

## **Appendix A: Guidelines for Supporting Breastfeeding in the Clinic Setting**

### **I. Prenatal Clinic Setting (from ABM 19):**

#### **A. Easily implemented; can be done by Medical Assistant**

1. Create breastfeeding-friendly office environment; display breastfeeding supportive signs and materials (ABM 19.1)
2. Integrate breastfeeding promotion, education, support throughout prenatal care (ABM 19.2); ideally educational material will align with Baby-Friendly Hospital Initiatives
3. Record/chart mother's desire to breastfeed (ABM 19.3)
4. Provide culturally competent care (consider family structure, influence of cultural beliefs/traditions, provide information in patients native language, employ multi-lingual staff, etc) (ABM 19.4)
5. By 24 weeks, provide patient with referral to breastfeeding education course (ABM 19.6), information on returning to work / childcare facilities (ABM 14.16), and opportunity to meet pediatrician (if applicable) (ABM 14.14)
6. Actively state support of breastfeeding and acknowledge breastfeeding as superior to artificial feedings
7. Assure patient has information on community breastfeeding support options, including referral to WIC

#### **B. More difficult to implement; must be done by provider, class, educator, or lactation specialist**

1. Take detailed breastfeeding history as part of prenatal history (ABM 19.3)
2. Incorporate breastfeeding as component of initial prenatal breast examination (ABM 19.5)
3. Discuss breastfeeding at each prenatal visit; review physiology of breastfeeding and impact of nutrition (ABM 19.6)
4. Empower women and their families to have the birth experience most conducive to breastfeeding, and confirm post-partum follow-up plans and adequate support in place (ABM 19.7)

## **II. Postpartum / Pediatric Clinic Setting (from ABM 14):**

### **A. Easily implemented; can be done by Medical Assistant**

1. Routinely communicate written breastfeeding policy to all healthcare staff (ABM 14.1)
2. Encourage exclusive breastfeeding for infants; delay introduction of bottles and pacifiers until breast-feeding is well-established (ABM 14.2)
3. Provide culturally competent care (ABM 14.3)
4. Collaborate with local hospitals and professionals (local breastfeeding groups) in community (ABM 14.5)
5. Schedule newborn visit 48-72 hours after hospital discharge (ABM 14.6)
6. Provide educational resources (ideally non-commercial) for parents (ABM 14.7)
7. Create a welcoming atmosphere for breastfeeding families. Encourage open breastfeeding in waiting room or provide private area when desired, display breastfeeding-supportive signs, advertise “baby-friendly” practice (ABM 14.8)
8. Eliminate formula marketing. Eliminate distribution of formula samples unless medically necessary; avoid display of images of infants bottle-feeding (ABM 14.9)
9. Commend breastfeeding at each visit (ABM 14.11)
10. Recommend exclusive breastfeeding until 6 months, and continue breastfeeding with appropriately-timed introduction of complementary foods (ABM 14.12)
11. Establish a mother-friendly worksite lactation policy for clinic employees (ABM 14.13)
12. Establish community resources (community breastfeeding support groups, pump rental, etc) for patient referral; promote cooperation between groups (ABM 14.14)
13. Provide formal staff training in breastfeeding education / lactation support; employ a lactation consultant or nurse trained in lactation (ABM 14.17)
14. Track data (breastfeeding initiation / duration) in practice; be aware of community breastfeeding rates (ABM 14.19)

**B. More difficult to implement; must be done by provider, class, educator, or lactation specialist**

1. Ensure access to lactation professional at newborn visit (ABM 14.6)
2. Provide follow-up telephone support to breastfeeding mothers (ABM 14.10)
3. Establish breastfeeding guidelines for the late preterm infant 34-36 weeks (ABM 10)
  - a. Properly recognize frequently encountered problems in breastfed late preterm infants (hypoglycemia, hypothermia, hyperbilirubinemia, excessive weight loss, failure to thrive)
  - b. Educate staff on issues specific to breastfeeding the late preterm infant in outpatient settings
  - c. Encourage immediate and extended skin-to-skin contact
  - d. Encourage breastfeeding ad libitum and on demand
  - e. Document discharge feeding plan and assess mother's ability to follow up on given instructions
  - f. Provide mother with written feeding plan if she does not have one
  - g. If a patient is given a nipple shield at hospital, Mother is to follow up with lactation professional at clinic
  - h. If supplementation is required, mother should pump after feedings- six to eight times in 24 hours until baby is breastfeeding well
  - i. An in-clinic or WIC observation of a feeding should be scheduled to evaluate latch, suck and swallow.

### **III. Hospital-to-Clinic Communication**

Clear communication between the clinic, patient, and delivering hospital of the mother's intent to breastfeed is critical. The clinic staff will initiate and strengthen the communication dialogue with the delivering hospital. Patients will be educated to communicate their choice to breastfeed, and the name of their postpartum healthcare provider to their delivering hospital. Delivering hospital and prenatal clinic will devise an appropriate notification process to provide patient breastfeeding intent information to delivering hospital.

Delivering hospitals may work with clinics to provide a discharge report to the postpartum healthcare provider/clinic. This report will include agreed-upon information regarding: type of delivery, in-hospital breastfeeding support provided, breastfeeding equipment provided, and other pertinent information related to breastfeeding that occurred in delivering hospital. Direct provision to clinic is best, but information given to patient to deliver to postpartum clinic provider is sufficient.