Sustaining Change in Challenging Times

California Needs Innovative Breastfeeding Support Strategies

For decades, California has provided national leadership in the promotion and support of breastfeeding. Local, regional, and statewide efforts have brought needed change to policies and practices, resulting in improvements in perinatal care in the majority of our hospitals. Using data from California's Department of Public Health Newborn Screening Program, policy makers and advocates have seen exclusive breastfeeding rates rise steadily from 2010 to 2016. However, data from 2017 indicate that our progress is slowing. Prompt action and innovative strategies are needed to reinvigorate efforts throughout our large and diverse state so that the lasting benefits of breastfeeding may be available to all California mothers and infants.

A Policy Update on California Breastfeeding and Hospital Performance

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Breastfeeding Keeps Mothers and Infants Healthy

Through breastfeeding, mothers and infants share lifelong health benefits that save lives and dramatically reduce health care costs.[1-6] Breastfeeding infants receive all the nutrients they need as well as other unique components of mothers' milk that promote growth, development, and a strong immune system.[1,3-5] For mothers, breastfeeding supports rapid recovery from childbirth and reduces the risk for some cancers and chronic diseases.[1-6] These benefits are greatest among mothers and infants who breastfeed exclusively, both during the hospital stay and for the first 6 months after birth.[2,3] Recognizing these benefits, the Healthy People 2020 (HP2020) objectives indicate that in-hospital supplementation for breastfed infants should be limited to 14.2%.[2]

Breastfeeding is a natural process, but most mothers need skilled support and encouragement during the hospital stay to gain confidence and overcome common early challenges.[1,7] Therefore, hospital policies and practices, such as those outlined in the WHO 10 Steps to Successful Breastfeeding, strongly influence mothers' abilities to meet their breastfeeding goals.[1,3,7,8] Researchers have shown that mothers who experience more of these practices during the hospital stay are more likely to breastfeed exclusively for a longer period than those who do not.[1]

In California,

$757,781,913

could be saved with...

95% initiation

85% in-hospital exclusivity

75% exclusivity to 6 months

75% breastfeeding until 12 months

Calculated with the Breastfeeding Saves Lives Calculator, using 2014 baseline rates. More information about calculations are available at www.usbreastfeeding.org/saving-calc (Accessed January 16, 2019) and in published report.[9]

Statewide Progress Has Slowed

Statewide efforts for systems change have improved the quality of maternity care in many California hospitals and substantially increased the number of Baby-Friendly hospitals throughout the state.[10] Recognizing the importance of high quality maternity policies, California legislators enacted a law (SB-402, De Leon) requiring that all maternity hospitals adopt Baby-Friendly or similar policies by 2025.[11] As a result of these collaborative efforts, exclusive breastfeeding rates in California hospitals have increased from 56.6% in 2010 to 69.6% in 2017.[12] Rates increased among all regional, racial, and income groups. Unfortunately, the most recent year-over-year change (2016-2017) indicates that, overall, this progress has slowed.[12]

Given that this slowdown can be an early indicator of declining resources or weakening efforts, it is important to identify specific causes of the most recent outcomes and to provide targeted support to facilities when and where necessary.[13-14] Early intervention may provide the boost needed to address barriers, reinvigorate staff, and to continue the progress towards providing optimal care for all mothers and infants in California.

Progress is Slowing in Every Region

Signs of a slowdown are evident in nearly every region of the state.[12] From 2010 to 2011, in-hospital exclusive breastfeeding rates increased in more than 27 California counties. Rates remained the same in 19 counties and declined in only 4. From 2016 to 2017, increases were seen in only 10 counties; rates remained stagnant in 29 counties and declined in 10.[12] While the statewide rate of exclusive breastfeeding has increased 13% since 2010, 92% of that increase occurred between 2010 and 2015. Increases between 2010 and 2015 averaged 2.4% per year. Since 2015, increases have averaged 0.5% per year. Reducing supplementation to 14.2% of breastfed infants to meet the HP2020 objective statewide[2] requires that we continue our progress. More than 30 California hospitals have exclusive breastfeeding rates that demonstrate this objective is within reach (TABLE 1). However, with more than 240 hospitals yet to achieve this level of exclusivity, California is far from the limit of what is possible.

