NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

[ISSUE BRIEF]
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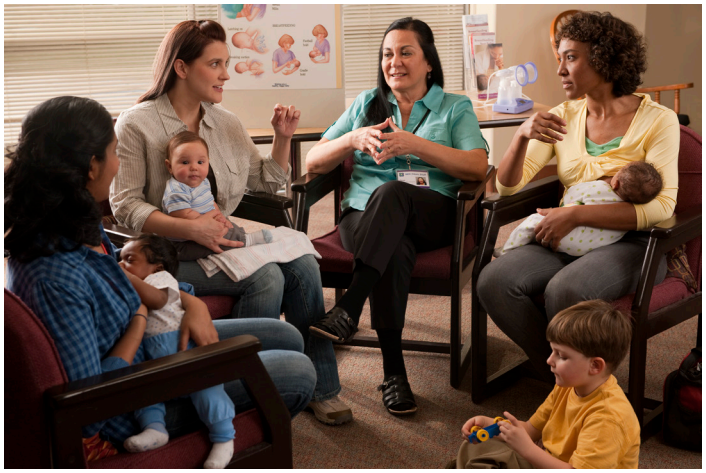
Breastfeeding and Continuity of Care: Closing the Care Gap

Introduction

In 2014, NACCHO, in partnership with the Centers for Disease Control and Prevention's (CDC), Division of Nutrition, Physical Activity, and Obesity (DNPAO), implemented the Reducing Disparities in Breastfeeding through Peer and Professional Support project, designed to increase breastfeeding rates among African American and underserved populations. The effort supported the implementation of 72 community-level peer and professional breastfeeding support programs by local health departments (LHDs), community-based organizations (CBOs), and hospitals in 32 states and territories from January 2015 through May 2016. Grantees provided direct breastfeeding support activities, based on recommendations of the CDC Guide to Strategies to Support Breastfeeding Mothers and Babies , while addressing families' challenges to access services.

This issue brief describes the importance of establishing a breastfeeding Community Continuity of Care, to improve the experience of families served within the community via various service agencies to enable women to sustain breastfeeding.



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Overview

What is Continuity of Care?

There are several definitions and names for Continuity of Care, such as Continuum of Care, Transitions of Care, and Integrated Care. The overall concept is that healthcare services should be consistent and collaborative across time and various providers or community agencies. When a community member or family accesses services and support from various providers and agencies, they frequently encounter ineffective transitions of care.

The NACCHO Breastfeeding Project team has defined breastfeeding Community Continuity of Care as the process by which families are given consistent, high-quality breastfeeding education and support and adequate care coordination across all providers and service institutions within their community, from the prenatal period through weaning.

When Continuity of Care does not exist, women are less likely to initiate breastfeeding, exclusively breastfeed, and breastfeed for less than the recommended exclusive six months, with complementary foods for the first year of life and beyond, as desired.[1]

Several factors influence Continuity of Care across a community, including communication among providers, identifying the central referent, and establishing internal and external frameworks of support through partnerships.

The outcomes of ineffective care transition, or lack of care continuity, result in a multitude of adverse outcomes within the healthcare system.

Miscommunication between providers is a known factor in up to 80% of serious medical errors and result in the aforementioned negative outcomes.[2] Indicators such as high hospital readmission rates are monitored for use as a reimbursement penalty marker from insurers and the federal government as they relate to the factors mentioned.[3] Multiple insurance companies are using practice and clinical data to offer incentives as well, when these negative outcomes are reduced.

There is also misunderstanding regarding the central referent. Is it the provider or the patient? From the provider perspective, continuity refers to integration, coordination, and information sharing. Providers also consider new service delivery models an aspect of continuity, as well as improved patient outcomes. Alternatively, patients view continuity in relation to the interpersonal aspects of care they receive, along with the finite details of actually being provided coordination of care. These differences can best be described as extrinsic (provider) and intrinsic (patient) factors.

