Chapter 1

The Lactation Consultant: Roles and Responsibilities

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A lactation consultant (LC) is a specialist trained to focus on the needs and concerns of the breastfeeding mother–baby pair and to prevent, recognize, and solve breastfeeding difficulties. LC services do not replace those of other healthcare workers; instead, the LC is an extender of maternal–child services. Lactation consultants work with the public in many settings: hospitals, clinics, private medical practices, community health departments, home health agencies, and private practices. Almost all lactation specialists are women; many have educational and clinical backgrounds in the health professions or mother-to-mother support. Many are registered nurses, although physicians, dietitians, speech therapists, and other health professionals practice as lactation specialists as well. A growing interest in the profession is also attracting many candidates who study and work to enter directly into the lactation consulting field.

Lactation consulting is a rapidly growing healthcare specialty. Prior to recognition of the LC as a paid specialist in 1985, individuals serving breastfeeding women did so as volunteers or as unrecognized practitioners. Over time, the lack of standardization of skills and minimal competencies prompted formal development of the specialty practice. This occurred in part through a certification examination administered by the International Board of Lactation Consultant Examiners (IBLCE), and through the establishment of the International Lactation Consultant Association (ILCA), which publishes the peer-reviewed *Journal of Human Lactation* and other documents relating to lactation consultant education and practice. In 1994, the Academy of Breastfeeding Medicine, an international physician organization, was formed. Its official journal, *Breastfeeding Medicine*, also publishes peer-reviewed articles and helpful clinical protocols. In addition, La Leche League International and the Australian Breastfeeding Association publish professional materials that teach and support the LC as well as patient/family information. This chapter traces the historical roots of lactation professionals and discusses work-related issues.

History

In a cultural setting in which nearly all mothers breastfed, help with breastfeeding was available through the shared knowledge of other family members, neighbors, and friends. As childbirth came to be managed by health professionals in hospital settings and formula-feeding became the cultural norm, however, knowledge of lactation—which a mother formerly shared with her daughters or a sister with her younger siblings—was set aside or even lost.

Thus, during the 1960s (at the nadir of breastfeeding) in the United States and shortly thereafter in other countries (such as Australia and

Scandinavia), volunteer mother-to-mother breastfeeding support groups became a major source of assistance and information about how to breastfeed (Phillips, 1990). As the number of breastfeeding mothers increased, healthcare providers at first ignored these groups; later they came to appreciate them for the important role they played in helping mothers and in forcing the medical profession to consider lactation as a missing piece of prenatal and postpartum care.

As these volunteers promoted the art of breastfeeding, they also sought more knowledge of the science of lactation. La Leche League responded by providing research information to its group leaders, who serve as mother-to-mother helpers, and by publishing a quarterly newsletter, *Breastfeeding Abstracts*, which focuses exclusively on the scientific literature. Through La Leche League's professional liaison department, key individuals sought to cultivate and maintain communication links to health providers in local communities.

Out of this context, some experienced breastfeeding support group members began to look beyond what they could accomplish as volunteers. Many of these women sought to apply in a paid work setting what they had learned from many years of helping breastfeeding mothers. In 1982, La Leche League formed its Lactation Consultant Department. From this beginning grew the concept of the need for a new healthcare worker, and in 1985 the independent certification board, IBLCE, was formed. Shortly thereafter, the *Journal of Human Lactation* (*JHL*) began. Edited by Kathleen Auerbach from 1985 to 1996, by Jane Heinig from 1996 to 2012, and currently by Anne Merewood, *JHL* is peer reviewed, professionally published, and cited on international indices with a competitive Impact Factor score (Bailey, 2005; *Journal of Human Lactation*, 2013).

Do Lactation Consultants Make a Difference?

In this day of cost containment in health care, administrators want to know if lactation consultants are effective. Put simply, do interventions by lactation specialists and other healthcare providers make a difference in breastfeeding outcomes? Randomized controlled trials of breastfeeding interventions worldwide, most of which were conducted in developed countries, that were published in a meta-analysis commissioned by the U.S. Preventive Services Task Force (USPSTF) can be accessed at http://www.uspreventiveservicestaskforce.org/uspstf08/breastfeeding/brfdartfig3txt.htm (USPSTF, 2008). In the meta-analysis, breastfeeding promotion interventions significantly increased both short- and long-term exclusive breastfeeding rates. In a subgroup analysis, combining prenatal and postpartum interventions had a greater effect on these rates, and including some form of lay or peer support increased breastfeeding rates even more.

In addition to this meta-analysis, a Cochrane review—the "gold standard" of medical research—studied the effect of any extra support given to breastfeeding women. Lay and professional support together extended duration of breastfeeding, especially that of exclusive breastfeeding (Britton et al., 2007). Face-to-face counseling (Figure 1-1) is the most effective intervention in increasing not only exclusive breastfeeding rates but also the total duration of breastfeeding (Albernaz et al., 2003; Andaya et al., 2012; Witt et al., 2012).

If the data from the randomized controlled trials included in the meta-analysis and Cochrane review were translated to healthcare costs saved by

Figure 1-1 Early Assistance Promotes Confidence.

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breastfeeding, the result would show that lactation services save the healthcare system enormous amounts of money through reduction in illnesses in both baby and mother. When rates of breastfeeding at hospital discharge were compared between facilities that employed certified lactation consultants and those that did not, those having LCs had a 2.28 times increase in the odds of breastfeeding at hospital discharge. Among women receiving Medicaid, there was a 4.13 increase (Castrucci et al., 2006).

Studies show that peer counselor interventions are also effective. Clearly, lactation services improve the health of the United States, but we have yet to document the extent of this effect in terms of money savings. We do know the estimated cost to U.S. society when medical recommendations for breastfeeding are not met: $13.6 billion for 10 infant illnesses and infections and 911 additional infant deaths per year (Bartick & Reinhold, 2010). In terms of maternal impact, 4981 excess cases of breast cancer, 13,946 heart attacks, and 53,847 cases of hypertension are estimated to occur when these recommendations are not met, compared to a cohort of 1.88 million U.S. women who optimally breastfed, leading to $17.4 billion in costs to society resulting from premature maternal deaths (Bartick et al., 2013).

Certification: International Board of Lactation Consultant Examiners

In 1981, experienced La Leche League leaders JoAnne Scott and Linda Smith were asked to develop a certification and training program for lactation consultants. This need derived from (1) an awareness that many healthcare providers discredited the value of the volunteer counselor because she was unpaid, (2) a need to establish minimum standards for individuals who were already providing LC services for a fee, and (3) the need for a knowledgeable healthcare team member who was responsible for lactation and breastfeeding care. A certification program was viewed as a way to recognize the important role of the volunteer and to provide a credential that identified knowledge and experience.

Scott and Smith assembled a small group of breastfeeding experts who had come to the field of lactation consulting through voluntary service, mostly through La Leche League. In 1984, these individuals gathered at a conference and concluded that legitimacy of the field would be heightened if minimal standards of knowledge and skills were recognized through a certification examination. Subsequently, a 62-member panel of experts was recruited and selected to serve as the respondent population for the first practice analysis and to develop the first exam blueprint with the guidance of a psychometrician. The work of this expert panel represented a broad-based practitioner and professional assessment of practice in the emerging profession of lactation consulting (Smith, personal communication, 2013).

The first examination was administered in July 1985 by the IBLCE. Since 1985, a psychometrically reviewed certification examination has been given annually to applicants who meet eligibility criteria for education and clinical training. To date, more than 26,000 candidates have been certified as International Board Certified Lactation Consultants (IBCLCs), the majority of whom live in Australia, Canada, Japan, South Korea, and the United States. Table 1-1 summarizes the number and regional

Table 1-1 Number and Distribution of IBCLCs

Year	Worldwide	Americas Region	Asia Pacific Region	Europe/ Middle East Region
2005	14,705	9305	3184	2216
2006	15,726	9726	3083	2917
2007	17,026	10,229	3464	3333
2008	18,032	10,554	3695	3783
2009	21,200	11,903	4754	4543
2010	22,736	12,827	4843	5066
2011	25,737	14,972	5076	5689
2012	26,815	15,929	5047	5839

Data from International Board of Lactation Consultant Examiners (IBLCE) www.iblce.org

distribution of completed IBLCE exams over 2005–2012 (IBCLE, 2013). In 2013, IBLCE administered the exam to 3660 candidates in 945 locations across 52 countries and territories in several languages. Recertification as an IBCLC is required every 5 years through the acquisition of continuing education credits or reexamination, and every 10 years by required reexamination. This dual-recertification option increases the likelihood that the IBCLC will stay current in knowledge and practice.

The IBCLC is the only international certification in breastfeeding and human lactation, awarded by an independently accredited organization. It has been accredited by the National Commission for Certifying Agencies (NCCA) since 1988—a mark of distinction for certification organizations (NCCA, 2013). IBLCE maintains a registry of IBCLCs who are currently certified. Employers, regulators, and the public, therefore, can confirm that an individual is currently certified. For more information on IBCLC certification, go to the International Board of Lactation Consultant Examiners' website at www.iblce.org.

Certification—a process by which an individual demonstrates advanced knowledge and/or experience in a specialty—is especially popular in the United States. More than 40 specialty certifications exist in the field of nursing alone, despite the fact that certification is a voluntary credential. Certified nurses and healthcare workers from across a wide variety of specialties consistently place a high value on certification (Niebuhr & Biel, 2007). Nurses in the United States and Canada who earned certification in a specialty area report feeling more confident and experiencing fewer errors in patient care since they were certified; thus certification may be a marker for excellence (Cary, 2000; Raudonis & Anderson, 2002).

Professional Association: International Lactation Consultant Association

About the same time that IBLCE certification began, the International Lactation Consultant Association (ILCA) formed as the professional organization for IBCLCs and others supporting the member association's mission (ILCA, 2005). ILCA has played a vital role in professional development of the IBCLC and in promoting policies to protect and support breastfeeding, IBCLCs, and the IBCLC profession worldwide (Bailey, 2005). ILCA arose primarily through the grassroots vision and creativity of its founding members; by 2013, there were nearly 6000 individual members from 85 countries worldwide (Brooks, 2013).

ILCA's website is a rich and current source of information and resources of interest to lactation professionals; many items are translated into several languages. In addition, ILCA hosts an annual international conference, serves as a nongovernmental organization (NGO) in official relations with the World Health Organization (WHO), and publishes the peer-reviewed research periodical *Journal of Human Lactation.* Directories list IBLCE-certified ILCA members who (1) provide lactation care to mothers (searchable by location, anywhere in the world), (2) offer support to employers/workplaces with breastfeeding employees, and (3) are speakers/writers for educational or conference settings (ILCA, home page, n.d.).

In addition to individual members, ILCA has affiliates organized primarily by country, focusing on IBCLC issues of particular geopolitical interest. For example, the United States Lactation Consultant Association (USLCA) is the professional organization for ILCA members living in the United States; it publishes the journal *Clinical Lactation*. The Canadian Lactation Consultant Association and the Lactation Consultants of Australia and New Zealand represent the interests of ILCA members in those countries.

Gaining Clinical Experience

IBLCE certification requires a considerable number of clinical hours in direct care of the breastfeeding dyad: from 300 to 1000 clinical hours, preferably supervised by an experienced IBCLC. For

specific criteria on qualifying under the IBLCE Pathways, go to http://iblce.org/certify/preparing-for-ibclc-certification/.

A healthcare professional who needs clinical hours to qualify to take the IBLCE certification examination under Pathway 1 should seek out a job where he or she will work with breastfeeding mothers. Working on a mother–baby unit in a hospital or in a community clinic setting are examples. Other candidates for Pathway 1 come from a mother-to-mother support background, meet the education requirements, and have acquired clinical experience through peer mentoring. Examples include La Leche League leaders, Australian Breastfeeding Association counselors, and peer counselors in the U.S. federal Women, Infants, and Children (WIC) program.

