individual and community support.	Personal breastfeeding experience and approximately **20 hours** of training through various community models, except for the La Leche League Leader program, which has **90 hours** of training.	Peer support organizations equip these LSPs to meet the needs of the families they serve, focusing primarily on individual and community support. Examples of national breastfeeding peer counselor organizations in the U.S. include: ○ **Breastfeeding USA** ○ **HealthConnect One** ○ **La Leche League (LLL)** ○ **Reaching Our Sisters Everywhere (ROSE)** ○ **Women, Infants, and Children (WIC)**
Lactation Educators	A Breastfeeding Educator is qualified to support and educate the public on breastfeeding and related issues but does not perform clinical care.	Generally, **20 hours** of training.	**Childbirth and Postpartum Professional Association (CAPPA)**

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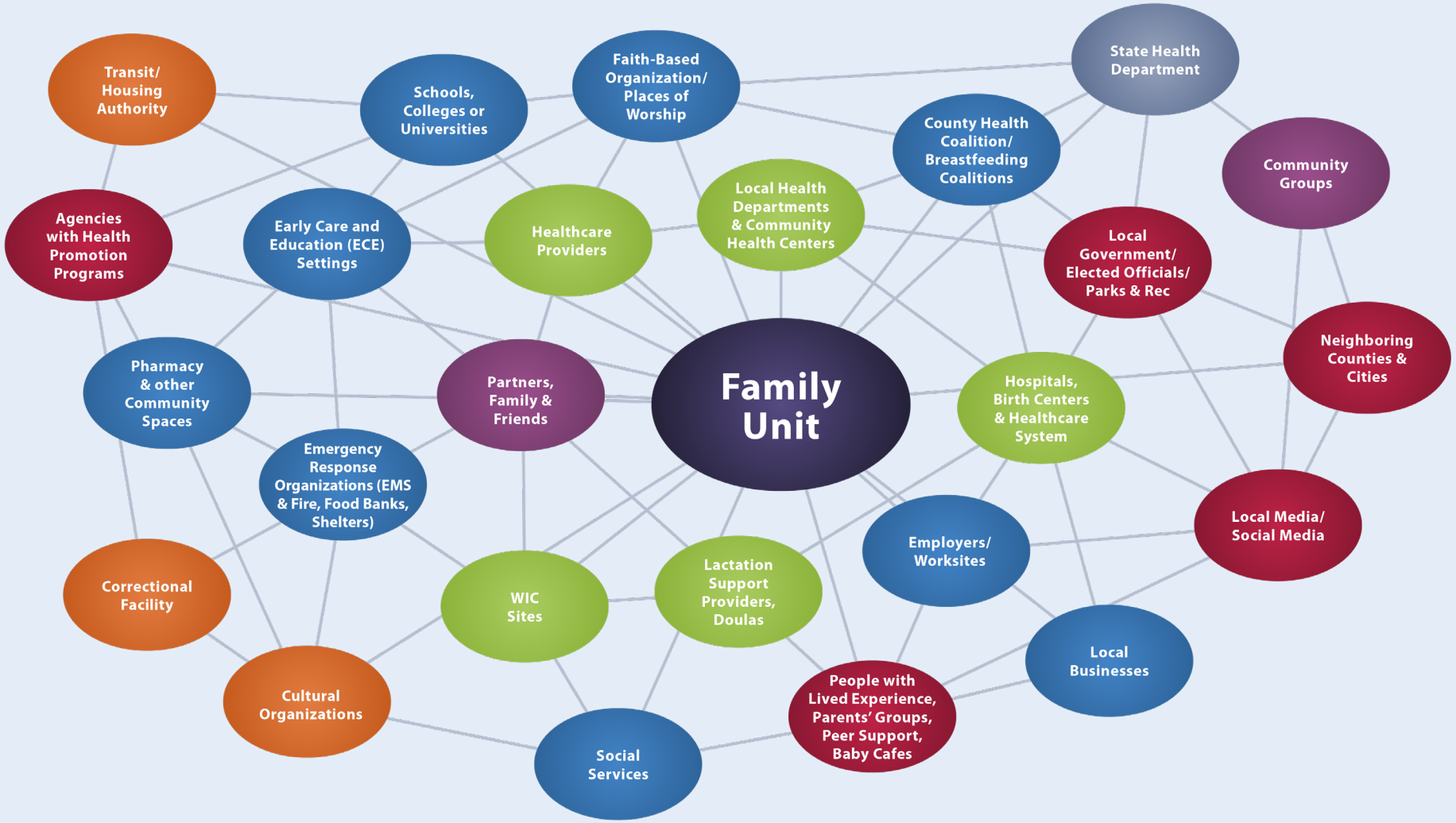
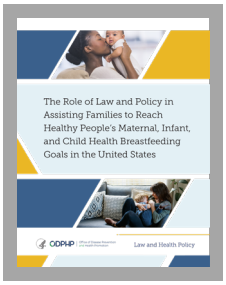
Local Health System for Chest/Breastfeeding