Table 1: California Hospitals With In-Hospital Exclusive Breastfeeding Rates at or above 85% in 2017

County	Hospital
ALAMEDA	ALTA BATES SUMMIT MEDICAL CENTER
ALAMEDA	KAISER OAKLAND
AMADOR	SUTTER AMADOR HOSPITAL
CONTRA COSTA	KAISER WALNUT CREEK
EL DORADO	MARSHALL MEDICAL CENTER
INYO	NORTHERN INYO HOSPITAL
LOS ANGELES	PROVIDENCE ST. JOHN'S HEALTH CENTER
MARIN	MARIN GENERAL HOSPITAL
MONO	MAMMOTH HOSPITAL
MONTEREY	COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA
NAPA	QUEEN OF THE VALLEY MEDICAL CENTER
NEVADA	SIERRA NEVADA MEMORIAL HOSPITAL
ORANGE	KAISER IRVINE
SACRAMENTO	MERCY HOSPITAL OF FOLSOM
SAN DIEGO	POMERADO HOSPITAL
SAN DIEGO	SCRIPPS MEMORIAL ENCINITAS
SAN DIEGO	SCRIPPS MEMORIAL LA JOLLA
SAN FRANCISCO	KAISER SAN FRANCISCO
SAN FRANCISCO	SAN FRANCISCO GENERAL
SAN FRANCISCO	UC SAN FRANCISCO
SAN LUIS OBISPO	FRENCH HOSPITAL
SAN LUIS OBISPO	SIERRA VISTA REGIONAL MEDICAL CENTER
SAN MATEO	MILLS-PENINSULA
SAN MATEO	SEQUOIA HOSPITAL
SANTA CLARA	EL CAMINO HOSPITAL LOS GATOS
SANTA CLARA	EL CAMINO HOSPITAL MOUNTAIN VIEW
SANTA CLARA	SAINT LOUISE REGIONAL HOSPITAL
SANTA CRUZ	DIGNITY HEALTH DOMINICAN HOSPITAL
SANTA CRUZ	SUTTER MATERNITY AND SURGERY HOSPITAL
SONOMA	KAISER SANTA ROSA
SOMOMA	PETALUMA VALLEY HOSPITAL
VENTURA	SANTA PAULA HOSPITAL
YOLO	WOODLAND MEMORIAL HOSPITAL

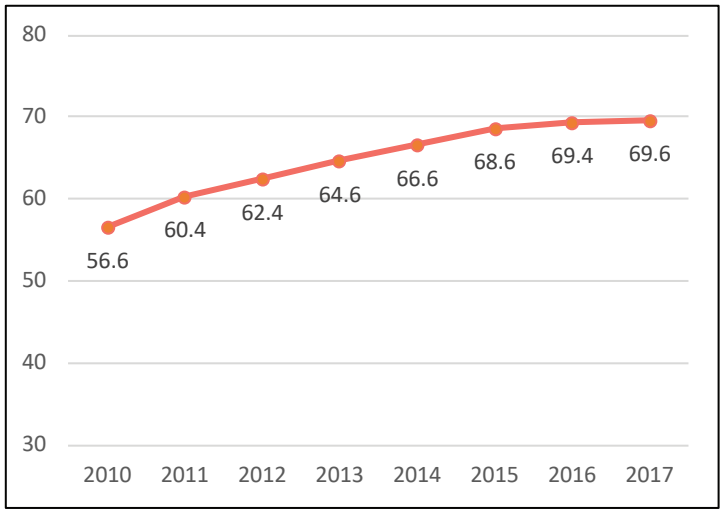
Source: California Department of Public Health Genetic Disease Screening Program, Newborn Screening Data, 2017.[12]