Not everyone who desires to work as a lactation consultant wishes to become a nurse or other type of health professional. Thus Pathway 2 covers direct-entry applicants who are in an academic lactation program that includes the required clinical training. Pathway 3 covers direct-entry applicants who come from other backgrounds, meet the educational requirements, and acquire their clinical experience in a formal arrangement supervised by experienced IBCLCs. Some of these arrangements are available at local hospitals or community settings or with IBCLCs in private practice. Box 1-1 provides general guidelines on mentoring lactation consultants, available on the ILCA website along with numerous other documents for clinical training programs: http://www.ilca.org/i4a/pages/index.cfm?pageid=3488.

Box 1-1 Mentoring and Precepting Lactation Consultants

Desired Qualities of a Mentor/Preceptor

- Acts as a role model and advocate
- Has leadership experience
- Is available and responsive
- Is willing to share expertise and insight
- Believes in the capabilities of the mentee/intern
- Motivates, supports, and enhances the mentee's/intern's development
- Has vision
- Is current in the knowledge of the field
- Knows how to access professional networks
- Seeks to enhance political awareness

Desired Qualities of a Mentee/Intern

- Has a desire to learn
- Has a capacity to accept constructive feedback and coaching
- Has an ability to identify personal and professional career goals
- Has a willingness to take risks
- Exhibits a desire for professional success
- Seeks challenging assignments and new responsibilities
- Actively seeks the advice and counsel of an experienced mentor/preceptor

Source: Modified from Lauwers, J. Mentoring and Precepting Lactation Consultants, International Lactation Consultant Association: http://www.ilca.org/i4a/pages/index.cfm?pageid=3488

Lactation Consultant Education

Because the IBCLC certification is relatively new (established in 1985), formalized lactation education programs, with approved curricula offered by independently accredited institutions of higher education, are not yet widely available. The Lactation Education Approval and Accreditation Review Committee (LEAARC) provides approval for individual short-term courses and classes on breastfeeding management and formulates recommendations to the Commission on Accreditation of Allied Health Education Programs (CAAHEP) for accreditation of an academic program (LEAARC, n.d.). LEAARC approval of short-term courses serves as a "reliable indicator of educational quality to employers, insurers, counselors, educators, governmental officials, and the public" (LEAARC, n.d., para. 2). LEAARC also has developed *Standards and Guidelines for the Accreditation of Lactation Education Programs*, available at www.leaarc.org.

Healthcare providers seeking to learn more about supporting breastfeeding families in their care can seek out the many other short-term courses in breastfeeding management that are available. For example, facilities seeking designation under the Baby-Friendly Hospital Initiative (BFHI) require all healthcare workers in maternal–child health to take a 20-hour course in basic breastfeeding management (WHO & UNICEF, 2009). Short-term courses may also be taken by those individuals seeking to provide mother-to-mother support, such as WIC peer counselors trained by the U.S. Department of Agriculture Food and Nutrition Service's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) (U.S. Department of Agriculture, n.d.). In addition, IBCLC aspirants seeking to meet IBLCE examination requirements in lactation-specific education may seek out excellent short-term courses offering evidence-based information on breastfeeding support.

Ideally, every woman giving birth will receive timely and appropriate lactation care delivered by qualified providers. Clinicians and nurses working in maternal–child health will have education and training in basic breastfeeding management (e.g., Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2008; also see United States Breastfeeding Committee [USBC] website http://www.usbreastfeeding.org/HealthCare/TrainingforHealthCareProfessionals/tabid/96/Default.aspx for listing of several sources of healthcare professional training). Mothers will have timely access to IBCLCs when needed—for example, in higher-acuity situations (Mannel, 2011)—and will also have community support from experienced breastfeeding mothers, such as La Leche League leaders.

Hospital Lactation Programs

A New York state law mandated in 1984 that any institution providing care for new mothers and babies had to have at least one person on staff who was designated to serve as a resource for other staff members and to provide breastfeeding assistance to patients. The need for skilled lactation support in the hospital during the perinatal period and for any other hospital admission of a breastfeeding mother or child has been recognized by many healthcare organizations including the World Health Organization (2003), the U.S. Department of Health and Human Services (2011), the European Union (EU Project on Promotion of Breastfeeding in Europe, 2004), and the Australian Health Ministers' Conference (2009).

The 1990s could be characterized as the decade for widespread emergence of breastfeeding programs and clinics (Figure 1-2). Only a small number of hospitals in the United States had a lactation program in the early 1990s, but over the past two decades lactation programs have proliferated rapidly. Today, most hospitals and birth centers have lactation services staffed by certified lactation specialists, who have thus grown in numbers and visibility (Figure 1-3). Although some lactation expertise has long been integrated into midwifery practice in countries where midwives predominate, IBCLCs are now available in many countries.

Developing a Hospital Lactation Service

Providing quality lactation and breastfeeding care is an essential part of a hospital's maternal–newborn

Figure 1-2 Breastfeeding Clinic.

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Figure 1-3 Hospital Lactation Service.

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service. The Baby-Friendly Hospital Initiative provides the evidence-based guidelines for quality hospital care (WHO, 1998), and Baby-Friendly designated hospitals demonstrate improved breastfeeding outcomes across all racial and ethnic groups. (DiGirolamo, Grummer-Strawn, & Fein, 2008). The U.S. Surgeon General's Call to Action to Support Breastfeeding compels the healthcare system to ensure that maternity care practices are supportive of breastfeeding and to provide access to IBCLC services. The Joint Commission (TJC) in the United States has adopted a quality core measure on exclusive breastfeeding that hospitals with greater than 1100 births per year will be required to report beginning in 2014 (TJC, 2013). The European Union's Blueprint for Action on Breastfeeding (EU Project of Promotion of Breastfeeding in Europe, 2004) expects all mothers to have affordable access to qualified lactation consultants. ILCA and IBLCE now award recognition to hospitals and community-based agencies that employ IBCLCs and provide training in breastfeeding management for other healthcare professionals. For a list of organizations that have received the IBCLC Care Award or for more information on the criteria, go to http://www.ibclccare.org/.

A key element in quality hospital lactation care is appropriate policy development and staff training. IBCLCs are ideally suited to work with a hospital's leadership team to develop evidence-based policies and education for nursing staff, including clinical competencies. Hospitals are particularly concerned with patient safety and risk management issues, both of which are increased when inadequate lactation care is provided, especially in high-acuity lactation situations (Table 1-2). Identifying mothers and children who are at higher risk for poor breastfeeding outcomes enables a hospital to allocate appropriate resources in a more timely fashion (Mannel, 2011, 2013).

Department heads particularly critical to securing support for a lactation program include the director of maternity nursing (who may oversee labor and delivery, mother–baby care, and sometimes the intensive care nursery), the director of the pediatric unit, and the chairman or medical director for obstetrics, pediatrics, and family medicine. If the institution has a midwifery service, the support of its director should also be sought.

Physicians remain influential figures in the hospital, although their power has diminished since the adoption of managed care; therefore, maintaining positive relations with physicians is critical for LCs. Even with managed care, the physician as "gatekeeper" plays a major role in the fiscal health of a hospital. If the physician's patients do not want to go to a particular hospital because it lacks certain amenities—such as a lactation service—the birthing service administrator, with the backing of

Table 1-2 Lactation Acuity Levels for Determining Lactation Resources

Acuity Level I	**Level I acuity patients can be cared for by nursing staff who have basic breastfeeding knowledge and competency.**
Maternal Characteristics	Basic breastfeeding education, routine management
	Latch/milk transfer appear optimal
	Maternal decision to routinely supplement
	Maternal decision to pump and feed expressed breastmilk (EBM)
	Maternal indecision regarding breastfeeding
	Mother can latch baby with minimal assistance
	Multiparous mother with healthy term baby and prior breastfeeding experience
Acuity Level II	Level II acuity patients should be cared for by RLC staff as soon as possible, or referral made to RLCs in the community. Early follow-up after discharge is critical.
Maternal Characteristics	Antenatal admission with increased risk of preterm delivery
	Cesarean section delivery
	Delayed breastfeeding initiation (defined as after 1 hour with routine vaginal delivery and after 2 hours with routine cesarean section)
	Maternal acute illnesses/conditions (e.g., preeclampsia, cardiomyopathy, postpartum depression, postpartum hemorrhage)
	Maternal age (mother < 18 years or > 35 years)
	Maternal chronic conditions (e.g., rheumatoid arthritis, systemic lupus erythematosus, hypertension, cancer, history of gastric bypass, obesity)
	Maternal cognitive impairment (e.g., mental retardation, Down syndrome, autism)
	Maternal endocrine disorders (e.g., polycystic ovary syndrome, infertility, thyroid disorders, diabetes)
	Maternal medication concerns
	Maternal physical disability (e.g., paraplegic, cerebral palsy, visual impairment, psychiatric)
	Maternal readmission (breastfeeding well established/noncritical issues)
	Maternal request
	Multiparous mother with history of breastfeeding difficulty
	Primiparous mother or first-time breastfeeding mother with healthy term baby
	Social/cultural issues (e.g., communication barriers, domestic/sexual abuse)
Infant Characteristics	Consistent LATCH score < 6 at day of discharge
	Breastfeeding Assessment Score ≤ 5
	Latch difficulties (e.g., pain)
	Infant readmission (breastfeeding well established/noncritical issues)
	Newborn birth trauma (e.g., cephalohematoma, shoulder dystocia)
	Suboptimal/inadequate milk transfer leading to medical recommendation to supplement

Table 1-2 Lactation Acuity Levels for Determining Lactation Resources (*CONTINUED*)

Acuity Level III	Level III acuity patients need to be cared for by RLC staff while in hospital. These patients will require in-depth assessment and ongoing management. Early follow-up after discharge is critical.
Maternal Characteristics	Abscess/mastitis
	High maternal anxiety
	Induced lactation
	Maternal breast conditions (e.g., breast/nipple anomalies, glandular insufficiency, history of breast surgery)
	Maternal illness/surgery
	Maternal readmission (breastfeeding not well established and/or critical issues)
	Pathologic engorgement
Infant Characteristics	High-risk infant on mother–baby unit (e.g., late preterm, small or large for gestational age, multiple gestation)
	Hyperbilirubinemia
	Hypoglycemia
	Infant admission to neonatal intensive care unit
	Infant congenital anomalies
	Infant illness/surgery
	Infant oral/motor dysfunction (e.g., tight frenulum, hypotonia, or hypertonia)
	Infant readmission (breastfeeding not well established and/or critical issues)
	Infant weight loss > 7% of birth weight before discharge

Note: Acuity levels can change based upon assessment by the RLC or other healthcare team members.
Source: Modified from Mannel, R. J Hum Lact. 2011; 27, 163–170. Defining lactation acuity to improve patient safety and outcomes.

physicians, may create such a program rather than lose patients to a competing institution. Supportive physicians are more likely to be mothers who breastfed, fathers of breastfed children, those building a new practice, and those from countries where breastfeeding is the norm.

If the institution has an employee health service or a women's health clinic, their supervisors should be informed of the proposal and asked for their support. Written proposals or documents that highlight how the new program will assist and support the services that are already being provided will help ensure their acceptance. For example, the head of employee health may be particularly interested in learning that the lactation program will include services to employees, such as a special place where employees returning to work after the birth of a baby can express milk or nurse their babies during work hours (Dodgson & Duckett, 1997). Many countries are now requiring employers to provide support for working breastfeeding mothers (International Labour Office, 2010; U.S. Department of Labor, 2010).