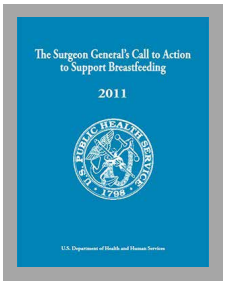


Families need consistent support environments and different levels of skilled lactation support at various times during at least the first 1,000 days.

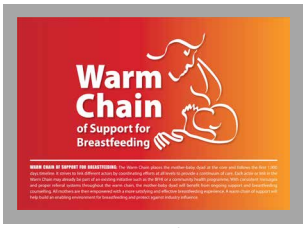
Related Community Breastfeeding and Continuity of Care Resources



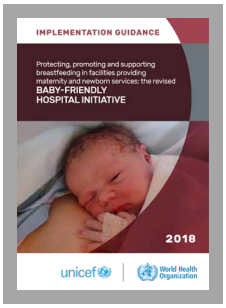
The Role of Law and Policy in Assisting Families to Reach Healthy People's Maternal, Infant, and Child Health Breastfeeding Goals in the United States. The report describes that laws and policies can help communities increase breastfeeding rates while supporting the achievement of national goals. This resources outlines efforts that have taken place across sectors and across the nation over the past decade.



The Surgeon General's Call to Action (SCCTA) to Support Breastfeeding . The SGCTA acknowledges that the parents' ability to begin and to continue breastfeeding can be influenced by a host of community factors. Action 8 recommended to develop systems to guarantee continuity of skilled support for lactation between hospitals and health care settings in the community, through a coordination of health care systems that partner with community breastfeeding programs to provide skilled lactation support pre- and post-birth.



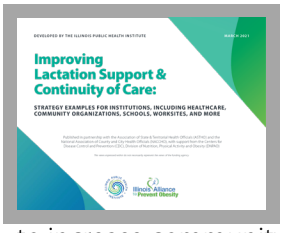
World Alliance for Breastfeeding Action (WABA) Warm Chain. The Warm Chain is an international campaign that places the mother-baby dyad at the core and follows the first 1,000 days timeline. It emphasizes the importance of working together with different stakeholders and coordinating efforts at all levels to care for the mother-baby dyad in each country or community. It strives to link different actors by coordinating efforts at all levels to provide a continuum of care.



The Baby-Friendly Hospital Initiative and similar state programs (such as Texas Ten Steps, NC Maternity Center Breastfeeding-Friendly Designation Program, Breastfeeding Friendly Washington). These documents include a set of evidence-based maternity care practice recommendations to improve internal continuity of care through supportive policies, systems and environmental solutions. Breastfeeding initiation rates are higher in settings that implement BFHI steps. The BFHI steps 3 and 10 provide recommendations that support continuity of care before and after birth in the community.

Breastfeeding-Friendly environments toolkits: There are several documents developed by state and local health agencies and other community-based organizations that follow the rationale of the BFHI 10 steps to successful breastfeeding. Overall, they include recommendations for institutional improvements in policies, systems, and environments in a consistent manner to improve breastfeeding support and (internal, organizational) continuity of care. Some examples are:

- 9 Steps to Breastfeeding-Friendly Health Centers: https://bit.ly/3tCLsbi
- 10 Steps for Breastfeeding-Friendly Health Department Toolkit: https://bit.ly/3xZyU1b
- New York Breastfeeding-Friendly Practices: https://on.ny.gov/3ezCSFX
- Colorado Medical Office Toolkit: https://bit.ly/3o7bN0b



States Improving lactation support & Continuity of Care: The Illinois Public Health Institute (IPHI) compiled and disseminated a list of strategies from a variety of sectors to increase community support and/or continuity of care for breastfeeding. This document provides examples of how institutions can support families on their breastfeeding journey. Check out page 30-31 for information on the role of state and territorial health agencies (S/THAs) in establishing breastfeeding continuity of care across and among organizations that support breastfeeding. Available at: http://bit.ly/LactationsupportCoC

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http://www.breastfeedingcontinuityofcare.org/blueprint