The outcomes of ineffective care transition, or lack of care continuity, result in a multitude of adverse outcomes within the healthcare system. These include, but are not limited to, increased hospital admission rates and increased medical costs.[4] When we consider these two concepts in the frame of breastfeeding, we translate this into the various negative outcomes seen with reduced breastfeeding.[5]

NACCHO's definition reinforces the idea that healthy behaviors, including breastfeeding, are influenced by factors within and outside of the healthcare domain. Community networks, workplaces, childcare agencies, and our social support service providers play an important part in a family's decision-making around breastfeeding, which impact their capacity to meet their goals.[6]

When families are not supported through their breastfeeding goals and experiences, negative outcomes of low rates of initiation, exclusivity, and duration are observed. In other areas of healthcare, we correlate low continuity of care to an increase of illness, accidents, and issues pertaining to safety. Recent studies report annual excess deaths attributable to suboptimal breastfeeding at 3,340 per year, with 721 of these being pediatric and medical costs totaling $3 billion; 79% being maternally related.[7] Not using this negative outcome language segregates breastfeeding goals from the broader picture of quality improvement. Using set terminology and weaving various implementation models into improving outcomes allows breastfeeding to be incorporated into the evolving world of healthcare improvement.

Continuity of Care Failures

Within the healthcare field, three causes are often identified and defined as root causes for the breakdown of Continuity of Care:

Communication breakdowns occur when information is ineffectively given between providers (healthcare and service organizations) or between providers and those they are serving. This happens when there are varied expectations during/after the transition, the organizational culture is not conducive to a proper hand-off, not enough time is given for a proper hand-off, or a lack of policy/procedure for how a proper hand-off occurs.

Other breakdowns in continuity pertain to **patient education**. This occurs when patients or family members are given conflicting recommendations, confusing treatment modalities (medical, physical, emotional), or are not included in the planning related to the transition of care. When they lack buy-in, they are unlikely to follow through with prescribed treatment for not understanding what they should be following through with, or how.

Often, those being served are given appropriate information and included in the planning for events including a discharge from the hospital. However, it is less common for a physician or clinical entity to ensure that care is coordinated and supported across settings when a transition or multiple entities of care are involved. This describes an **accountability breakdown**. When multiple providers or agencies are involved, or will be involved in the care of an individual or family, steps must be taken to provide communication between all involved. Lacking this creates confusion for those being served and increases the likelihood of a negative outcome related to adequate knowledge and resources.

The Joint Commission:

"Transitions of care refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change."

American Academy of Family Physicians:

"Concerned with quality of care over time. It is the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost effective medical care."

Healthcare Information and Management Society workgroup:

"Covers the delivery of healthcare over a period of time, and may refer to care provided from birth to end of life. Healthcare services are provided for all levels and stages of care."