Resources

Determining the resources needed for a quality lactation program depends on the level of service provided by the hospital in other areas (Mannel & Mannel, 2006) and the goals of the lactation services. For example, does the hospital have a neonatal intensive care unit, provide high-risk

Figure 1-4 Outpatient Breastfeeding Clinic.

Source: © Addie Imseis

antepartum care, or have inpatient pediatric units? Does the hospital want a lactation service that provides telephone follow-up, outpatient care, or prenatal education (see Figure 1-4)? All of these services need to be factored into the equation when determining the necessary resources.

Jan Riordan has estimated three visits (one 20-minute initial visit and two 15-minute follow-ups) from a lactation consultant are needed, for a total of 50 minutes per dyad per day. Given these numbers, a lactation specialist would spend at least 8 hours each day to see 9 dyads on a mother–baby unit. This figure does not take into account time spent charting, having lunch, meetings, planning, and so on. Daily rounds on breastfeeding women may be feasible in a hospital in which the LC sees fewer than 9 patients per day; it may not be feasible if more than 9 breastfeeding mothers are housed in the maternity unit on a given day—unless there is more than one specialist in the service or staff members providing other care are trained to provide optimal lactation-related care as well, thus reserving the LC for mothers and babies needing additional help and as a resource for the staff (Angeron & Riordan, 2007).

Another author reported 2.6 full-time equivalent (FTE) LC positions (about 90 hours) were required for a hospital with 1600 deliveries (Hinson, 2000). These lactation consultants saw each breastfeeding mother every day but later, to keep up with the demand for their services, they saw each breastfeeding mother once, and again only if there was a referral. In an effort to meet patient needs, it is not uncommon for LCs to volunteer additional time for which they are unpaid. Heinig (1998) addressed this issue as "closet consulting," warning that when the caseload is invisible to the employer, the LC's professional time is undervalued and may result in further limits on LC time.

The two reports cited previously relied on "educated guesses." Mannel and Mannel (2006) collected data from the lactation program's productivity reports at a tertiary care teaching hospital (4200 births per year). They measured actual hours worked by LCs over a 2-year period, allocated the hours to their respective activities, and developed ratios for optimal IBCLC staffing for each component of service. Optimal IBCLC staffing was calculated as follows:

- Mother–baby inpatient care requires 1 FTE per 783 breastfeeding couplets.
- Neonatal intensive care unit (NICU) inpatient care requires 1 FTE per 235 infant admissions.
- Mother–baby outpatient care requires 1 FTE per 1292 breastfeeding couplets discharged.
- NICU outpatient care requires 1 FTE per 818 breastfeeding infants discharged.
- Telephone follow-up requires 1 FTE per 3915 breastfeeding couplets or infants discharged.
- Education requires 0.1 FTE per 1000 deliveries.
- Program development and administration requires 0.1 FTE per 1000 deliveries.
- Research requires 0.1 to 0.2 FTE total.

Using these ratios, IBCLC staffing needs can be calculated for hospital staffing according to number of deliveries (Box 1-2). All three hospitals have inpatient service, follow-up telephone service and education, administration, and research. Table 1-3 is a calculation of the staffing needs for a hospital with 3000 births per year using the Mannel and Mannel (2006) model. A similar table for hospitals with 1000 and 6000 births per year can be found in their article in the *Journal of Human Lactation*. These data were utilized in the staffing recommendations released by the USLCA (2010) and the Association of Women's Health, Obstetric and Neonatal Nurses (2010).

Box 1-2 IBCLC Staffing Guidelines from the United States Lactation Consultant Association

Hospital with Level I Neonatal Service

The hospital with level I neonatal service would require 1.3 FTEs per 1000 deliveries per year for the inpatient setting. To include the breastfeeding rate in this calculation, multiply the FTEs calculated times the percentage of breastfeeding mothers in that facility.

Hospital with Level II Neonatal Service

The hospital with level II neonatal service would require 1.6 FTEs per 1000 deliveries per year for the inpatient setting. To include the breastfeeding rate in this calculation, multiply the FTEs calculated times the percentage of breastfeeding mothers in that facility.

Hospital with Level III (Tertiary Care) Neonatal Service

Based on the standard of a 20% preterm delivery rate (Mannel & Mannel, 2006), the tertiary care facility would require 1.9 FTEs per 1000 deliveries per year for the inpatient setting. To include the breastfeeding rate in this calculation, multiply the FTEs calculated times the percentage of breastfeeding mothers in that facility.

Source: Reproduced from United States Lactation Consultant Association IBCLC Staffing Recommendations. *http*://www.ilca.org/files/USLCA/Resources/Publications/IBCLC_Staffing_Recommendations_July_2010.pdf

Managing a Hospital Lactation Service

A quality lactation service requires dedicated positions for lactation consultants to ensure timely access to care. Some hospitals hire only IBCLCs who are also RNs and plan to use them in nursing staffing. When it is not busy in labor and delivery, then the IBCLC/RN can "do lactation." Unfortunately, this type of service leads to inconsistent access to care and increases risk management concerns. When census is higher and no lactation consultants are available, mothers are more likely to be discharged with inadequate knowledge of breastfeeding management or even knowledge of how to identify if their baby is feeding adequately (Centers for Disease Control and Prevention [CDC], 2011; Martens, Derksen, & Gupta, 2004; Paul et al., 2006).

In other hospitals that have dedicated lactation positions, nursing staff may stop providing basic breastfeeding care based on their belief that all breastfeeding care is handled by the lactation consultant (Spatz, 2010). This type of environment is not effective either. As Spatz (2010, p. 500) said, "Educated nurses should be the first level of intervention for all breastfeeding women and their infants. If this occurred in all institutions, the burden on the LC would decrease, and the LC could focus on complex breastfeeding cases. Educated nurses can change institutional and community breastfeeding cultures."

In 2010, Mannel described an effective lactation service where the IBCLCs make lactation rounds each morning to identify high-acuity patients, using a daily lactation census and scripted rounding questions (see Box 1-3). Low-acuity breastfeeding couplets (level I) are managed by nursing staff, all of whom have training in basic breastfeeding management. The IBCLCs are then able to focus more effectively on higher-acuity breastfeeding couplets/patients (level II or III). This system represents a change from the hospital's previous method of relying only on referrals from physicians, nurses, and patients—a common practice in many hospitals.

Table 1-3 Breakdown of Staffing for Hospital Lactation Program with 3,000 Births per Year

Approx. number of births/yr = 3000 (68% initiate breastfeeding)

Approx. number of NICU admissions/yr = 400 (85% initiate breastfeeding)

One FTE =

1900 work hours (excluding vacations, sick days, etc.)

1292 hours direct consult time

608 hours indirect clinical time

FTE ratio is number of available direct consult work hours divided by the amount of hours per dyad.

For example, 1292 hours/FTE divided by 1.65 hrs of direct consult with each dyad = 783 dyads per LC FTE.

2040 births (68% breastfeeding of 3000) divided by 783 = the number of LC FTEs that are needed for direct consult inpatient care.

Category	FTE Ratio	Calculation	Number	FTEs
Inpatient	1:783	3000 × .68 = 2040	2040/783 =	2.6
Outpatient	1:1292	120 couples 120 hours (1 hr each)	1292/120 =	0.1
Telephone	1:3915	3000 × .60	1800/3915 =	0.45
NICU inpatient	1:235	400 × .85 85% initiate BF	340/235 =	1.44
Education	0.1:1000	3000 × .68	2040/1000 =	0.2
Program admin	0.1:1000	3000 × .68	2040/1000 =	0.2
Research/QA	0.2:1000	3000 × .68	2040/1000 =	0.4
Total				about 5.4

Source: Adapted from Mannel R, Mannel RS. Staffing for hospital lactation programs: recommendations from a tertiary care teaching hospital. J Hum Lact. 2006;22:409–417.

Box 1-3 Lactation Rounding Script for the Lactation Consultant

Introduction	"Hi, Ms. Jones, I'm Paula, one of the registered lactation consultants here at OUMC and I'll just be in here for one or two minutes. I'm checking on all the new moms to see who is breastfeeding or wanting to breastfeed and who might need some extra help from us. Were you planning to breastfeed?" [or: "I see you've been doing some breastfeeding already…"]
Mother says, "I'm bottle-feeding" (i.e., exclusively formula-feeding)	"Well, you have a great nurse to help you with that. You know, your body will still make milk to feed your baby so you will have some breast fullness in 1–2 days. You can apply ice packs and take acetaminophen or ibuprofen if the swelling gets uncomfortable. It should get better in a couple of days. Here's one of our brochures in case you ever need to call us."

Mother says, "I'm breastfeeding"	"Great, then I have just a few quick questions to help us decide who might need a visit from us later today…"
Questions for breastfeeding mothers	"Is this your first baby?" If multiparous: "Have you breastfed any of your others?" "Have you had to give any formula?" (i.e., Has her baby been EBF so far?) "Have you had any nipple or breast pain when your baby is nursing?" If yes, rate on pain scale. (Pain scale = 1–10, with 10 being most severe.)

Results from rounding and identifying high-acuity patients have improved quality of care, lactation staff productivity, and employee satisfaction on the lactation team. As one IBCLC said, "Rounds make us more efficient… I know where to start." This model has been adopted by many hospital lactation programs.

The Unique Characteristics of Counseling Breastfeeding Women

There are unique aspects of working with breastfeeding women that differ from other aspects of health care. Breastfeeding is an emotion-laden subject for almost anyone who has had a child, whether the new mother or the healthcare provider. Some professionals remain concerned about making mothers feel guilty by encouraging breastfeeding, so they abdicate this important responsibility completely. Others counsel mothers by relating their own personal experiences, whether positive or negative. Mothers deserve objective, evidence-based information to help them make informed decisions, such as whether to breastfeed at all, or whether to supplement with formula when the mother is not sure if her baby is getting enough sustenance. Mothers who do not reach their breastfeeding goals tend to blame themselves, when often it is the lack of timely and skilled support that made breastfeeding difficult, if not impossible.

This emotional context makes breastfeeding counseling, like sex counseling or childbirth education, unusually sensitive. Healthcare workers assisting breastfeeding families must be especially intuitive, caring listeners and advisors. For more information on communication and counseling skills, see other sources such as Lauwers and Swisher's (2010) *Counseling the Nursing Mother: A Lactation Consultant's Guide* or Lauwers's (2012) chapter in *ILCA's Core Curriculum for Lactation Consultant Practice*.

Roles and Responsibilities

The LC is responsible to the mothers she sees to provide up-to-date, accurate information and appropriate assistance. Quality practice and service are core responsibilities of any profession in regard to the public. ILCA standards of practice are measures or levels of quality that are models for the conduct and evaluation of practice (ILCA, 2013).

LCs report that the majority of their time is spent in direct care of clients. The role of the LC may closely parallel that of the clinical nurse specialist, in that it requires in-depth clinical knowledge and expertise in a particular area. Gibbins et al. (2000) describe a model of the nurse practitioner (NP) or clinical nurse specialist (CNS) in the role as a lactation consultant in a breastfeeding clinic. This advanced practice role encompasses key dimensions of the advanced practice model: research, leadership, education, and clinical practice. Like the clinical specialist, the LC does the following:

- Gives direct care
- Teaches
- Consults
- Conducts or assists in conducting research

Giving breastfeeding mothers consistent breastfeeding information is vital. Many times mothers identify support received from healthcare providers as the single most important intervention in the healthcare system in helping them breastfeed (Taveras et al., as cited in Shealy et al., 2005, p. 15). The patient takes for granted that the healthcare professional advising her is giving her accurate information and "new mothers rarely request care different from that offered them by health professionals" (Shealy et al., 2005, p. 1). If confusion or controversy is found among the staff, healthcare providers cannot expect the patient to become knowledgeable and comfortable with learning mother–infant tasks. Staff and clinician training in basic breastfeeding management increases the likelihood that the healthcare team will provide consistent information.

