BRITISH COLUMBIA

BC LCA

LACTATION CONSULTANTS ASSOCIATION

LACTATION SUPPORT IN BRITISH COLUMBIA: PROFESSIONAL BARRIERS

A project of the British Columbia Lactation Consultants Association

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A Comment on Language
This report recognizes language around feeding a baby is often gendered in a way that does not reflect how all individuals identify. Not all people who give birth and feed their baby with the milk they produce identify as female, mothers or as having breasts. This report uses the terms parents, and infant feeding in an attempt to be inclusive of all families. The term breastfeeding is used commonly throughout however our intent is not to exclude those who chestfeed or bodyfeed.

BRITISH COLUMBIA

BC LCA

LACTATION CONSULTANTS ASSOCIATION

TABLE OF CONTENTS

BRITISH COLUMBIA

BC LCA

LACTATION CONSULTANTS ASSOCIATION

LACTATION SUPPORT IN BRITISH COLUMBIA: PROFESSIONAL BARRIERS

INTRODUCTION

Breastfeeding support starts in pregnancy and continues during birth, the postpartum hospital stay, transition home and through to weaning. Challenges can happen at any time along this continuum, and British Columbia does not have a regulated health care professional that can provide consistent lactation care throughout this timeline.

The World Health Organization, United Nations Children's Fund (UNICEF), the Public Health Agency for Canada (PHAC), Health Canada, the Canadian Pediatric Society (CPS), Dieticians of Canada and the BC Ministry of Health all recommend exclusive breastfeeding for 6 months, followed by breastfeeding in addition to healthful family foods up to 2 years and beyond. Families in BC are committed to breastfeeding and meeting these targets. BC has the highest initiation rate in Canada at 93%. Unfortunately, only 42% meet the 6-month exclusive target and few continue breastfeeding to 2 years[1]. Why are breastfeeding rates so low in our province? BC has a lack of skilled breastfeeding support integrated into its healthcare system. Many systemic barriers exist within our province and without care many families end up weaning early, or paying for services privately.

These low breastfeeding rates have significant public health and economic implications. Substantial health benefits for both the lactating patent and baby exist when breastfeeding targets are met. Breastfeeding can reduce rates of SIDS, diabetes, obesity, infectious diseases and breast cancer to name just a few. Many of these illnesses result in significant healthcare costs. Breastfeeding has one of the highest returns on investment for healthcare systems: every dollar invested in breastfeeding yields an estimated $35 in economic gains[2]. The Canadian Public Health Association further cites the following:

DEFINITIONS

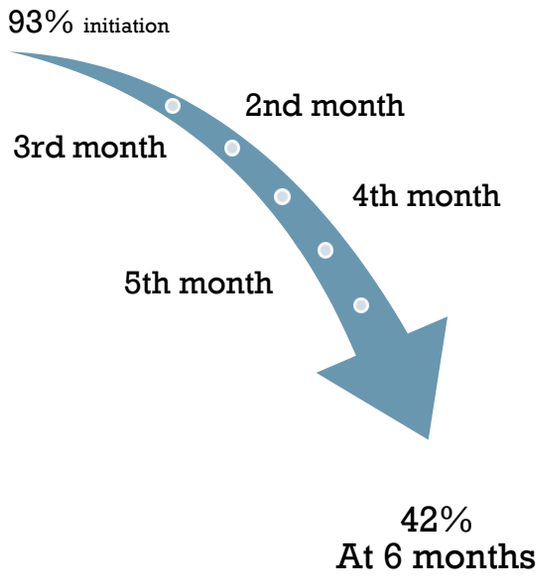
International Board Certified Lactation Consultant (IBCLC)? IBCLC's are healthcare providers with specialized training in the clinical management of infant feeding challenges. The IBCLC credential is recognized around the world as the only standardized, board certified credential in lactation care. IBCLC's are commonly referred to as a "Lactation Consultant" or "LC" and come from a wide range of professional backgrounds.

Baby Friendly Initiative (BFI): The Baby Friendly Initiative is a global programme of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) aiming to protect, promote and support breastfeeding. Hospitals and health centres following the 10-steps to successful breastfeeding and following best practice in infant feeding can be designated as "baby friendly."