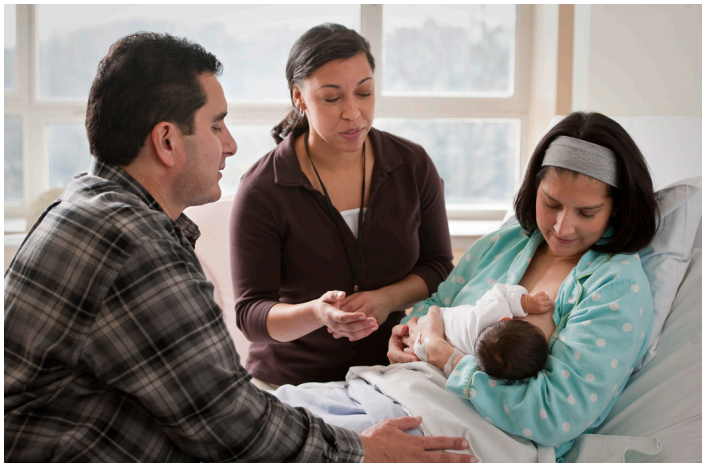
Creating Continuity of Care

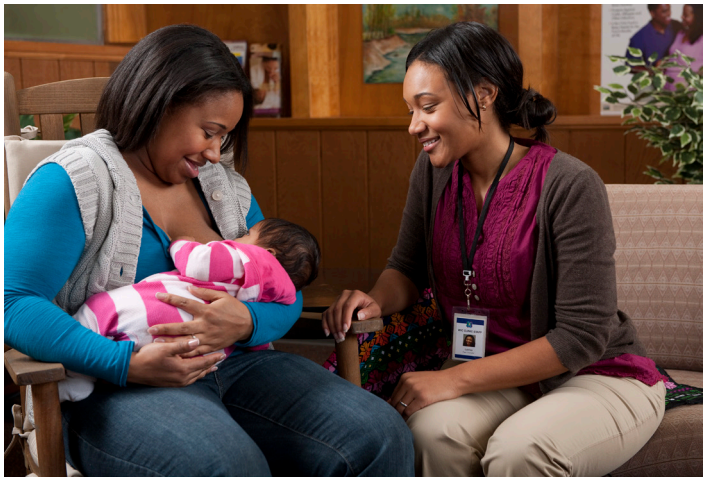
Communication breakdowns are often referred to as handoff communication problems. Clarifying the sending and receiving roles are critical to decreasing gaps in care. The sender is responsible for sending patient information to all relevant providers and/or agencies and the receiver is responsible for obtaining patient information and accepting care of the patient. Simple tactics to reduce errors in communication include adopting the same techniques for hand-off, formatting electronic health records for checklists, and using standardized forms.

A former NACCHO Breastfeeding Project grantee, Florida's Lee Memorial Health System, used twice-daily huddles across care teams to address various needs. Staff were encouraged to present ideas on areas of improvement, and all data is publicly posted on the floor to increase transparency. Breastfeeding assessment questions were incorporated into the medical chart with various indicators for referral to in-house support. A comprehensive discharge plan included coordination with breastfeeding support follow-up systems, both internally and by the local WIC agency.

Other mechanisms to reduce communications gaps of care relate to birth notification to organizations serving expectant families such as WIC or Nurse Family Partnership, as well as scheduling follow-up appointments for pediatric care, lactation support, and postpartum check-ups.

Likewise, patient education is an essential step to successful breastfeeding, particularly for communities with hospitals pursuing Baby Friendly designation. Breakdowns in patient education continuity result in a lack of consistent education where messages may be conflicting or instructions unclear. This can be solved with clear guidance pertaining to prenatal or postpartum conditions. Care plans encompassing basic information as well as upcoming appointments and questions to ask other providers create an easy-to-use tool for patient education. The Agency for Healthcare Research and Quality (AHRQ) and Boston University Medical Center developed the Reengineering Design (RED) toolkit to assist hospitals, particularly those that serve diverse populations, which includes education and information as well as upcoming appointments all in one packet.[8] This includes a calendar of upcoming appointments and an area to write questions to ask other providers and information pertaining to the condition. This model can be adapted for postpartum hospital discharge and breastfeeding follow-ups, while also incorporating other postpartum guidance. The pivotal component is that the information is collected in one place.





Using similar tactics, NACCHO's former grantee, the Dakota County Public Health Department in Minnesota, created a rapid referral system where advanced lactation support is provided within 24 hours of referral, to improve critical gaps in breastfeeding support services for African American, low-income, and underserved communities in Dakota County. This is an improvement from only being given a brochure of places to access care, resulting in more than double the number of rapid-response lactation visits — from 2.8 to 6.9 visits/month — during the grant period. Family League of Baltimore created a coordinated messaging campaign to assist with an integration of services across a wide area of geography and providers, as well as messaging consistency. Both of these examples work towards solving communication and patient education breakdowns.

The most challenging component is the lack of accountability among organizations and providers to ensure continuity. A basic example within the healthcare field would be a family physician referring a patient to several specialists after a yearly physical and scheduling a follow-up visit to review all results and check in. Typically, a doctor's office has a referral clerk who will schedule these appointments, send records, if needed, with a release of information, and pass on these appointments to the patient. Before the patient returned, reports from various specialists would be received and follow-up scheduled for the patient.