A leadership function of the LC, whether based in a hospital or the community, is policy development. Identifying needed policies related to breastfeeding and ensuring they are evidence based is an important element that lays the foundation for a breastfeeding/family-friendly environment and optimal patient care (ILCA, n. d.; WHO, 2003).

Stages of Role Development

Roles of health professionals have been extensively studied and shown to progress through stages of development. For example, Benner (1984) used the Dreyfus and Dreyfus (1980) model of skill acquisition to describe the progression of skills and competencies of nurses in the clinical setting. This model—which outlines a structure for the metamorphosis that occurs as nurses persevere in their practice—can also apply to lactation consultants. According to Benner (1984), there are five stages of role acquisition:

- Novice: Develops technical skills, has a narrow scope of practice, needs a mentor
- Advanced beginner: Enhances clinical competencies, develops diagnostic reasoning and clinical decision-making skills, begins to incorporate research findings into practice
- Competent: Expands the scope of practice, becomes competent in diagnostic reasoning and clinical skills, senses nuances, develops organizational skills
- Proficient: Achieves the highest level of clinical expertise, conducts or directs research projects, acts as a change agent, uses a holistic approach, interprets nuances
- Expert: Global scope of practice, consults widely, empowers patients and families, serves as a mentor

In following Benner's progression from novice to expert, LCs will spend more time as consultants and in scholarly work as they gain experience in the field (Auerbach, Riordan, & Gross, 2000). Because the role of the lactation consultant is relatively new, other health providers may be unclear about what to expect of this healthcare team member. Some nursing managers may be unclear as to the competency of an IBCLC versus an RN/IBCLC. All IBCLCs should be clinically competent as outlined in the IBLCE's (2012a) *Clinical Competencies for the Practice of International Board Certified Lactation Consultants*. This document is suitable for verifying the competency of any IBCLC during orientation to a clinical position (available at http://iblce.org/resources/professional-standards/).

Lactation Consultants in the Community Setting

Breastfeeding is a public health imperative. It was identified by the U.S. Surgeon General in her 2011 *Call to Action to Support Breastfeeding* as "the best source of infant nutrition and immunologic protection, [providing] remarkable health benefits to mothers as well" (U.S. Department. of Health and Human Services, 2011, p. v). The CDC's Division of Nutrition, Physical Activity, and Obesity "is committed to increasing breastfeeding rates throughout the United States and to promoting and supporting optimal breastfeeding practices toward the ultimate goal of improving the public's health" (CDC, n.d. para. 1). The Baby-Friendly Hospital Initiative's *Ten Steps to Successful Breastfeeding* have been shown to increase breastfeeding initiation and duration; Step 10 says, "Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center" (Baby-Friendly USA, n.d.).

Because of this heightened awareness of the importance of breastfeeding support, both access to highly skilled lactation care in the community and ongoing breastfeeding support for mothers are important. Women's preventive healthcare protections outlined in the 2010 Affordable Care Act are intended to provide, at no out-of-pocket expense to U.S. women with health insurance, "comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment (U.S. Department of Health and Human Services, Human Resources and Services Administration, n.d., para. 4). This community-based health care differs from hospital-based care in that the healthcare provider works with the mother over the long term—throughout her pregnancy, childbirth, and postpartum course; thus community-based healthcare workers have an advantage over those working in the hospital in that they see the mother and her family in their total environment. Someone once described this as seeing a whole movie, whereas in the hospital the healthcare provider sees only one frame. Being in the family home gives a much wider perspective on the mother's needs that might not otherwise be apparent. Moreover, community-based services are organized around a system of interdisciplinary resources. A community health nurse may work with low-income mothers who are eligible for many different programs of assistance besides breastfeeding support.

Worksite Lactation Programs

Corporate lactation programs pay off. Women prefer to work at jobs where the breastfeeding woman is welcomed. Not only that, but breastfeeding mothers miss less work than mothers who are formula-feeding (Cohen, Mrtek, & Mrtek, 1995). As a result, many corporate offices are becoming "breastfeeding friendly," offering pumping rooms and multiuser pumps. Mothers working full-time spend less than 1 hour over the course of one workday expressing breastmilk. The *Business Case for Breastfeeding* published by the Office on Women's Health (2008) is an excellent resource for employers and employees and is available online.

Medical Clinics/Offices

A growing number of physicians are emphasizing breastfeeding in their practices. For some, this entails advocating for breastfeeding among patients in their general practice (family practice, obstetrics, or pediatrics) and providing staff to assist mothers to be successful. For other physicians, their general practice also becomes a consulting practice for more complex breastfeeding problems referred by lactation consultants or other physicians. A small number of physicians are developing breastfeeding and lactation specialty clinics or programs either in an academic setting or as a private practice. The specialty clinics serve as tertiary referral practices for complicated medical conditions of mother and baby, for conditions that require prescription medications, or for minor procedures that may be indicated (e.g., frenulotomy for tongue-tie). Such tertiary centers often rely upon the close working relationships of the physicians with other non physician lactation consultants.

Physicians, especially pediatricians, realize the value of having staff who are knowledgeable about breastfeeding and can quickly and effectively work with breastfeeding women in their practice; thus many lactation consultants are employed in the medical office. Their responsibilities include answering phone calls from breastfeeding women, making home visits, and working with the physician during postpartum visits to the medical office and while making hospital rounds. The physician office usually pays the lactation consultant a salary; however, some IBCLCs may do their own billing, particularly if they are also advanced practice nurses.

Professional Lactation Care and Volunteer Counselors

Breastfeeding support does not always require professional lactation care. The mother/client will obtain the best in comprehensive care when IBCLCs, volunteer breastfeeding support counselors, and other healthcare or program service providers all work together to provide support.

While volunteer counselors and IBCLCs can offer general support to mothers, the scope of practice

and clinical competencies for the IBCLC include skill at assessing both mother- and infant-related lactation issues, as well as an ethical duty to protect the breastfeeding relationship (IBLCE, 2011, 2012a, 2012b). Volunteer counselors are an excellent source of general support for mothers, offering preventive healthcare information pertaining to breastfeeding and lactation. They also spend more time giving long-term assistance as the child ages, whereas the IBCLC may see clients/patients only in a clinic or hospital setting. It is not uncommon for a mother to continue to receive assistance and caring concern from a volunteer counselor throughout the entire lactation course; only rarely will an IBCLC meet with a client regularly during that entire period. Instead, IBCLC contact may be sporadic, initiated by the client/patient when a question or concern requiring specific clinical skills to assess or resolve a problem arises.

Volunteer breastfeeding helpers and lactation specialists can assist one another (Thorley, 2000). The volunteer may have seen a certain mother in her own home and, therefore, may be able to alert the IBCLC working in a hospital, doctor's office, or clinic to elements of the mother's home life that may bear on her lactation course. The IBCLC, in turn, may serve as a referral source for persons with complex problems. When the IBCLC works in a medical center where ongoing research is part of this role, he or she helps generate new knowledge. Both the volunteer and the paid IBCLC can review materials written for clients/patients. The volunteer may be sensitive to ongoing issues that crop up after the mother has left the hospital, including those that the mother may choose not to mention to her healthcare providers. The IBCLC may be aware of aspects of the healthcare system that influence breastfeeding.

Mentoring and Networking

Mentoring plays a major role in any clinically based profession, especially a new specialty. A mentor (whether serving by informal or formal arrangement) is a trusted counselor, guide, or coach for the student/intern, and fills this role over a long period of time. Mentors nurture the novice's growth with advice, information, and support (Altman, 2010; ILCA, 2012; Lauwers, 2007). The early pioneers in this relatively new field are now the teachers and mentors of novice IBCLCs (Wiessinger, 2003). Educational programs with a clinical component are rare at this early stage in the evolution of LCs, and supervised clinical preceptorships are difficult to obtain. Shadowing experienced lactation specialists in one's area, however, is an excellent way to hone clinical skills. Students in rural areas with fewer qualified mentors may need to travel to visit the work setting of a colleague for mentoring purposes. The IBLCE defines the stages of training that a student will achieve during supervised clinical mentoring: observation, supervised practice, and independent practice with mentor nearby. See Pathway 3 in the *Plan Approval Guide 2013*, at http://www.iblce.org/preparing-for-ibclc-certification#Description%20of%20the%20Pathways.

Networking, whereby members of a group exchange information and get help in solving problems, is a valuable mechanism for gaining and sharing expertise. When a difficult case arises, IBCLCs can use local in-person gatherings, telephone, and e-mail lists to gain insight from colleagues (while being careful, of course, to protect client/patient privacy). Networking can identify job openings, colleagues who will cover for one another, and referrals for clients needing equipment or specialized help. Networking also enhances advocacy efforts that seek to change systems and improve methods of providing care.

Opportunities to communicate with others also abound on the Internet, especially with social media networks, which are, in the early 21st century, a predominant means of fact gathering and communication. A forerunner of such interactions was LACTNET, a worldwide breastfeeding e-mail list with more than 3000 subscribers in English, and a sister list in German (LACTNET-DE). Electronic communication is inexpensive and connects professionals in far-flung parts of the world with diverse cultural perspectives. Being able simply to vent and obtain sympathetic commiseration provides validation for the hard-working but perhaps isolated practitioner. The Internet has allowed for an explosion in the availability of valuable, evidence-based practice-guiding websites, research articles, and other resources.

Documentation

It is the responsibility of the lactation specialist, regardless of where he or she practices, to chart each contact with clients and to provide complete reports to referring physicians and other healthcare providers (IBLCE, 2010; Williams, 1995). Almost all record keeping involves using a computer; thus computer skills are a necessity for healthcare workers. As in other healthcare practices, computers can be used to generate records, reports, and charts that do the following:

- Provide other health workers with valuable information
- Reflect quality of care delivered (quality assurance, continuous quality improvement)
- Highlight sometimes subtle observations or findings
- Validate health services for insurance companies to determine reimbursement
- Provide data that can be used for research
- Serve as evidence in a legal dispute

In the hospital, the mother's and infant's charts are clinical records that contain information about the hospital stay and all contacts with everyone involved in their care. Because the mother and infant usually have separate charts, it is often necessary to "double chart." At the same time, care plans tend to be geared toward the mother, because it is she who is taught and the baby who is the recipient of her learning.

Health professionals use computers or smart phones to look up medical information and to document their interventions. Free and fee-based software and applications ("apps") for coding, charting, and medication information are available online. The most commonly used methods of charting are narrative charting and problem-oriented charting. Flow sheets and standard care plans that are individualized are becoming more popular, however, as they reduce paperwork and save time (and money).

Narrative Charting

Narrative documentation uses a diary or story format to document client-care events. A simple paragraph describes the client's status and the care that was given. Narrative notes, sometimes called progress notes, are used less frequently now, owing to the adoption of flow sheets and clinical care plans that capture the routine aspects of care. Narrative notes (Box 1-4) can be easily combined with flow sheets or any other client record.

Problem-Oriented Charting

Charting based on a problem uses a structured problem list and logical format for each entry in the medical record. The format used in problem-oriented charting is called the SOAP or SOAPIE method. Each letter stands for a different phase of the process: subjective data, objective data,

Box 1-4 An Example of a Narrative Note

Date	Time	Progress note
05–22–03	0800	Infant alert. Rooting and suckling movements noted. Infant latched on breast and suckled effectively until asleep. Breastfeeding assessment score 9/10.
05–22–03	1500	Discussed basic breastfeeding information including normal infant elimination patterns to watch for after discharge. Mother given written materials on sore nipples, engorgement, use of breast pump, and breastmilk storage.
05–23–03	1100	Explained that a follow-up call will be made 2 to 3 days after discharge. Mother will have the option of a home visit.

