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Overview of the Baby - Friendly NICU Designation in the United States

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Speaker Disclosures

- The speaker discloses employment with Baby-Friendly USA, Inc.
- There are no other conflicts of interest.
- This presentation is not supported by any funds from companies that violate the International Code of Marketing of Breastmilk Substitutes.

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Objectives

- Describe why the Baby-Friendly NICU designation is important.
- Describe the work that has been accomplished globally on the BFHI-NICU designation: NEO-BFHI.
- Describe the work that has been done on the designation by the BFHI-US NICU Task Force to date.
- Describe some of the challenges before us in implementing the BFHI-US NICU designation.

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State of the BFHI in the US

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US DATA

329 Designated Facilities

712 working towards designation

- 270 facilities in the Discovery Phase
- 138 facilities in the Development Phase
- 135 facilities in the Dissemination Phase
- 169 facilities in the Designation Phase

656,000 births **16.49% of US births**

~3250 total birthing facilities in US

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Re-Designations

2015 Designated Facilities
- 59 working towards Re-Designation
- 165 doing Annual QI
  - Step 3
  - Steps 5, 8, 9 and 10

2016 Designated Facilities
- 65 working towards Re-Designation
- 261 doing Annual QI
  - Code
  - Steps 4&7

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California DATA

77 Designated Facilities

174,140 births

4.3% of US births

(Counts KP Orange and Ventura County as 1 each)

74 working towards designation

19 facilities in the Discovery Phase

10 facilities in the Development Phase

17 facilities in the Dissemination Phase

28 facilities in the Designation Phase

~ 73,000 births (missing data for some hospitals)

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2016 Projections

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2016 Projections

16 hospitals working on QIP – ~ 34,000 births

6 hospitals will be revisited - ~ 17,000 births

23 Assessments scheduled between 1/1/16 and 3/31/16 – ~ 22,000 births

#s put 18% or 721,000 births in sight for mid-2016

126 potential additional assessments for 2016

(171 D4 hospitals - 45 hospitals above = 126)

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2016 Projections

12/31/2016 - 20% of US births in BFHI hospitals

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EMPower Impact

94 working towards designation
191,146 births
will be ~ 5% increase in BFHI births

7 facilities in the Discovery Phase
6,864 births

67 facilities in the Development Phase
139,224 births

15 facilities in the Dissemination Phase
35,821 births

5 facilities in the Designation Phase
9,237 births

NOTE: Not all facilities have submitted Facility Data Sheets

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EMPower Impact

EMPower - 25% of US births in BFHI hospitals

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WHY NICU?

Importance of a Baby-Friendly NICU Designation

Photo courtesy of
K. Marinelli MD

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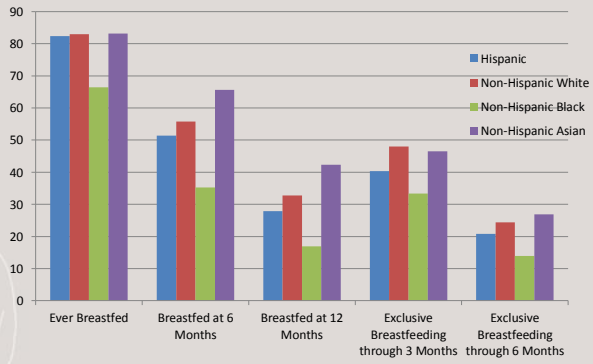
Addressing Disparities

Rates of Any and Exclusive Breastfeeding by Socio-demographics among Children Born in 2012



SOURCE: http://www.cdc.gov/breastfeeding/data/nis_data/index.htm

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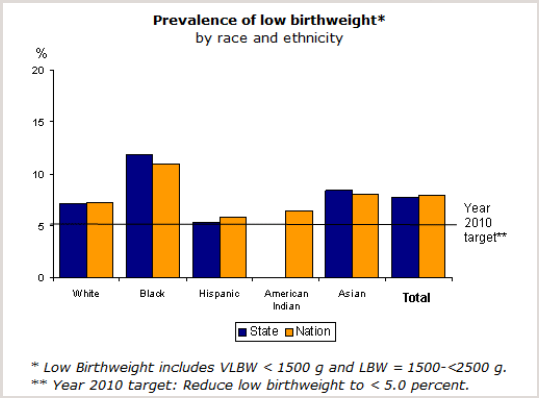
Addressing Disparities

Which mothers are most likely to deliver infants of low birthweight?



http://www.cdc.gov/pednss/how_to/interpret_data/case_studies/low_birthweight/who.htm accessed 1/25/16

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FUNDAMENTAL PRINCIPLES

1. Policy drives practice.
2. Well trained staff safely practice evidence-based care.
3. Monitoring of practice assures adherence to policy.

Photo courtesy of K. Marinelli MD

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National Multi-Disciplinary Task Force

Chaired by Kathleen Marinelli, MD

Photo courtesy of K. Marinelli MD

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National Multi-Disciplinary Task Force

- 5 Neonatologists
- 3 NICU Nurses - lactation consultants
- 1 Bioethicist
- 1 NICU Dietitian
- 1 NICU Developmental Care Therapist
- 1 Donor milk banking professional
- 2 Epidemiologists
- 1 Evaluator

Geographic, racial and cultural diversity were also criteria in task force selection

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Task Force Charge

DEVELOPMENT OF:

- NICU Guidelines and Evaluation Criteria
- Staff Training Requirements
- Tools to Assist Facilities with Implanting Criteria
- Question and Answer Document
- Assessment Tools
- Evaluation Method