The American Academy of Pediatrics (AAP) currently recommends that newborns be seen 48-72 hours after hospital discharge.[9] It is common for hospitals to include this appointment, or confirmation of the appointment, prior to mother-baby discharge. However, with breastfeeding, Step 10 of the Baby-Friendly Hospital Initiative simply recommends, "Foster the establishment of breastfeeding support groups and refer mothers

to them on discharge from the hospital or birth center."[10] For most hospitals, this is completed in the form of a brochure of community resources available for breastfeeding. To align with continuity of care objectives, a warm hand-off needs to be given and accountability of follow up should be done. Many hospitals make follow-up phone calls post-discharge, but these are rooted in satisfaction surveys and not staffed by those who are educated to support mothers in the early days after birth; to recognizing indicators for referral; to complete a referral; and follow up to ensure its use.

Examples from the field do exist. Another NACCHO former grantee, Contra Costa Health Services in Contra Costa County, California, serves over 180,000 members. When families deliver at the local hospital, they are visited by trained nurses and lactation support staff during their stay. Part of discharge includes scheduling their follow-up pediatric appointment in a clinic convenient for them and on certain days and times, so that an International Board Certified Lactation Consultant (IBCLC) can assess feeding and support any early needs. The healthcare provider and IBCLC team together within the clinic to ensure all needs are met. Follow-up phone calls from the hospital ensure mothers took their newborns for follow-up checks and were assisted with breastfeeding.

Other examples using the Project RED Post-Discharge Follow-Up Phone Protocol include hospital systems calling within 72 hours of discharge and three follow-up phone calls within 31 days post-discharge. A separate hospital system works with private doctor's offices within their region to streamline appointment scheduling for patients being discharged, thus transferring the responsibility over to the regular physician in following up to ensure specialist appointments were attended.

Internal vs. External Frameworks of Support

When reviewing the roots of continuity failures, it is easy to determine that a high level of partnership needs to be in place for families to be served consistently and adequately across time and through different systems. Internally, this means leadership must create a coordinated and consistent framework within their own organization to offer messaging, support, coordination, and promotion of breastfeeding.

Kent County, a former grantee, addressed this through recognizing that breastfeeding support does not exist only within their county-run WIC program. They already nested services together between WIC and their immunization program, but had not considered how on a broader level, supporting low-income women and their unique needs was greater than their breastfeeding outcomes within the WIC program. They suffered barriers with peer staff retention due to health needs and childcare issues. The recognition that breastfeeding is a health behavior, largely influenced by outside factors, contributed to the entire health department reviewing how they could better support families overall and where else breastfeeding in particular could be supported.

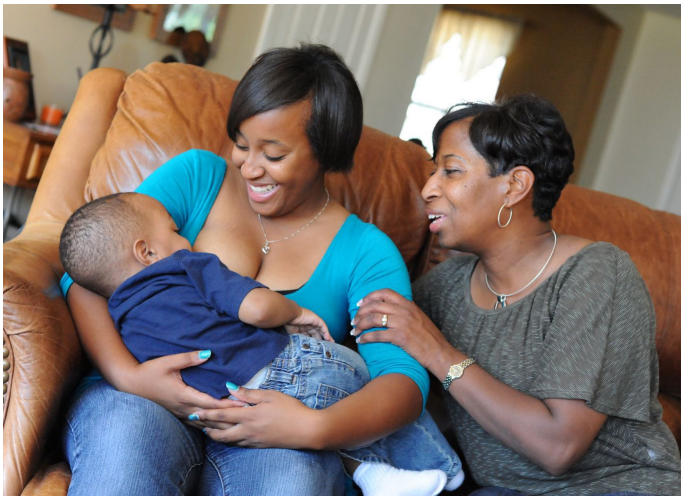
Externally, partnerships are needed to help address continuity through information sharing across networks and the willingness to provide screenings and referrals to all community organizations for breastfeeding education and support. An example in many communities would be a family applying for WIC benefits but also being screened, with needed information sent or provided for other programs such as NFP, Medicaid, or Early Head Start.

Looking past information sharing or referral coordination, Family League of Baltimore used funding for strategic planning and training across various WIC sites in Baltimore. Family League shared not just information for strategic planning, but financial support to benefit the entire community by increasing IBCLC support across various agencies.