Box 1-5 Example SOAP Note

1. Subjective = what mother tells you
   a. For example: *Mom c/o nipple pain and not sure if baby is getting enough.*
2. Objective = what LC saw and did, and information from medical record (e.g., interventions, education, mother return demonstration)
   a. For example: *P2B2 mom, term infant <48 hrs old, output WNL to date (2 voids, 4 stools), baby is 8% below birth weight. Maternal pain = 8 out of 10.*
   b. *Baby latched with areolar compression, rhythmic sucking, audible swallowing. Adjusted positioning and latch to decrease pain and increase milk removal. Mom needed moderate assistance with positioning and latch.*
   c. *LATCH Score = 8 (L2A2T2C1H1).*
   d. *Breasts: full, heavy, milk easily expressed.*
   e. *Nipples: everted, compressible, midline cracks.*
   f. *Educated re: s/s adequate infant intake, position and latch, newborn nutrition in 1st 48 hrs, milk production.*
3. Assessment = identify the problem; YOUR assessment of what the situation is (a lactation diagnosis)
   a. Example for a normal mother–baby couplet, IF you assessed the mother's breasts or baby at breast: *Transitioning to Lactogenesis II. Effective breastfeeding with milk transfer.*
   b. For a NICU mother: *Lactogenesis I apparent, at risk for compromised milk production due to lactation risk factors: preterm delivery, PIH, GDM, late initiation of milk expression.*
4. Plan = what is the goal and plan to get there
   a. With a normal breastfeeding couplet with effective breastfeeding: *EBF on cue of baby or at least 8×/day, monitor output, call (community resources) prn.*
   b. For a NICU mother: *Express milk 8–10×/day, use hand expression/hands-on pumping, monitor milk volume collected, practice kangaroo care with baby daily as possible, acquire pump for use after discharge, request LC support when baby ready to initiate direct breastfeeding. Call prn.*

assessment, plan, interventions, and evaluation of care (see Box 1-5). When the LC functions as a consultant, problem-oriented charting is more appropriate.

In private practice, the completeness of reports also assists the referring healthcare worker to understand the "how" as well as the "why" of an LC's practice and methods. Reporting provides a database for all types of information (e.g., an increase in the number of referrals from a particular physician's practice). Early referrals may be for one or two common problems, whereas tracking over an extended time period may reveal that later referrals deal with a wider variety of problems.

Electronic Health Records

A patient's lactation information is usually incorporated into existing information systems (IS) in clinics and hospitals. Lactation professionals need to work closely with IS technicians to make sure that the format employed for electronic healthcare records accommodates breastfeeding information, especially if mother–infant care is involved. Transition to such a system takes significant amounts of time and resources, and often engenders a great deal of staff frustration. Each facility, outpatient lactation clinic, private lactation practice, medical office, and hospital will have unique needs.

The Cincinnati Children's Center for Breastfeeding Medicine developed a lactation-friendly electronic health record (EHR) at its pediatric facility, which has a breastfeeding clinic. New forms specific to breastfeeding are (1) maternal history, (2) maternal exam, (3) infant feeding history, and (4) breastfeeding assessment. This organization's computer system includes electronic prescriptions, printed patient handouts, and telephone notes (List et al., 2008). LCs will find the computer pages and drop-down lists in this article to be helpful for developing their own computerized records.

Clinical Care Plans

A clinical care plan provides basic information about client assessment, diagnosis, and planned interventions. It also offers a guide for care, establishes continuity of care, and represents a means of communication among all caregivers. Two types of care plans may be created: individual and standard. Individual care plans are developed "from scratch" for each client based on her specific needs. A standard care plan is a preprinted plan of care for a group of patients within the same diagnosis. Because each standard care plan must be tailored according to the needs of a particular client, they are designed to include space for adding information.

The Joint Commission requires a care plan for each patient in the hospital as a necessity for accreditation; however, the plan of care can be computer generated, be preprinted, or appear in progress notes or standards of care (American Nurses Association, 1991). Care plans are legal requirements of practice and may also serve as protocols or standards of care.

Traditionally, individual care plans are divided into columns. Column headings change over the years to reflect new ideas in nursing, and some column labels are preferred over others. In this text, for instance, the clinical care plans include assessment, interventions, and rationale. Other commonly used labels are "problem," "evaluation," "nursing diagnosis," "patient outcomes," "nursing action," or simply "intervention-evaluation." Box 1-6 provides an example of a nursing diagnosis and nursing care plan. The critical care path or clinical path is a commonly used type of care plan in hospitals. These paths, which are abbreviated care plans that focus on the client's length of stay in the hospital, integrate infant feeding into the overall care plan.

Legal Concerns

As credentialed allied healthcare providers, IBCLCs will take care to use best practices in clinical care, to abide by the ethical rules of their profession, to stay within their scope of practice and clinical competencies as lactation professionals, and to follow the legal requirements of the workplace setting. Liability may result when the mother or baby is placed at risk, even if the IBCLC is following a physician's order. While no caregiver is immune from litigation (even excellent clinicians can be named in a specious lawsuit), excellence in professional practice is the best way to reduce such risks (Miller, 2006).

The following guidelines suggest ways to avoid liability:

- Carry professional liability (or malpractice) insurance, covering all of your practice settings. If you are named in a suit, the insurance entitles you to legal counsel and advice.
- Keep up-to-date on new research findings and clinical practices. Read current relevant articles, network with respected colleagues, attend live or online conferences.
- Use mother-centered care with all of your patients/clients, meeting each woman's needs and supporting her choice after she has been offered evidence-based information and consultation. People tend to sue healthcare providers when they feel they were not treated with respect and dignity.
- Thorough documentation, as close to the time of the intervention/assessment as possible, will verify your excellence in care. Document development of the care plan, suggested interventions, and the rationale for doing so. Methodically record updates and revisions to the plan, based on follow-up contacts (often made by phone).
- In the newborn period at the hospital or birthing center, a latch and feed by the infant

BOX 1-6 NURSING INTERVENTIONS • NURSING CARE PLAN *LACTATION COUNSELING*

COUNTY OF ORANGE • HEALTH CARE AGENCY • FIELD NURSING

NURSING INTERVENTIONS • NURSING CARE PLAN

Client's Name:_____ **Client's Number:**_____

Lactation Counseling — 5244

DEFINITION: Use of an interactive helping process to assist in maintenance of successful breastfeeding.

ACTIVITIES:	**DATE:**					
Determine knowledge base about breastfeeding						
Educate parent(s) about infant feeding for informed decision making						
Provide information about advantages and disadvantages of breastfeeding						
Correct misconceptions, misinformation, and inaccuracies about breastfeeding						
Determine mother's desire and motivation to breastfeed						
Provide support of mother's decisions						
Give parent(s) recommended education material, as needed						
Inform parent(s) about appropriate classes or groups for breastfeeding *(e.g., La Leche League)*						
Evaluate mother's understanding of infant's feeding cues *(e.g., rooting, sucking, and alertness)*						
Determine frequency of feedings in relationship to baby's needs						
Monitor maternal skill with latching infant to the nipple						
Evaluate newborn suck/swallow pattern						
Demonstrate suck training, as appropriate						
Teach mother about:						
• Relaxation techniques, including breast massage						
• Ways of increasing rest, including delegation of household tasks and ways of requesting help						
• Record keeping of length and frequency of nursing sessions						
• Infant stool and urination patterns						
• Adequacy of breast emptying with feeding						
• Quality and use of breastfeeding aids						
• Appropriateness of breast pump use						
• Formula information for temporary low supply problems						
• Skin integrity of nipples						
• Nipple care						
• Relieving breast congestion						
• Applying warm compresses						
• Signs of problems to report to health care practitioner						
• How to relactate						
• Continuing lactation upon return to work or school						
• Signs of readiness to wean						
• Options for weaning						
• Alternative methods of feeding						
• Contraception						

Source: Reproduced from Parris KM. Integrating nursing diagnosis, interventions, and outcomes in public health nursing practice. Nurs Diag. 1999;10:49–56.

at the breast should be assessed and documented before the mother and baby are discharged. If this has not occurred, the IBCLC should make certain the baby's primary healthcare provider is apprised of the situation. The mother and baby may be allowed to stay a day or two longer; if not, the discharge care plan should describe how the mother can know when breastfeeding is going well and how she can access support and expert care if she is unsure about its effectiveness. Immediate follow-up care by the IBCLC might include a daily phone call, helping the mother to schedule an early visit to the baby's physician, or an outpatient consult or home visit—or all three.

- Refer to someone else if the situation calls for expertise you do not have in special situations.

People tend to become disenchanted with their healthcare providers (and are more likely to sue) not because of clinical actions, but rather because the patient/client felt uninformed, ignored, or rudely treated. Therefore, the most effective protection against such actions is establishing clinical rapport

and forging a mutually respectful relationship (Miller, 2006). The lactation specialist's pattern of practice should seek to avoid causing the mother, the baby, or any other member of the client's family any emotional distress as a result of words said, reports written, or other actions taken.

A clearly written, detailed record of the healthcare provider's actions, initial recommendations, and follow-up assistance is one of the most effective ways of avoiding legal scrutiny. Well-written, complete reports will allow the other healthcare providers in your community to become familiar with your standards of excellence. Information that is sent in a timely and professional manner may lead to future client/patient referrals to the IBCLC. While charts and client records are considered admissible in the case of a lawsuit, clear records can also prevent cases from going beyond the discovery phase and into the courthouse. Lawsuits often are won or lost based on what appears in the written or digitized record.

The IBCLC who works in a doctor's office, clinic, or hospital may be considered an employee who is covered in an "umbrella" professional liability policy for the office/institution. The IBCLC in private practice must obtain her own insurance policy coverage. Members of CLCA and USLCA have access to professional liability insurance coverage at a reasonable cost as a membership benefit. Although legal action against an IBCLC is rare, it does occur; therefore, all individual practitioners need to consider how they will protect themselves (and their personal/family assets) against protracted litigation, and even a judgment.

Confidentiality

Maintaining confidentiality and protecting the privacy of the mother, baby, and family is a primary healthcare provider responsibility. It is part of the IBCLC's professional conduct code, clinical competencies, and scope of practice (IBLCE, 2011, 2012a, 2012b) and is identified by the professional association as a standard of best practices (ILCA, 2013). To fail to preserve confidentiality is an invasion of privacy and a tort (wrongful act) that occurs when information is revealed without permission to someone not entitled to know it.

Privacy obligations are also imposed by federal regulatory law in the United States, enforceable by civil and criminal sanctions. The Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the subsequent requirements under the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, are intended to standardize and protect the communication of electronic health information between healthcare providers and health insurers. The regulations are very clear: protect the privacy and security of the patient/client (Health Insurance Portability and Accountability Act, 2002; Omnibus Final Rule [HITECH], 2013).

Intellectual Property Rights

The IBLCE Code of Professional Conduct (IBLCE CPC) contains a principle specifically mandating IBCLC respect for intellectual property rights (IBLCE, 2011). While all people around the world should respect all laws, the IBLCE CPC provision means that IBCLCs can be sanctioned under the disciplinary procedures of their profession in addition to whatever liability they may assume under the laws of their country. Intellectual property covers patents, trademarks (including certification marks and service marks), trade secrets, and copyright law. For IBCLCs, copyright is the form of intellectual property law most likely to affect professional practice, as these consultants typically rely heavily on written, audio, and visual images in education and support of breastfeeding families. Unless materials created by others are clearly marked as available for redistribution, permission *must* be sought from the creator *before* the material can be reproduced, distributed, performed, displayed, licensed, communicated, or broadcast (Brooks, 2013).