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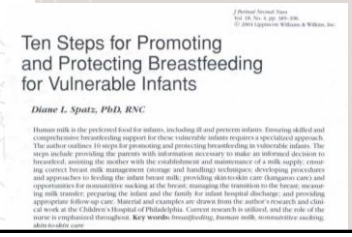
Compare Initiatives

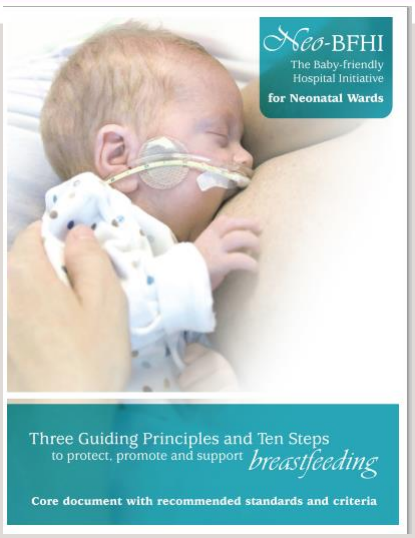
www.babyfriendlyusa.org

"Health care systems should ensure that maternity care practices provide education and counseling on breastfeeding. Hospitals should become more "baby-friendly," by taking steps like those recommended by



Ten Steps for Promoting and Protecting Breastfeeding for Vulnerable Infants

Diane L. Spatz, PhD, RNC



www.ilca.org

Comparison of the Ten Steps

BFHI US	10 Steps Vulnerable Infants-Spatz	NEO BFHI
1. Have a written breastfeeding policy that is routinely communicated to all health care staff.	Informed decision	Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.	Establishment & maintenance of milk supply	Educate and train all staff in the specific knowledge and skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.	Human milk management	Inform all hospitalized pregnant women at risk for preterm delivery or birth of a sick infant about the management of lactation and breastfeeding and benefits of breastfeeding.

Comparison of the Ten Steps

BFHI US	10 Steps Vulnerable Infants-Spatz	NEO BFHI
4. Help mothers initiate breastfeeding within one hour of birth.	Feeding the infant the milk	Encourage early, continuous, and prolonged mother–infant skin-to-skin contact (kangaroo mother care) without unjustified restrictions. Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.

Comparison of the Ten Steps

BFHI US	10 Steps Vulnerable Infants-Spatz	NEO BFHI
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.	Skin-to-skin care	Show mothers how to initiate and maintain lactation and establish early breastfeeding with infant stability as the only criterion.
6. Give infants no food or drink other than breast-milk, unless medically indicated.	Non-nutritive sucking	Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming in - allow mothers and infants to remain together 24 hours a day.	Transition to breast	Enable mothers and infants to remain together 24 hours a day.

Comparison of the Ten Steps

BFHI US	10 Steps Vulnerable Infants-Spatz	NEO BFHI
8. Encourage breastfeeding on demand.	Measuring milk transfer	Encourage demand feeding or, when needed, semi-demand feeding as a transitional strategy for preterm and sick infants.
9. Give no pacifiers or artificial nipples to breastfeeding infants.	Preparation for discharge	Use alternatives to bottle-feeding at least until breastfeeding is well established and use pacifiers and nipple shields only for justifiable reasons.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.	Appropriate follow-up	Prepare parents for continued breastfeeding and ensure access to support services/groups after hospital discharge.

NEO-BFHI— +Three Guiding Principles

1. The staff attitude to the mother must focus on the individual mother and her situation.
2. The facility must provide family-centered care, supported by the environment.
3. The facility must ensure continuity of care, that is, continuity of pre-, peri-, and postnatal, and post-discharge care.

BFHI-US and NEO-BFHI + the International Code...

25

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Where are we now?

Photo courtesy of K. Marinelli MD

Where we are now?

Guiding Principles have been drafted.

Guidelines have been drafted.

Evaluation Criteria is under development.

NICU Infant Feeding Policy Check-off tool is drafted.

Literature Review to assure all Guidelines are based in the most up to date evidence. Assigning levels of evidence to each study.

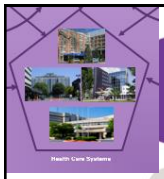
Where we are now?

Annotated Bibliography is under development.

Example Implementation Strategies are under development.

Crosswalk of NICU Guidelines to the Hospital Guidelines to assure consistency is underway.

Crosswalk of training requirements between the NICU Guidelines and Hospital Guidelines is underway.



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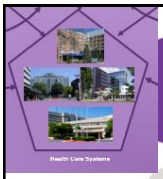
Considerations

- Should a facility with both a mother/baby unit and a NICU be allowed to achieve one designation and not the other?
- Should a facility with both a mother/baby unit and a NICU be required to achieve both designations at the same time?
- Is there a hierarchy for the two designations?
  For example, should a facility with both a mother/baby unit and a NICU be BFHI designated first and then BF NICU designated? If so, should there be a timeframe for which the second designation must be achieved?



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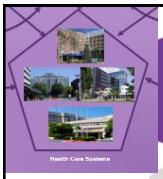
Considerations

- How should BFUSA handle a NICU that is a part of a Children's Hospital without a birthing facility?
- How should BFUSA handle a NICU that is a part of a Children's Hospital but is located in a different hospital that does have a birthing facility?
- Can the NICU be BF NICU designated if the birthing hospital is not?



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Considerations

- Should the birthing hospital be required to become Baby-Friendly?
- How should BFUSA handle the Children's hospital for which the NICU is a part of, but not located in?
- Are there other issues at this time you think BFUSA should consider in the BF NICU process?

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Thank you!

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Photo courtesy of K. Marinelli MD