Sustaining Change is Not Easy

Quality improvement processes have been used in many areas of medical practice, including breastfeeding promotion and support.[15-18] As more California hospitals have adopted optimal policies and practices, exclusive breastfeeding rates among women of all races and ethnicities have increased. Despite these improvements, disparities persist.[12] As we move closer to the requirement that all California hospitals use evidence-based policies and practices, we must ensure that staff are trained and support is provided to meet the needs of all California women. This is especially important in communities where any breastfeeding may not be a norm[19-21] or where exclusive breastfeeding is rare.[22-24] In these populations, peer support and culturally sensitive counseling are needed in addition to policy reform to address specific community needs and concerns.[21,25,26]

If the recent data are truly indicative of a slowdown in our progress, action is needed now to regain our momentum (Figure 1). Researchers have found that changes in policy and practice are difficult to sustain in many health care sectors, even when initial projects result in significant changes to clinical outcomes.[13,27,28] Common barriers to sustaining these efforts include lack of ongoing leadership, reduction or reallocation of resources, reduced interest, and change fatigue.[14,23]

Figure 1: Exclusive Breastfeeding Rates in California Hospitals, 2010 to 2017[11]



Source: California Department of Public Health Genetic Disease Screening Program, Newborn Screening Data, 2010-2017.

Many California hospitals have demonstrated that the HP2020 objective of 14.2% supplementation is attainable.

Fortunately, research is available to help advocates, decision-makers, health care providers, and staff to reinvigorate and sustain beneficial clinical improvements. Key strategies include development of leadership skills related to change initiatives, identification and retention of clinical champions, allocation of adequate resources (time, funding, etc.) for ongoing training, and recurrent promotion activities.[13,15,27,28] In a multicenter quality improvement project focused on increasing breast milk feeding among very low birth weight infants, sustained progress was linked to multidisciplinary-team involvement and training, staff buy-in, planned integration of change into daily processes, and ongoing data-related feedback.[28]

In California, hundreds of individuals have worked collectively for more than a decade to improve policies and practices in our hospitals. The consistent increases in breastfeeding rates over the last 8 years have confirmed the value of their work. Given the size and scope of the overall progress, the current slowdown may seem inconsequential. However, early and careful evaluation of the root causes of the slowdown must be a priority. It is far more difficult to move forward in any collaborative endeavor when progress has halted and energy and momentum are lost.

Advocates and policymakers also must be cautious not to allow the slowdown to be used as evidence to support a view that California hospitals have reached a limit for change. There are many California hospitals that have demonstrated that the HP2020 objective of 14.2% of breastfed infants receiving supplements is attainable. Reaching that objective statewide will benefit millions of California mothers and infants and potentially result in the savings of hundreds of millions of dollars in health care costs.[4,5]

Barriers to Sustained Progress

Given the variation in size, circumstances, and management of California hospitals, it is likely that there are many reasons for the statewide slowdown in rates. Decision-makers and staff in each facility should investigate their unique barriers before taking action.[13,14] For example, some hospitals are still facing roadblocks to becoming Baby-Friendly or implementing other evidence-based policies. Other facilities may be Baby-Friendly, but rates have stagnated as resources used to achieve designation have been shifted to other initiatives.[13,15,27] Without sufficient resources to maintain training, communications, and skilled support, further rate increases are unlikely to occur.[15] Other hospitals may find their rates have stalled despite policy reforms and new approaches are needed to move forward.

Although exclusive breastfeeding rates in California have increased among women of all races and ethnicities, disparities remain. Rates are consistently lower among African American, Asian, Pacific Islander, and Latina women.[12] Barriers for these groups often extend beyond the hospital setting. For example, studies show that African American and Hispanic women often lack support from friends, family, and employers for exclusive breastfeeding. In addition, a high value is placed on infant independence in many African American families. resulting in different perspectives on some of the 10 Steps, including rooming in.[19,21,25] Due to a lack of targeted research, little is known about specific barriers faced by families who are identified as Asian and Pacific Islander.[21] To be successful, change initiatives to improve rates must address the specific needs and barriers faced by women of color both during and after the hospital stay.