Note that copyright law is not concerned with assembling proper citations in professional or scholarly writing. Academic, clinical, and professional rigor require appropriate attribution, in a bibliography, of any materials used to help inform the knowledge, thoughts, and conclusions of the practitioner. It is important to acknowledge the original creator or provider of written material, slides/photographs, video clips, Internet sites, blogs, illustrations, online courses, and other materials.

Note, too, that the IBCLC has the additional requirement, also unrelated to copyright law, under IBLCE CPC Principle 3.1, to obtain *prior, written consent* from the mother for *any* photograph, recording, or taping of her or her baby. Even if the image will be stored and viewed only by the IBCLC (perhaps to measure how interventions are helping to promote healing of nipple trauma), prior written consent is required.

The following basic concepts apply when using other people's original, copyright-protected materials:

- Seek authorization (permission) of the creator/source to reproduce, present, record, broadcast, translate, or adapt materials protected by copyright. A work is considered copyright-protected as soon as it exists in tangible form. The copyright-holder does not have to file it with the U.S. Copyright Office (although doing so fixes in time the creator's rights—a critical element when enforcing rights).
- There is no official form or format for seeking permission to reuse another person's materials. A phone call, e-mail, letter, or fax may be used for this purposes, but the requestor should always keep a record of the contact. Indicate who you are, the conditions under which reproduction is sought and will be used, and whether there is any commercial aspect to the reuse.
- Credit summaries of research findings or ideas to the original authors or copyright owners; indicate when adaptations have been made.
- Users of another's work are generally limited to one photocopy or download per person; making several copies even for educational, noncommercial purposes is not allowed.
- Quote directly from the original source, citing the exact page or paragraph where the quote is found. Use the citation style required of your workplace or academic institution; often a quotation of five or fewer typewritten lines should be enclosed in quotation marks, followed by a reference. Some styles require quotations of lengthier material to be indented in addition to having adequate citation (U.S. Copyright Office, 2012).

Legal issues for IBCLCs are discussed generally by Priscilla Bornmann (2013) in *Core Curriculum for Lactation Consultant Practice*, third edition, and by Elizabeth Brooks (2013) in *Legal and Ethical Issues for the IBCLC*.

Ethics

Ethical decisions are a routine, inherent part of lactation practice. Legal requirements for the IBCLC (and all healthcare providers) may be characterized as black-and-white, applicable to all practitioners equally. Ethics analysis looks at the gray: the considerations and evaluations of what is "right and wrong" differ with each instance, as the facts and players change (Brooks, 2013; Noel-Weiss, Cragg, & Woodend, 2013). The IBLCE Code of Professional Conduct (2011) is a "must," describing mandatory professional behaviors by the practitioner, whereas the ILCA Standards of Practice (2013) are a "should," describing voluntary best practices. The purpose of these documents, along with the mandatory ("must") IBLCE Scope of Practice (2012b) and Clinical Competencies (2012a), is to provide guidance to IBCLCs in their professional practice. The IBLCE Code of Professional Conduct is an ethical code built on the premise that it is in the best interests of the IBCLC profession, and serves to protect the health, welfare, and safety of the public, to have required minimum standards of acceptable conduct. IBCLC certificants agree to abide by these principles, and are subject to disciplinary action for failure to do so (IBLCE, 2011).

Ethical Questions in Lactation Practice

Different personalities, ethical obligations, and value systems may come into play in the LC's practice, complicating judgment or limiting neutrality. Many times there is no clear right or wrong course of action in trying to resolve ethical dilemmas. Consider the following issues:

- Whether to attend a continuing education lunch sponsored and paid for by a formula

company. Attendees may also receive other free products.

- Whether to distribute free samples of formula or coupons to breastfeeding women who are being discharged from the birth setting. Do IBCLCs employed at the facility have a right to refuse to distribute these items?
- Whether to file a complaint against a colleague who transferred client files out of the health agency without prior consent, thereby failing to protect privacy and security under HIPAA/HITECH regulations. What are the circumstances surrounding this incident? Was it intentional? Was the offender aware of privacy regulations ? Did any harm come of the action—that is, was, in fact, any client/patient's privacy compromised?
- How to offer evidence-based information and support for the breastfeeding mother who is a smoker, who is a user of illicit drugs, who seeks to informally share breastmilk with her friend, or who does not want to express milk for her hospitalized, premature baby.
- Whether to write an article with evidence-based information about breastfeeding for mothers that will be published in a magazine or on a website that also carries ads for formula, bottles, and teats.

Ethics considerations are relevant for lactation specialists, in part because this is a relatively new profession in health care. As such, the public is just now becoming aware of LCs, their special knowledge and skills, and the role they play and the impact they have in the maternal–child and public health fields (ILCA & Henderson, 2011). Our professional behaviors contribute to IBCLC acceptance by the public as a welcomed, respected discipline.

The nature of IBCLC practice involves assessment of the mother (including touching her breasts) and assessment of the infant (including touching the mother's precious baby). The birth of a child is a major family and life event. The circumstances surrounding it will be remembered (for good or ill) by the mother and her family for years to come. Further, a mother is emotionally vulnerable during and after childbirth. The IBCLC holds a place of great privilege and honor to be welcomed into this close circle of family members celebrating a birth, and struggling perhaps with normal concerns of parenthood. Technologies used in lactation practice have expanded dramatically in the last quarter century. New families need guidance, free from conflict of interest on the part of the healthcare provider, as to the appropriate use of such devices.

International Code of Marketing of Breast-milk Substitutes ("WHO Code")

Predating the IBCLC profession and the IBLCE examination, WHO's 1981 *International Code of Marketing of Breast-milk Substitutes*, in conjunction with the 18 relevant World Health Assembly resolutions passed since then (WHO, n.d.; WHO & UNICEF, 2009), is a model policy against predatory marketing practices that could reduce optimal breastfeeding by mothers and children worldwide. It recognizes the public health imperative of breastfeeding promotion and support. It seeks to limit commercial marketing of infant formula, bottles, teats (called bottle nipples in the United States), and baby foods or juices meant to replace breastfeeding at the breast. Sales and purchases of those products are allowed.

For the IBCLC, or any other healthcare provider, the principles of the WHO Code can be easily met and supported, regardless of the status of legislative enactment in one's country. The practitioner should refuse any free gifts, samples, or other financial inducements from product marketers. The practitioner should confine clinical or educational discussion of the use of WHO Code–covered products to a one-on-one setting. The practitioner should avoid the professional conflict of interest inherent in the use of pens, handouts, lanyards, tote bags, coffee mugs, or any other gadget bearing the logos and brand names of any commercial product manufacturer. The healthcare provider markets good health; commercial vendors market products (Brooks, 2013; International Baby Food Action Network [IBFAN] & International Code Documentation Centre, 2009).

Moral and Ethical Dilemmas

Moral dilemmas and ethical issues can be subtle and complex, and are intertwined in some situations. Often they entail simply a feeling that something is not quite right about a situation, and this uneasy feeling lasts for a long time. Most of us remember an incident in our childhood where a parent made it very clear that we were doing the wrong thing. Although it was painful at the time, our parents inculcated a moral sense that gave us a behavior compass so that we headed in the right direction as we grew up (Noel-Weiss et al., 2013; Noel-Weiss & Walters, 2006).

What should healthcare workers do when their job responsibilities conflict with their ethics—for example, when they are asked by a supervisor to distribute free samples of formula to a breastfeeding mother? When lactation specialists feel that they are being asked to do something outside their professional ethical code, an analysis can be conducted by looking at legal and ethical obligations, and flexibility within the workplace to explore other options. Sometimes the IBCLC will not be able to change the outcome of the situation at hand but can initiate a review of policy and procedure to form better options for future mothers (and colleagues).

Most hospitals and large clinics have an ethics or risk assessment committee to help in sorting out these types of issues. The committee may hold a forum for interdisciplinary review where discussion of the dilemma and answers to questions are addressed.

Principles of Bioethics

Ethics is the branch of philosophy that structures morality; morality concerns choosing actions perceived to be right or wrong, and bioethics is the study of ethics in healthcare (Noel-Weiss et al., 2013). Major principles of bioethics include the following (Paola, Walker, & Nixon, 2010):

- Autonomy
- Beneficence
- Nonmaleficence
- Justice

Autonomy

The principle of personal autonomy refers to self-governance; it is respect for self-determination and freedom to make one's own decisions.

Example. Autonomy includes the mother's right to choose whether to follow a treatment suggestion, or to refuse treatment or care plan options. Autonomy fits well with caring for breastfeeding families because we know so much about the advantages of breastfeeding that it is difficult for us sometimes to stand back and accept the well-informed mother who decides to supplement her baby when she goes back to work even after we suggest ways that she can exclusively breastfeed in this situation. Autonomy for the patient requires the IBCLC to recognize and appreciate the client and family's value choices.

Beneficence

Beneficence is the principle of the duty to do good. It may ask the IBCLC to prevent or remove harm. Beneficence is just what it sounds like: being kind, merciful, and caring about the welfare of others. It involves promoting the interests and well-being of others in one's sphere, including colleagues and clients/patients.

Example. Maintain nurturing relationships with your colleagues and your clients/patients. That includes those providers who are in training to become an IBCLC. Critical comments and gossip about other colleagues' skills do not promote a spirit of collaborative care by the healthcare team. Such behavior can undermine the confidence of the mother if she thinks the IBCLC has no trust in the abilities of other caregivers.

Nonmaleficence

Nonmaleficence is the duty to do no harm, and underlies the medical maxim "Above all, first do no harm" (Paola et al., 2010, p. 52). It must be balanced with the principles of beneficence.

Example. Giving an injection to a patient causes the harm of pain, but if it delivers medicine to cure disease, then it is justifiable. The rare mother who must take a powerful medication that is contraindicated during lactation can be counseled by the IBCLC about preventing harm to the baby through her breastmilk, or by discussing options to maintain lactation until the medication is no longer in the mother's bloodstream.

Justice

Justice speaks to the principles of fairness, and how social benefits and burdens should be distributed.

Example. Is the need for skilled expertise of an affluent breastfeeding mother who can access private, individualized care because she can afford to pay the IBCLC on an out-of-pocket basis, without regard to her health insurance coverage, any greater than that of the mother who must rely solely on her health insurance benefits? Or the mother with no insurance at all?

IBLCE Ethics and Discipline Committee

IBLCE has established an enforcement and sanctions procedure for its mandatory IBLCE Code of Professional Conduct, which is triggered by the filing of a complaint with the IBLCE Ethics and Discipline Committee (IBLCE, 2011). Once such a complaint is filed, a hearing process commences to review the allegations, with an opportunity for all parties to be heard and represented. Remedies can range from dismissal of the complaint to public censure and revocation of the IBCLC certification. Examples of matters brought before IBLCE include the following:

- An IBCLC was accused of contradicting a physician's order. There was not clear evidence to prove the accusation. The case was dismissed because it was unsubstantiated.
- An IBCLC suggested a potentially dangerous practice in a published article, which carried her name and IBCLC certification. This was substantiated, but there were mitigating circumstances. Private reprimand was given.
- IBCLC certification was revoked for proof of theft of products while at a conference, and for making copies of the IBLCE certification exam in violation of testing protocols (IBLCE, 2010).

Reimbursement

In most countries, lactation services are a part of the national healthcare system, and reimbursement for these services occurs mainly through salaried positions paid for by government programs. In the United States, reimbursement for lactation services is extremely complex and depends on the setting where the services are provided, the educational qualifications of the provider, and the type of insurance. Reimbursement has also been made more complicated by recent changes in federal law requiring increased access to preventive care services; among those services listed for women are access to skilled lactation care and equipment to support breastfeeding (U.S. Department of Health and Human Services, Human Resources and Services Administration, n.d.).