Conclusion

Breastfeeding education and support is an area of healthcare commonly left out of common language and approaches to change or quality improvement. Yet the negative outcomes associated with the lack of continuity are clear. When parents are not educated across their prenatal time or receive conflicting information, they are less likely to initiate breastfeeding. When the mother-baby dyad are not identified within their birth setting and handed off to the next level of breastfeeding support prior to discharge, they are lost in the cracks and more likely to start supplementing with infant formula. When coordination between programs does not occur to ensure support is given when needed and/or programs are not referred to so breast pumps can be accessed when needed, women stop breastfeeding earlier than they plan to. These are all indicators of low continuity and commonly heard concerns from families who were unable to sustain breastfeeding to recommended levels. Applying core concepts of improving healthcare systems throughout a community increases the likelihood of a family receiving the care and support they require to succeed. With continuity of care intact, communities will see an increase in breastfeeding rates and overall health outcomes for their community, both in the present and in the future.

Continuity of Care Resources



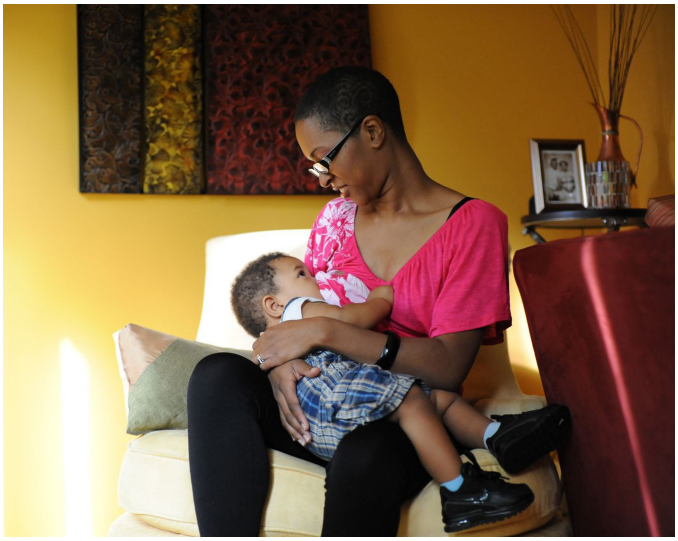
Public Health Breastfeeding Webinar Series: Breastfeeding in the Community: Closing the Care Gap http://breastfeeding.naccho.org/disclosure-statements-for-ce/

No Cost Continuing Education Available (1.5 CMEs, 1.5 CNEs, 0.7 CEUs, 1.5 CECHs, 1.5 CERPs)

Link for other CEs – http://bit.ly/2mRL48m

Continuity of Care – A Worthy Goal
http://www.aappublications.org/news/2017/06/15/Continuity-Of-Care-A-Worthy-Goal-Pediatrics-6-15-17

Continuity of Care in Alabama: Coalition Partnerships Make a Difference
https://www.youtube.com/watch?v=Rby6omMqXdI



Continuity of Care in Breastfeeding: Best Practices in the Maternity Setting
http://www.jblearning.com/catalog/9780763751845/

Continuity of Care in Infancy and Early Childhood Health Outcomes
http://pediatrics.aappublications.org/content/early/2017/06/13/peds.2017-0339?sso=1&sso_redirect_count=1&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token

Continuity of Care in Kansas: The Story of a Community
http://www.usbreastfeeding.org/p/cm/ld/fid=250&tid=551&sid=120

Discontinuity of Breastfeeding Care: "There's No Captain of the Ship."
https://www.ncbi.nlm.nih.gov/pubmed/26566010

Improving Continuity of Care
http://medicaleconomics.modernmedicine.com/medical-economics/news/improving-continuity-care?page=full

Joint Commission Transitions of Care Portal
https://www.jointcommission.org/toc.aspx

Project RED toolkit and case studies
https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

Towards integrated care in breastfeeding support: a cross-sectional survey of practitioners' perspectives
https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/s13006-016-0072-y

United States Breastfeeding Committee
http://www.usbreastfeeding.org/p/cm/ld/fid=100

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