Quality improvement projects to increase breastfeeding rates are not likely to be the only change initiatives in California hospitals. Today's medical environments are constantly transforming as advances in technology, safety, and efficiency have been introduced in combination with new staffing structures intended to reduce costs. As staff cope with continual, and sometimes competing, quality improvement cycles, change fatigue may occur.[29-31] Change fatigue is characterized as overwhelming feelings of stress and fatigue, emotional exhaustion, and burnout associated with rapid and continuous change in the workplace.[31] As changes are made to daily workflow, staff inevitably lose proficiency. Loss of proficiency increases perceived workload and places greater strain on staff time and energy. Without periods of stability between cycles, staff may become uncertain, disengaged, apathetic, ambivalent, and disempowered.[30] Change fatigue is costly, as it may lead to increases in staff stress-related disorders and absenteeism.[29-31] Change fatigue may directly and indirectly impede campaigns to improve breastfeeding support.

Change Fatigue: *overwhelming feelings of stress and fatigue, emotional exhaustion, and burnout associated with rapid and continuous change in the workplace.*

Continued Progress Requires Innovative Approaches

Shifting patient demographics may require innovative methodologies for promotion, education, and support to meet the needs of a new generation of California mothers. To achieve the HP2020 objective statewide, facilities, policy-makers, and communities must work together to serve local needs. Using collaborative, innovative, and thoughtful approaches, decision-makers can continue the significant progress made over the last decade.

Evidence-based strategies are available for every phase of policy reform.[13,14,27-34] For example, hospitals still working to implement evidence-based policies and practices for the first time can find guidance in published accounts of hospitals that have gone through the same process.[15-18] Common strategies used by these facilities include identifying and supporting clinical champions, establishing operational teams that include all relevant departments, allowing flexibility in training methods and delivery, creating engaging support materials, and celebrating important milestones.[15-18]

In California facilities that have acheived designation or adopted model policies, skilled staff and resources needed to maintain change may be diverted to other areas now that the work is considered "complete." However, researchers have found the maintenance of resources is vital to sustaining change.[27-28] Since SB-402 requires that all hospitals adopt supportive policies, administrators may find that returning resources to breastfeeding support now will prevent erosion in rates and streamline compliance efforts.

In California hospitals that have already undergone policy reform, onging improvements are critical to increasing breastfeeding rates statewide. To reinvigorate staff, administrators must first clarify the institutional vision to give staff a better understanding of institutional goals and departmental objectives. Administrators should create brief, strategically-paced, engaging, and meaningful communications that clarify policies, expectations, and milestones.[13,27,28] To sustain change, practice improvements, resources, and monitoring must be integrated into day-to-day operations and institutionalized.[13,27,28]

Policy-makers and advocates must acknowledge the effects of quality improvement on staff workload and pressures. To prevent change fatigue, managers must find the balance between quality improvement and periods of stability, allowing staff time to reorient and adjust.[31,33] Environments with established practices and processes are more likely to have staff who are able to adapt to change.[30,31] Obtaining staff input and utilizing their knowledge of existing processes will create more effective, equitable, and sustainable change initiatives.[35] Managers must consider the pace of change, the degree of change, and the amount and type of support available to staff when developing quality improvement cycles. Well-planned and carefully paced change initiatives are associated with increased staff participation and sense of security.[30] Given that the pace of change in medical environments is not likely to slow in the near future, state-level guidance is needed now for compliance with SB-402 so that administrators can include needed changes in their long-term planning.[30]

To achieve the HP2020 objective, facility staff must reach out and work synergistically with other groups and agencies within their communities.[3,36] Hospitals can play a vital role in ensuring continuity of care and support for all of the mothers they serve. In hospitals serving high proportions of women of color, additional changes in practice may be needed to address breastfeeding disparities after evidence-based policies are in place. Some of the factors associated with these disparities may fall outside of the purview of hospitals, such as mothers' concerns about returning to work.[21] Ongoing collaboration among hospitals, public health agencies, advocates, employers, and health care providers is needed to support mothers throughout the perinatal period. Other barriers, such as perceived lack of support from family and friends or the incompatibility of practices with cultural norms, require additional tools and training for staff to understand and support shared decision-making with the families in their care. One of the most consistently powerful interventions used to increase breastfeeding is the use of peer support.[21,24,26] Because peer support is not always available, all health care providers serving California mothers should be trained in culturally sensitive and appropriate practices.[21]

Action Recommendations

California has long been a national leader in the promotion and support of optimal infant feeding. Advocates and policy makers must work together to develop action plans to combat potential reversals in breastfeeding rates and improve the quality of care in all of the state's maternity hospitals.