Lactation specialists who work in a birthing center, hospital, or medical office are usually salaried employees reimbursed with a set hourly or weekly wage. Hospitals usually include lactation services as part of the total cost of the maternity "package." The cost package is an agreement between the insurance company and the hospital to charge a certain amount of money for healthcare coverage for each birth—a reimbursement mechanism known as capitation. Managed care companies compete through price bids to win the healthcare contract, with the lowest bid winning the contract.

If postpartum home visits are part of a maternity insurance package, breastfeeding assistance is given as part of a routine postpartum visit to the mother's home. Nurses providing these home visits are usually salaried employees of the home health

company. Services above and beyond the packaged IBCLC services are paid for either by a separate insurance claim or by the family themselves.

For the IBCLC in private practice, cash payment for services rendered or for equipment may be requested from the client at the time of the service. The client, in turn, may seek reimbursement from her insurance company and provides the third-party payer with the information it needs, perhaps using forms supplied by the IBCLC for sending to the insurer in the hope of being reimbursed. Such a lactation consult bill with payment- and assessment-related codes is displayed in Box 1-7.

Box 1-7 Lactation Services Bill

OU PHYSICIANS FOR WOMEN'S HEALTH

Department of Obstetrics and Gynecology
825 N.E. 10th Street, Suite 3300
Oklahoma City, OK 73104
(405) 271-9494 Scheduling (405) 271-5293 Billing
TAX ID# 73-1477155

Patient Name_____
Patient SSN_____
Patient DOB_____
Date of Service_____
Insurance_____
MRN#_____

Prenatal _____

Postpartum _____ **Delivery Date / Baby's Date of Birth:** _____

LACTATION CONSULTANT: _____

(PRINT NAME)

	SERVICE PROVIDED		**Supplies to Be Charged for**
S9443	Initial Lactation Consultation		
S9445	Follow-up Lactation Consultation		
	MATERNAL DIAGNOSIS - PRIMARY		**CHILD DIAGNOSIS - PRIMARY**
675.14	Abscess, Breast	783.2X	Abnormal or Rapid Weight Loss
676.44	Agalactia	796.1	Abnormal Reflex
676.34, 757.6	Anomaly of Breast or Nipple (Includes Breast Surgery)	750.1	Anomaly of Tongue
676.34, 757.6	Axillary Breast Tissue	767.9	Birth Trauma
649.24	Bariatric Surgery (Status Post) Complicating Puerperium	774.39	Breast Milk Jaundice
676.34	Breast Pain	771.7	Candidiasis / Thrush
675.84,112.89	Candidiasis of Breast or Nipple	749.10	Cleft Lip, 749.00-Cleft Palate, 749.20-Cleft Palate w/Cleft Lip

676.14	Cracks or Fissures of Nipple
676.84	Delayed Lactation
648.04	Diabetes, Mellitus
648.84	Diabetes, Gestational
676.34	Ecchymosis of Breast or Nipple
676.34, 692.9	Eczema of Breast or Nipple
676.24	Engorgement of Breast
676.84	Galactocele
676.64	Galactorrhea
676.34, 757.6	Hypoplasia of Breast
675.94	Infection Breast or Nipple Unspecified (Specified - 675.84)
676.04	Inverted Nipple(s)
675.24	Mastitis - Non-purulent (Interstitial)
675.14	Mastitis - Purulent (Infective)
649.1, 278.00	Obesity
676.84	Breastfeeding Difficulty
676.34	Painful Nipple (No Apparent Trauma)
676.84	Plugged Duct
676.84	Polygalactia
676.84	Relactation
676.54	Suppressed Lactation
676.34	Trauma to Nipple
649.0	Tobacco Use Complicating Puerperium
676.34	Ulceration of Nipple
V24.1	Lactation Care / Exam
V67.59	Follow-up Exam (When the original reason for visit is resolved)

775.5	Dehydration, Newborn
758.00	Down Syndrome
787.20	Dysphagia - Difficulty Swallowing
783.41	Failure to Thrive
783.3	Feeding Problem - Infant, 787.03 - Vomiting - Infant
779.3	Feeding Problem or Vomiting - Newborn (Includes Prematurity)
780.91	Fussy Baby
779.89	Hypertonicity or Hypotonicity - Newborn or Infant
750.15	Macroglossia (Hypertrophy of Tongue)
750.16	Microglossia (Hypoplasia of Tongue)
524.06	Microgenia: Recessive/Small Chin
315.4	Oral Motor Dysfunction/Jaw Clench
750.0	Tongue-Tie/Ankyloglossia

CHILD DIAGNOSIS - SECONDARY

787.70	Abnormal Stools
770.81	Apnea
789.00	Colic
787.91	Diarrhea
779.5	Drug Withdrawal
754.0	Facial Assymetry
767.5	Facial Palsy
767.2	Fractured Clavicle
693.1	Food Allergy
530.81	GE Reflux
750.26	High Arched Palate
478.29	Hyperactive Gag Reflex
775.6	Hypoglycemia 775.0 - (IDM)
764.90	Intrauterine Growth Retardation
774.6	Jaundice/Hyperbillirubinemia
766.1	Large for Gestational Age

(*continues*)

(Continued)

	MATERNAL DIAGNOSIS - SECONDARY	524.00	Micrognathia
304.90	Drug Dependency	315.9	Motor Retardation
244.90	Hypothyroidism (Unspecified)	769	Respiratory Distress Syndrome
761.5	Multiple Birth	764.00	Small for Gestational Age
642.44	Pre-eclampsia (Mild or unspecified)	520.7	Teething syndrome
V10.3	Unilateral Mastectomy	528.9	Ulceration of Oral Mucosa - Traumatic
		528.2	Ulceration of Oral Mucosa - Nontraumatic

Diagnosis Codes:

1. _____ 2. _____ 3. _____ 4. _____

Return

Days: _____ Weeks: _____ Months: _____

LACTATION CONSULTANT _____ TIME SPENT _____

SIGNATURE

Form 2008-G Revised 10'08

Source: Reproduced from Oklahoma University Department of Obstetrics and Gynecology.

Insurance and Third-Party Payment

Insurance and third-party payment for lactation services is a complex issue. Third-party payment—insurance or payment by another entity besides the patient—varies according to the state (and country) where the services were given. In the United States, third-party payers can be divided into two general categories: government or public health insurance (Medicare, Medicaid) and managed care organizations (MCOs).

Medicare applies to individuals older than age 65 and is not applicable for breastfeeding except that insurance companies usually follow Medicare rules for payment. Medicaid is a federal program administered by the states, and state regulations apply to mothers and children who qualify on the basis of low income. The regulations in various states may differ in billing rules and regulations. Approximately one-third of U.S. births are paid for under Medicaid. Medicaid reimbursement for health care is further complicated by the fact that some Medicaid recipients are also enrolled in managed care plans. These plans' policies on reimbursement differ from the state and federal rules governing reimbursement when the patient is not enrolled in managed care. Medicaid requires a practitioner to be licensed to be eligible for reimbursement; no U.S. state licensed IBCLCs in 2013.

Insurance policies usually spell out by title who may be reimbursed with third-party payment. Physicians and midlevel providers such as nurse practitioners, certified nurse midwives, and physician assistants are recognized by third-party payers as providers who can receive direct payment for their services.

To receive reimbursement from Medicaid, the lactation consultant must be accepted as a Medicaid

provider by his or her state Medicaid agency to be admitted to the provider panel of an MCO. Generally, providers are accepted on the basis of having a medical or medically related degree, state licensure, and national certification. Lactation consultants can receive direct reimbursement if they are also a licensed care provider (physician, nurse practitioner [NP], or certified nurse–midwife) who has graduated from an accredited educational program, is licensed, and is certified nationally in a specialty.

Physicians or nurse practitioners can apply for a provider number through the state Medicaid agency by filing a provider application. If accepted as a provider, they can bill the state Medicaid agency on an HCFA 1500 form using the patient's name and identifying information, the ICD-10 code, the Current Procedural Terminology (CPT) code, the charge, and the provider's name, number, and location for services. Fees for CPT codes vary according to locations and providers. For example, in many states to receive third-party payment, LC services must be provided in collaboration with a physician. A book by Carolyn Buppert (2008), *Nurse-Practitioner's Business Practice and Legal Guide*, third edition, is an excellent resource for learning about reimbursement. The USLCA also has a section on reimbursement on its website, available at http://uslca.org/resources. In addition, the U.S. Breastfeeding Committee has published a document giving guidance for third-party payers on implementing the lactation care provisions in the Affordable Care Act; this document is available at http://www.usbreastfeeding.org/NewsInfo/NewsRoom/201307ModelPayerPolicy/tabid/345/Default.aspx.

"Incident to" Billing

Lactation services that fall under the category "incident to" can be billed if they are an integral but incidental part of a physician's professional services; however, the physician must personally treat the client on the first visit to the practice and be on site when the service is rendered. Thus, if the IBCLC is a nurse practitioner working in a medical office, he or she can bill for services to the breastfeeding dyad offered "incident to" the physician also seeing the mother and baby, and also being on-site. Medicare requires that the claim form for an "incident to" service be filled out with the physician's name and provider number.

Rejection of Billing

If the company rejects a bill, the HCFA 1500 form is returned with a short explanation about why it is being rejected. Sometimes several letters back and forth are necessary before the bill will be paid. Persistence is the key, as many claims may not be paid on the first submission. Anyone in a medically related practice quickly learns from trial and error how to best file third-party insurance claims to maximize the number of paid claims.

Payers may require documentation to validate that the care was given, the site of the care, and the medical necessity and appropriateness of services provided. Fees for care of breastfeeding women on Medicaid are based on number and type of services provided using the CPT, published in the tenth edition of *International Classification of Diseases* (ICD10) (see Box 1-8).

Major barriers to third-party reimbursement for nonphysician healthcare workers such as lactation consultants have been lack of state licensure for IBCLCs, opposition by other medical professions, and third-party payers that fear expansion of provider eligibility. The 1997 passage of a provision in the budget bill Public Law 105-33 to expand Medicare reimbursement for NPs allows for reimbursement of NP services including lactation services; however, each state has the option of covering NP services. Since the law was passed, these nonphysician providers have continued to encounter difficulties in getting third-party payment.

Physicians in the United States are able to obtain reimbursement by using established ICD-10 medical codes for breastfeeding diagnoses, billing for both mother and baby as indicated, and submitting bills for insurance coverage. This type of reimbursement often falls under the constraints of contracted fees, managed care, and/or HMO contracts. The American Academy of Pediatrics' section on breastfeeding published *Breastfeeding and Lactation: The Pediatrician's Pocket Guide to Coding* in 2006. However, owing to the time-consuming nature of fully evaluating the breastfeeding dyad and observing a feeding, the physician's time will rarely be adequately

Box 1-8 ICD-10 Lactation Diagnosis Codes

Maternal

091.21 Non-purulent mastitis associated with pregnancy
091.22 Non-purulent mastitis associated with puerperium
091.23 Non-purulent mastitis associated with lactation
091.11 Purulent mastitis; mammary abscess during pregnancy
091.12 Mastitis associated with puerperium
091.13 Mastitis associated with lactation
091.03 Infected nipple associated with lactation
092.03 Retracted nipple associated with lactation
092.13 Cracked nipple associated with lactation
092.3 Complete failure of lactation
092.4 Partial failure of lactation
092.5 Suppressed lactation
092.79 Other disorders of lactation
Q83.3 Supernumerary nipple
Q89.9 Breast or nipple deformity/anomaly, congenital
N64.82 Hypoplasia of breast
N64.89 Subinvolution (postlactational or postpuerperium); galactocele
L24.4 Irritant contact dermatitis due to skin contact with drugs (see list of drugs for fifth and sixth digits)

Infant

P92.5 Neonatal difficulty feeding at breast
P74.1 Dehydration of newborn
P37.5 Neonatal candida
M26.06 Microgenia (hypoplasia of chin)
M26.04 Micrognathia (hypoplasia of mandible)
M26.11 Maxillary asymmetry
M26.19 Retrognathia (other specified anomalies of jaw–cranial base relationship)
Q35 Isolated cleft palate (.1 hard palate, .3 soft palate, .5 hard and soft palate, .7 cleft uvula, .9 unspecified cleft palate)
Q36 Isolated cleft lip (.0 bilateral, .1 median, .9 unilateral)
Q37 Cleft palate with either bilateral (even fourth digit)/unilateral (odd fourth digit) cleft lip (.0/.1 cleft hard palate, .2/.3 cleft soft palate, .4/.5 cleft hard and soft palate)
Q 90.9 Down syndrome
Q38.1 Ankyloglossia (tongue-tie)
Q38.2 Macroglossia
R 13.10 Dysphagia (.11 oral phase, .12 oropharyngeal phase, .13 pharyngeal phase;)
P92.6 Failure to thrive in newborn (younger than 28 days)
R62.51 Failure to thrive in child (older than 28 days)
R68.12 Fussy infant (irritable infant)

Source: Reproduced with permission from ICD-10 Lactation Diagnosis Codes. ICD10Data.com.

compensated in full. Creative use of staff is often featured in the physician-led lactation clinic to allow effective time management for the physician.

