

Breastfeeding as the Norm

The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for six months and continuation of breastfeeding for at least one year and for as long as mutually desired by mother and child. Breast milk is the most ideal source of nutrients essential for the optimal growth and development of the newborn. Breastfeeding reduces the risk of childhood infections, obesity, leukemia, diabetes, celiac disease, allergic disease, and necrotizing enterocolitis. It also promotes maternal cardiovascular health, emotional bonding, rapid uterine involution, and reduces the risk of maternal type II diabetes mellitus and ovarian cancer. A cumulative breastfeeding duration longer than one year potentially reduces the mother's risk of breast and ovarian cancer by up to 28 percent. The benefits garnered from breastfeeding are dose dependent, with exclusivity and longer duration of breastfeeding providing the most benefits to both the mother and child.¹ Breastfeeding initiation rates have increased over the years. However, breastfeeding retention rates remain low with the figures still lagging behind the Healthy People 2020 goals.² The most recent

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A Breastfeeding Action Call for Health Care Professionals

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breastfeeding report card shows that while eight out of 10 infants start out breastfeeding, only five out of 10 were still breastfeeding at six months with less than one third breastfeeding at 12 months.^{3,4}

BREASTFEEDING REPORT CARD			
Time breastfeeding	80%	50%	<33%
In first month	✓		
6 months		✓	
12 months			✓

The Health Care Professional's Role in Breastfeeding

Mothers often start out breastfeeding with the best intentions, sometimes unaware of the potential hurdles that can accompany breastfeeding. If a mother with the best intentions does not continue to get the necessary support during the crucial first few weeks postpartum, she may end up giving up on breastfeeding.^{3,5} Health care professionals serve a pivotal role in breastfeeding support as the primary and ongoing contacts for parents. The mother-infant dyad will have a minimum of 12 contacts with health care professionals during the child's journey from the newborn period to a primary care office in the first year of life. All of these visits serve as critical opportunities for physicians to support parental breastfeeding goals.⁵ While parents trust their physicians for the best advice for their newborn,⁶ they often report not receiving adequate breastfeeding support from their physicians. Moreover, the surgeon general has released a call to action for all health care professionals who care for women and children to receive breastfeeding education.⁷

Recent research of pediatricians' breastfeeding attitudes by the AAP shows that pediatricians are becoming less confident in their ability to successfully support mothers in achieving their optimal breastfeeding goals.⁸ In addition to sociocultural influences, the most common barriers to breastfeeding retention are perception of low milk supply, early addition of supplemental formula feeds, and inadequate breastfeeding support postpartum.^{9,10} It is therefore not surprising that the U.S. Preventive Services Task Force (USPSTF) recommends a spectrum of interventions from pregnancy to the

postpartum period to promote and support the breastfeeding mother.⁵ Pediatricians have a major role to play in supporting exclusive breastfeeding and mitigating barriers to breastfeeding retention. An understanding of the barriers to breastfeeding and the physiology of lactation will help physicians understand where lactation problems can arise. Moreover, pediatricians will be better equipped to support parental breastfeeding goals and evaluate breastfed babies so as to limit the recommendation of supplementation to only those who need it.^{11,12}

Physiology of Lactation and Troubleshooting Problems in the Early Postpartum Period

The first two stages of milk production are hormonally driven and will occur in all mothers regardless of breastfeeding initiation as long as hormonal levels are normal. The first stage of lactogenesis starts with colostrum synthesis around 15 to 20 weeks of pregnancy. The second stage, triggered by birth and the removal of placental tissue, starts around 30 to 40 hours after delivery. Mothers often perceive fullness of their breasts after the second stage of lactogenesis, between days two and three post-childbirth. The second stage can be delayed by cesarean section, obesity, stressful vaginal delivery, and maternal medication use. The third stage of milk production, however, is under autocrine control and depends on continued effective milk removal.¹¹ Problems can arise at this stage if breast milk is not removed completely from the breast as production and volume are directly related to demand. Mothers should be encouraged to put the baby directly to the breast frequently and early in the first hours of life to stimulate an increased production of prolactin receptors, which in turn stimulates more milk production.

Lactation Failure

Primary lactation failure only occurs in a few women with hypoplastic breast tissue leading to primary failure of milk production. These women have insufficient glandular tissue for adequate breast milk production and often have far spaced out nipples. In this situation, mother's supply should be optimized to limit supplementation needs. Mothers more commonly experience **secondary lactation failure** because of unaddressed problems in the early postpartum period that lead to inadequate breast stimulation and milk