- **The California Department of Public Health must provide clear guidance and associated metrics or benchmarks to be used for implementation of SB-402 so that hospital administrators can include compliance efforts in their long-range planning.**
- **Policy makers should consistently collect and use data to monitor progress toward statewide goals for breastfeeding rates.**
- **Policy makers and advocates must work to ensure that resources are returned to quality improvement efforts targeted to reducing breastfeeding disparities.**
- **All efforts must include culturally sensitive approaches needed to support all California mothers to meet their breastfeeding goals.**
- **Facilities should provide staff with training and skills related to change initiatives. Better understanding of change processes will improve the quality and efficiency of these efforts.**

- **Change initiatives should be carried out by broad-based multi-disciplinary teams, including relevant clinical departments, marketing, personnel, training, and technology.**
- **Staff input and buy-in should be included in all phases of planning to improve acceptance and efficiency of implementation.**
- **Leaders and clinical champions in California hospitals must be identified and supported to adopt the innovative partnerships and practices needed to reinvigorate quality improvement processes.**
- **In order to sustain change, administrators must work to integrate successful strategies into facility culture and existing processes.**
- **Administrators should ensure that change initiatives are paced appropriately to minimize the risk of change fatigue among staff members.**
- **Change fatigue must be identified and addressed as early as possible to prevent negative consequences for staff.**
- **Facilities with the lowest exclusive breastfeeding rates should work with the state or regional consortia to identify evidence-based and cost-effective solutions to remaining barriers and challenges.**
- **Facilities should reach out to community agencies to foster partnerships needed to further understand community needs and increase breastfeeding rates.**

References

1. Perez-Escamilla, R., et al. Impact of the Baby-friendly Hospital Initiative on breastfeeding and child health outcomes: a systematic review. Matern Child Nutr, 2016. 12(3): p. 402-17.

2. Centers of Disease Control and Prevention. Breastfeeding Report Card 2018. (https://www.cdc.gov/breastfeeding/data/reportcard.htm).

3. World Health Organization. Guideline: Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services. Geneva; 2017.

4. Bartick, M.C., et al., Disparities in Breastfeeding: Impact on Maternal and Child Health Outcomes and Costs. J Pediatr, 2017. 181: p. 49-55 e6.

5. Bartick, M.C., et al., Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs. Matern Child Nutr, 2017. 13(1).

6. Bartick, M.C., et al., Cost analysis of maternal disease associated with suboptimal breastfeeding. Obstet Gynecol, 2013. 122(1): p. 111-9.

7. Spaeth, A., et al., Baby-Friendly Hospital designation has a sustained impact on continued breastfeeding. Matern Child Nutr, 2018. 14(1).

8. Patterson, J.A., N.S. Keuler, and B.H. Olson, The effect of Baby-friendly status on exclusive breastfeeding in U.S. hospitals. Matern Child Nutr, 2018. 14(3): p. e12589.

9. Stuebe, A.M.,et al., An Online Calculator to Estimate the Impact of Changes in Breastfeeding Rates on Population Health Costs. Breastfeed Med, 2017. 12(10): p.645-658.

10. Baby Friendly USA. Baby-Friendly Facilities by State. 2018. (https://www.babyfriendlyusa.org/).

11. Leon, D., SB 402 (Breastfeeding). 2013.

12. California Department of Public Health, Center for Family Health, Genetic Disease Screening Program, Newborn Screening Data, 2017. (https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx)

13. Bray, P., et al., After the collaborative is over: what sustains quality improvement initiatives in primary care practices? Jt Comm J Qual Patient Saf, 2009. 35(10): p. 502-8.

14. Beer, M. and N. Nohria, Cracking the code of change. Harv Bus Rev, 2000. 78(3): p. 133-41, 216.

15. Krauss, M.J. and M. Sharp, Baby-Friendly as a Regional Collaborative Quality Improvement Project in an Academic Medical Center Environment. J Perinat Neonatal Nurs, 2018. 32(2): p. 136-143.