Coding

Accurate and complete coding for services and supplies is vital to the financial success of a lactation program or service. Several resources related to coding, billing, and reimbursement, specific to skilled lactation care and frequently updated in light of fast-changing regulations in this area, are available from the United States Lactation Consultant Association (USLCA, n.d.)

Private Practice

The need to provide continuity of care in community-based settings has led to a rise in the number of private practitioners offering skilled care. Some physicians have built practices that specialize in breastfeeding medicine; others are making IBCLC care a regular part of their practice. Lactation consultants in private practice may have full- or part-time practices; they may partner with other IBCLCs or align themselves formally or informally with other healthcare practices (such as obstetricians or midwives, childbirth educators, pediatricians, chiropractors, and complementary or holistic practitioners). Some IBCLCs also offer a retail side to the business—perhaps renting breastfeeding equipment or offering classes. IBCLCs may do home visits (handling all clinical contact in the mother's home), have a home-based office, or rent or share office space.

The Business of Doing Business

A private practice is a small business, and there are important legal and business considerations that any IBCLC must take into account before deciding to open a practice. Each IBCLC must choose which business form the practice will take, run the practice, market it, and report income (and pay taxes) for fees earned as part of the practice. The IBCLC's insurance should cover business and professional liability contingencies, and consider the locations where the IBCLC conducts his or her clinical work (Smith, 2003).

Payment and Fees

Most clients pay for their lactation consultation services at the time of service. Practitioners can elect to waive or reduce their fees in light of exigent circumstances of mothers, but the IBCLC's professional responsibilities remain unchanged. Setting fees is an important part of establishing a thriving practice, taking into account what the market will bear for the location of the IBCLC practice as well as the IBCLC's particular level of experience and expertise. The prospective private-practice IBCLC can investigate the fees charged by comparable professionals in his or her community. Other factors to consider in setting fees are the anticipated length of visits, costs and time to travel and park, and providing single-user breastfeeding supplies during the consult. While visits to a physician's office may last only 15 to 20 minutes, a thorough IBCLC consult (involving assessment of the mother, the baby, and a full breastfeeding session) may run 60 to 120 minutes.

Phone consultations may also be considered in establishing IBCLC services. The risk in "answering a few questions" for the mother who calls is that the formalities of establishing a professional relationship are not evident. No consent forms have been signed, no histories have been taken or assessments noted, and no individualized care plan has been created with follow-up built in. This is bad for business, and bad for excellent clinical care. IBCLCs in private practice are most successful when they have ongoing, mutually respectful relationships with other healthcare providers in the community, who refer clients to them.

Private practice is clearly not for every lactation consultant. However, those who choose this practice model enjoy rewards not found in other practice settings. The independence also offers an opportunity to flexibly structure the workday, offering better work–life balance for some LCs. Linda Smith's (2003) book, *The Lactation Consultant in Private Practice: The ABCs of Getting Started,* is a valuable resource for the IBCLC thinking of opening a private practice. Box 1-9 lists some dos and don'ts suggested by IBCLCs in private practice—either when establishing a private practice or when initiating an office-, clinic-, or hospital-based lactation service.

Box 1-9 Dos and Don'ts of Lactation Consulting

DO . . .

- Insist on gaining credibility for the profession by passing the IBLCE examination. Ensure that people know this is the minimum credential for any person practicing as an LC in the community.
- From the very first client, behave with the utmost professionalism.
- Charge what you are worth; do not apologize for your fees.
- Set limits immediately, so that people know the boundaries of your availability.
- Establish your own knowledge and skills boundaries. Do not be afraid to ask for help.
- Develop a network of LCs in the community; they can serve as a sounding board for problems and as back-up when you are not available.
- Avoid repeating problems other LCs have experienced by learning from those with more experience than you have.
- Know what you are doing if you rent or sell equipment. Learn how the equipment works, and who should and should not use it. Be aware that its availability from you may influence what you tell a client to do.
- Use a computer to maintain a database of clients and practice documents and for maintaining your business.
- Learn as much as possible about running a business. It can take years to break even.
- Get a competent business advisor for accounting, marketing, and taxes. Ensure that those advisors understand exactly what you are trying to do.
- Bill the client directly for the service. The client then files a claim to her insurance company. Use standard forms for billing and a letter that the client can use to seek insurance coverage.
- Develop a specialization within the field and make your work visible to others through good care (Brimdyr, 2002).
- Document what you have done and send the original to the primary care provider, whether or not this individual made the initial referral.
- Recognize that this business is a labor of love. Do not expect to get rich.

DON'T . . .

- Don't get heavily involved in phone consultations, paid or unpaid, without having seen the mother and baby. An overall assessment is needed.
- Don't give away your time without reimbursement.
- Don't waste your money on a lot of expensive advertising. Advertise judiciously and be patient.
- Don't use someone else's opinion as a reason for doing something. Experiment; be creative. What works in one practice may not work in another one.
- Don't get too many partners at the beginning. Knowing how each partner works as an individual will not necessarily predict how each works as part of a group. The more partners one has, the greater the number of problems that can arise.
- Never forget that a happy mother and thriving baby are your best advertisements.

Acknowledgments

The authors of this first chapter of the fifth edition of *Breastfeeding and Human Lactation* acknowledge, thank, and laud Jan Riordan. She served as editor on the first four editions of this seminal text in human lactation; she authored the first chapter of each of the four earlier editions of this publication. We all learned from Jan Riordan as we began our careers as International Board Certified Lactation Consultant certificants. We are honored to have been asked to write the introductory chapter to the fifth edition, and to carry on Jan's tradition of educating and mentoring the next generation of skilled lactation consultants.

Summary

The field of lactation, now into its third decade, is an allied healthcare specialty. Most hospitals now offer lactation services, provided by IBCLCs or other licensed caregivers (e.g., nurses) who also have IBCLC certification. Some physicians are also starting breastfeeding specialty private practices. The opportunity to work with families and babies—and to enhance early parenting and maternal/child health—has made professional lactation care a popular, satisfying field. As this is a fairly young field of healthcare, there remains some confusion by families, and administrators who hire healthcare providers, about the range of expertise an IBCLC can bring to bear.

Key Concepts

- A lactation consultant (IBCLC) is a specialist trained to focus on the needs and concerns of the breastfeeding mother–baby pair in hospitals, clinics, private medical practice, health departments, home health agencies, and private practices. IBCLCs usually have educational and clinical backgrounds in the health professions.
- Randomized clinical trials consistently show that interventions by healthcare workers have a positive effect on breastfeeding. Translated to healthcare costs, these studies show that IBCLC services save the healthcare system enormous amounts of money through reduction in illnesses for both baby and mother.
- The number of candidates taking the IBLCE certification examination for lactation consultants has grown steadily since the exam's inception in 1985. Most candidates are from Australia, Canada, South Korea, Japan, and the United States. Periodic recertification is required.
- Opportunities to gain clinical experience working with breastfeeding dyads can be obtained through La Leche League; finding a preceptor arrangement with an experienced IBCLC, nurse, or physician; serving as a WIC peer counselor; and teaching prenatal classes.
- Certification by the IBLCE is the gold standard for working as a lactation consultant.
- Most hospitals have lactation services. These services usually include inpatient consults and may include telephone hotline and post-discharge telephone calls; prenatal classes on breastfeeding; outpatient postpartum consults; and continuing education for staff.
- A hospital with 3000 births per year should have at least five full-time LC positions, which can be split into part-time positions. The usual time per visit with mothers when doing daily rounds is 15 to 20 minutes. The majority of LC work time is spent in direct care of patients.
- A "prime mover" (e.g., a nursing director, administrator, or physician) who has institutional power is needed to develop a lactation program as well as to obtain the wide support of those who have influence in deciding budget allocations.
- The role of the LC is based on an advanced practice model. Roles develop sequentially according to experience, as follows: novice, advanced beginner, competent, proficient, and expert.
- A major responsibility of the LC is documentation through reports and charting. Narrative and problem-oriented charting and

clinical care plans are popular methods to organize and chart clinical care. Computer skills are mandatory.

- Ethics is a set of principles that guide human conduct. Morals are specific behaviors based on beliefs. A situation in which an individual feels compelled to make a choice between two or more actions that he or she can reasonably and morally justify, or when evidence or arguments are inconclusive, is called an ethical dilemma.
- Physicians and midlevel providers such as nurse practitioners, certified nurse–midwives, and physician assistants are recognized by third-party payers as providers who can receive direct payment for their services. In the United States, IBCLCs are increasingly being recognized by third-party payers as providers who can receive direct payment for their services. Physicians and nurse practitioners, clinical nurse specialists, and certified midwives who are also IBCLCs can choose which role to claim reimbursement under for lactation services.

Internet Resources

Academy of Breastfeeding Medicine: A worldwide organization of physicians dedicated to the promotion, protection, and support of breastfeeding and human lactation. Publishes numerous evidence-based clinical protocols related to breastfeeding. www.bfmed.org

International Board of Lactation Consultant Examiners: Provides information on how to qualify to take the certification exam to be awarded the credential of International Board Certified Lactation Consultant. Includes a worldwide registry of IBCLCs. www.iblce.org

International Lactation Consultant Association (ILCA): Educational, conference, and professional development resources including the *Journal of Human Lactation*. www.ilca.org

Canadian Lactation Consultant Association (CLCA): National Canadian affiliate. Provides professional liability insurance and professional development opportunities.

Lactation Consultants of Australia and New Zealand (LCANZ): Multinational affiliate that provides professional development opportunities in Australia and New Zealand.

United States Lactation Consultant Association (USLCA): National U.S. affiliate that provides professional development opportunities, offers professional liability insurance, and publishes the *Clinical Lactation Journal*. www.uslca.org

Lactation Education Accreditation and Approval Review Committee (LEAARC): Reviews and grants formal recognition to education programs in lactation. LEAARC recognition is a formal, nongovernmental, peer-review process of voluntary self-evaluation. Approved/accredited programs can be found on its website. www.leaarc.org

United States Breastfeeding Committee: An independent nonprofit coalition of more than 40 nationally influential professional, educational, and governmental organizations that share a common mission to improve (U.S.) health by working collaboratively to protect, promote, and support breastfeeding. www.usbreastfeeding.org

Hale Publishing: Publishes books on breastfeeding and lactation consulting. www.ibreastfeeding.com

Jones and Bartlett Learning: Publishes books on breastfeeding. http://www.jblearning.com/

La Leche League International: Provides publications, seminars, and answers to breastfeeding questions. www.lalecheleague.org

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