removal. Supplementation is known to be a major factor contributing to secondary lactation failure and early weaning.^{2, 10, 13} It reduces the intensity and duration of infant sucking at the breast which in turn reduces maternal supply. Similarly, **nipple pain and anxiety about low milk supply** can inhibit oxytocin release, which is needed for initiation of the letdown reflex, and inhibits breast milk removal. Physicians can learn the skills to assess the child for improper positioning and shallow latch, which may contribute to nipple pain and suboptimal milk transfer. A pre- and post-weight check after breastfeeding in clinic can objectively evaluate adequate milk transfer. On the other hand, some mothers have a **fast letdown reflex** causing babies to latch and quickly unlatch appearing to be choking after feeds. This can be addressed with upright breastfeeding position with the baby's head above the mother's breast or a laid down breastfeeding position. Manually expressing or pumping a little milk just before feeding can help the child tolerate breastfeeding better since the flow of the milk letdown is reduced. When a mother experiences a **low milk supply**, the rule is to evaluate the cause of the low supply, feed the baby, and preserve the maternal supply by encouraging frequent expression of breast milk.

Ineffective Milk Transfer

Infants may have difficulty with effective breastfeeding due to **improper positioning and a shallow latch, lethargy, or excessive sleepiness**, which reduces effective suckling at the breast. Babies who have been introduced early to a bottle-feed may have difficulty maintaining a latch and may need a nipple shield to return to feeding at the breast. Maternal use of a nipple shield, however, provides less stimulation at the breast and will reduce effective milk removal. This may lead to breast engorgement and mastitis if engorgement is not properly cared for. Mothers with engorgement should be encouraged to massage the breast and apply moist warmth for a few minutes just before breastfeeding or expressing milk, with 15 to 20 minutes application of cool compresses off and on after feeds and in between feeds.¹⁵ The feedback inhibitor of lactation is a protein that accumulates in the breast tissue when milk is incompletely removed; it operates via a feedback loop that sends a negative feedback to the brain to reduce the amount of milk produced with higher concentrations.^{10-12, 14} Moreover, if a newborn has problems with feeding effectively at the breast or fully emptying the breasts, the mother should be encouraged to express breast milk manually or by hands-on pumping at least eight times per day. Mothers can pump every two to three hours during the daytime and preferably go no longer than five hours between breastfeeds at night to empty the breasts and optimize milk production and supply.^{10, 13}

Approach to Supplementation

There are only a few contraindications to breastfeeding including maternal HIV and infant metabolic problems like galactosemia. Mothers with active tuberculosis need to wait for two weeks after treatment before directly breastfeeding, but they can give expressed breast milk. Similarly, mothers with active herpes can pump and discard the milk from the affected side until lesions are healed, while mothers with varicella can pump and use the expressed breast milk. Babies with excessive weight loss should be individually evaluated by the physician to determine the medical necessity for supplementation.^{1, 13} If the need for supplementation arises, this is best done with care by choosing a method that minimizes interference with mother's supply, limiting the

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supplemental volume with a plan to return to exclusive breastfeeding as much as possible. Methods for supplementation include use of supplemental nursing system, paced bottle-feeding, syringe feeds, and cup feeds. Choice of method should be determined based on mother's preference and infant's condition. Each method has its advantages and disadvantages. Cup feeding appears to be the method that minimally interferes with feeding at the breast. The use of mother's expressed

breast milk for supplementation where possible reinforces the benefits of breastfeeding.¹³ Breastfeeding retention rates can be improved when health care professionals identify and address early signs of problems with milk production and milk transfer with basic breastfeeding skills. Physicians should utilize the support of an International Board Certified Lactation Consultant (IBCLC) in the clinic when additional lactation support is warranted.

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Breastfeeding Resources

How to support breastfeeding families

<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/Resources-to-Support-Breastfeeding-Families.aspx>

Breastfeeding tips for mothers

<https://kellymom.com/>

Breastfeeding handouts for parents and professionals

<https://www.lactationtraining.com/resources/educational-materials/handouts-parents>

Opportunities to be involved: join American Academy of Pediatrics section on breastfeeding

<https://www.aap.org/en-us/about-the-aap/Sections/Section-on-Breastfeeding/Pages/SOBr.aspx>

Lactmed NIH website to determine compatibility of drugs used in lactation, most drugs are compatible

<https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

Ten Steps to Successful Breastfeeding

<https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps>

Clinical Protocols, Academy of Breastfeeding Medicine.

Breastfeeding protocols, for the care of breastfeeding mothers and infants

<https://www.bfmed.org/protocols>

Ten Steps to Support

1	Make a commitment to the importance of breastfeeding.
2	Train all staff in skills necessary to support breastfeeding.
3	Inform women and families about the benefits and management of breastfeeding.
4	Assess infants during early follow-up visits.
5	Encourage mothers to breastfeed on demand.
6	Show mothers how to breastfeed and how to maintain lactation when they will be away from their babies.
7	Use appropriate anticipatory guidance that supports exclusive breastfeeding until infants are about six months old, and encourage the continuation of breastfeeding as long as mutually desired by the baby and mother.
8	Support breastfeeding by providing accurate information about maternal issues.
9	Communicate support for breastfeeding in the office environment.
10	Expand the network of support for breastfeeding.