16. Ward, L.P., et al., Improving Exclusive Breastfeeding in an Urban Academic Hospital. Pediatrics, 2017. 139(2).

17. Feldman-Winter, L., et al., Best Fed Beginnings: A Nationwide Quality Improvement Initiative to Increase Breastfeeding. Pediatrics, 2017. 140(1).

18. Kahin, S.A., et al., Key Program Findings and Insights From the Baby-Friendly Hawaii Project. J Hum Lact, 2017. 33(2): p. 409-414.

19. Kim, J.H., B.H. Fiese, and S.M. Donovan, Breastfeeding is Natural but Not the Cultural Norm: A Mixed-Methods Study of First-Time Breastfeeding, African American Mothers Participating in WIC. J Nutr Educ Behav, 2017. 49(7S2): p. S151-S161 e1.

20. Munn, A.C., et al., Factors Influencing Southeastern U.S. Mothers' Participation in Baby-Friendly Practices: A Mixed-Methods Study. J Hum Lact, 2018. 34(4): p. 821-834.

21. Louis-Jacques, A., et al., Racial and ethnic disparities in U.S. breastfeeding and implications for maternal and child health outcomes. Semin Perinatol, 2017. 41(5): p. 299-307.

22. Rhodes, K.L., et al., American Indian breastfeeding attitudes and practices in Minnesota. Matern Child Health J, 2008. 12 Suppl 1: p. 46-54.

23. Wright, A.L., et al., Using cultural knowledge in health promotion: breastfeeding among the Navajo. Health Educ Behav, 1997. 24(5): p. 625-39.

24. Wouk, K., et al., Clinical Interventions to Promote Breastfeeding by Latinas: A Meta-analysis. Pediatrics, 2016. 137(1).

25. Miller, E.M., et al., One Step for a Hospital, Ten Steps for Women: African American Women's Experiences in a Newly Accredited Baby-Friendly Hospital. J Hum Lact, 2018. 34(1): p. 184-191.

26. Newton, K.N., et al., Factors associated with exclusive breastfeeding among Latina women giving birth at an inner-city baby-friendly hospital. J Hum Lact, 2009. 25(1): p. 28-33.

27. Weaver, L., et al., Making quality improvement stick and stay: Two lines of insurance. Healthc Manage Forum, 2016. 29(1): p. 28-32.

28. Stone, S., et al., Perceived Factors Associated with Sustained Improvement Following Participation in a Multicenter Quality Improvement Collaborative. Jt Comm J Qual Patient Saf, 2016. 42(7): p. 309-15.

29. Camilleri, J., V. Cope, and M. Murray, Change Fatigue: The frontline nursing experience of large-scale organisational change and the influence of teamwork. J Nurs Manag, 2018.

30. Ead, H., Change Fatigue in Health Care Professionals--An Issue of Workload or Human Factors Engineering? J Perianesth Nurs, 2015. 30(6): p. 504-515.

31. McMillan, K. and A. Perron, Nurses amidst change: the concept of change fatigue offers an alternative perspective on organizational change. Policy Polit Nurs Pract, 2013. 14(1): p. 26-32.

32. Aldrich, H., et al., Identification and assessment of childhood obesity by school-based health center providers. J Pediatr Health Care, 2014. 28(6): p. 526-33.

33. Brown, R., H. Wey, and K. Foland, The Relationship Among Change Fatigue, Resilience, and Job Satisfaction of Hospital Staff Nurses. J Nurs Scholarsh, 2018. 50(3): p. 306-313.

34. Vestal, K., Change Fatigue: A Constant Leadership Challenge. Nurse Leader, 2013. 7: p. 10-11.

35. Burkoski, V. and J. Yoon, Continuous quality improvement: a shared governance model that maximizes agent-specific knowledge. Nurs Leadersh (Tor Ont), 2013. 26 Spec No 2013: p. 7-16.

36. Sinha, B., et al., Interventions to improve breastfeeding outcomes: a systematic review and meta-analysis. Acta Paediatr, 2015. 104(467): p. 114-34.

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