Iowa: Recommendations for EPSDT Care for Kids Dental Services

These recommendations are based upon guidelines from the American Academy of Pediatric Dentistry¹ and Iowa's definition of a dental home in [Iowa Administrative Code](#).



Component	Child's Age	
	Birth to 12 months	1 year through 20 years
Clinical oral examination/oral screening	Upon the eruption of the first tooth and no later than 12 months	Every 6 months, or as indicated by child's risk assessment
Caries risk assessment	At every visit	At every visit
Radiographs	For trauma or emergency	Timing, selection, and frequency determined by child's history, clinical findings, and risk assessment
Prophylaxis	NA	Timing, selection, and frequency determined by child's history, clinical findings, and risk assessment
Fluoride varnish	2 – 4 times per year, as indicated by child's risk assessment	2 – 4 times per year, as indicated by child's risk assessment
Pit and fissure sealants	NA	Through age 18, as indicated by risk assessment (primary molars and/or permanent molars/premolars)
Oral hygiene instruction/dietary counseling	At every visit (with parent)	At every visit (with parent and/or child)
Anticipatory guidance/counseling	At every visit (with parent) <ul style="list-style-type: none"> • Injury prevention • Non-nutritive sucking • Speech/language development • Fluoride exposure • Diet/carbohydrate exposure 	At every visit (with parent and/or child) <ul style="list-style-type: none"> • Injury prevention • Non-nutritive sucking • Speech/language development • Fluoride exposure • Diet/ carbohydrate exposure • Substance abuse • Intraoral/perioral piercing
Assessment and treatment of developing malocclusion	NA	As indicated
Assessment and/or removal of third molars	NA	Children over 12 years of age

1. www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf;
www.aapd.org/media/Policies_Guidelines/G_DentalPeriodicitySchedule.pdf

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Cavity Free Iowa

Making a Difference in a Child's Smile

By Katie McBurney, RDH, Oral Health Consultant, Bureau of Oral and Health Delivery Systems, Iowa Department of Public Health

Tooth decay is the most common chronic disease in children, five times more common than asthma. Early Childhood Caries (ECC), commonly referred to as baby bottle tooth decay, is tooth decay that occurs in children under age six. Despite being highly preventable, the American Academy of Pediatrics states that 23 percent of children ages two to five experience dental caries.¹ ECC often requires outpatient surgery to treat the condition effectively. Left untreated, children with active tooth decay may experience mouth pain, difficulty learning and concentrating, impaired eating, and delayed speech development. Cavity Free Iowa is a new initiative in central Iowa focused on the prevention of ECC and health disparities. Recognizing that young children often see their primary care provider on a routine basis for well-child visits, the goal of Cavity Free Iowa is to increase the number of children ages zero to 35 months receiving preventive oral health services in the primary care setting. Dental hygienists, serving as regional I-Smile™ coordinators throughout Iowa, provide onsite oral health training and assist primary clinical staff in developing systems of care to meet EPSDT oral health guidelines. This includes oral screenings, risk assessments, fluoride varnish applications, and referrals to local dental providers. The initiative was launched in central Iowa in 2017. To date, more than 13 clinics have been trained. Statewide expansion is planned for



2018 and any medical provider serving young children is encouraged to participate.

Interested in providing fluoride varnish in your office? Through the patient's MCO, Iowa Medicaid reimburses physicians and nurse practitioners for application of fluoride varnish in conjunction with an EPSDT well-child screening using procedure code 99188. If you are interested in learning more about Cavity Free Iowa, including details on fluoride varnish application and billing, contact your local

I-Smile™ coordinator, available at ismile.idph.iowa.gov or download "Be the Difference in a Child's Smile" at <http://www.iowaepsdt.org/wp-content/uploads/2015/03/Be-the-Difference.pdf>.

Reference

1. American Academy of Pediatrics. 2016. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_OralHealth.pdf

Care for Kids newsletter now available via email

To opt in, go to iowaepsdt.org and subscribe using the electronic sign-up form at the bottom of the webpage. You can also subscribe by contacting Michelle Johnston (michelle-johnston@uiowa.edu). The EPSDT program will continue to send the printed version of *Care for Kids* to providers on the current mailing list.



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If you have questions about **billing** related to EPSDT Care for Kids services, please call Provider Services: **1-800-338-7909**. If you have questions about **clinical issues** and EPSDT Care for Kids services, please call **1-800-383-3826**. Please note: Due to budget restraints, the *EPSDT Care for Kids Newsletter* is sent to offices and organizations, rather than to individuals. **The newsletter is also available online at www.iowaepsdt.org.** Readers are welcome to photocopy or download material from the newsletter to share with others. If you wish to reproduce material from the newsletter in another publication, whether print or electronic, please obtain permission prior to publication by contacting the editor. Please include the following acknowledgment with reprinted material:
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