[1] Perinatal Services BC. (n.d.). *Surveillance*. Retrieved from perinatalservicesbc.ca/health-professionals/data-surveillance/surveillance

[2] Global Breastfeeding Collective. (2017). *Nurturing the Health and Wealth of Nations: The Investment Case for Breastfeeding.*

- A report[3] from the United Kingdom showed that the economic costs of treating just 3 illnesses (gastroenteritis, lower respiratory tract infections, acute otitis media) associated with not breastfeeding cost £75.5 million (CAD $121.8 million) per year.
- A further study[4] investigated the potential health care cost savings that could be realized by investing in support services for breastfeeding parents. Increasing exclusive breastfeeding rates to 65% at four months could result in potential health care cost savings of £17 million (CAD $27.5 million) annually for those three diseases. This increase in exclusive breastfeeding was also shown to result in net savings of £21 million (CAD $33.9 million) in breast cancer treatment costs over the lifetime of each annual cohort of first-time parents.



Research consistently demonstrates the potential for major cost savings to the health care system through strengthening and investing in services that support breastfeeding. For this reason, breastfeeding support must be seen as a fundamental preventative health and economic strategy.

Despite this potential for economic gains, BC is not investing in skilled lactation care. Healthcare providers struggle to navigate systemic barriers to deliver quality breastfeeding support. A lack of funding and scope limitations are common challenges seen across professions. Creative solutions are being explored, but challenges remain. Rural, remote, northern and Indigenous communities are disproportionately impacted by these struggles. With such substantial gaps in services, how do we support health care providers to deliver consistent care?

The British Columbia Lactation Consultants Association (BCLCA) sought to answer the question:

Why are there so few breastfeeding clinics and dedicated lactation care services in British Columbia?

On Feb 11th, 2022 the BCLCA facilitated a discussion amongst an interdisciplinary group of health care providers and breastfeeding clinics. Recruitment was conducted via email blasts, social media as well as targeted invitations. Participants raised barriers they face in their respective professions as well as challenges and successes in operating breastfeeding clinics. Follow-up discussions took place with professional groups and clinic representatives to get a full understanding of each one's barriers. This report is a summary of these discussions.

[3] Pokhrel S, Quigley MA, Fox-Rushby J, McCormick F, Williams A, Trueman P, et al. Potential economic impacts from improving breastfeeding rates in the UK. *Arch Dis Child* 2015;100:334–40.

[4] Renfrew M, Pokhrel S, Quigley M, et al. Preventing disease and saving resources: The potential contribution of increasing breastfeeding rates in the UK. London, UK: UNICEF, 2012

PROFESSIONS SUPPORTING LACTATION

MIDWIVES (RM)

Midwives are eager to support breastfeeding and the Midwifery Education Program includes a full course on "Lactation and Infant Feeding" – the most comprehensive lactation education of all health care providers. Additionally, midwives have the ability to offer home visits and long appointment times. 20% of the 2022 graduating class is pursuing International Board Certified Lactation Consultant (IBCLC) certification, and ~5% of registered midwives hold the IBCLC credential. In the past year, midwives in BC have opened 4 new breastfeeding clinics.

Midwives are well poised to provide comprehensive breastfeeding care across the province, unfortunately they are limited by a scope and payment model that stops care at 6 weeks postpartum. Many breastfeeding problems start or are not yet resolved at this time, and families then have to pay privately for services. This has limited many midwives from offering lactation support consultations or from opening breastfeeding clinics.

STRENGTHS

- Midwives receive lactation training during their education program equivalent to 1 university course. This is less than an IBCLC but more than any other health care professional.
- Midwives traditionally have long appointment times and offer home visits.
- Since the establishment of the consultative care fee code there is a growing group of midwives getting IBCLC certification and opening breastfeeding clinics or doing IBCLC support alongside their existing practice. An estimated 5% of BC Registered Midwives are IBCLC's or working towards certification. Of the 2022 graduating cohort, 20% of graduates are actively pursuing IBCLC certification.
- Some RM/IBCLCs are doing inpatient consultations for their hospital's postpartum unit or NICU when the hospital does not have their own staff IBCLC. These services are billed to MSP allowing the hospital to have a lactation consultant available. This has proven especially useful for smaller low-volume hospitals and rural communities that do not have funding for an IBCLC position. Midwives feel strongly that such programs in rural communities are helping reduce breastfeeding inequities.

BARRIERS

- The midwifery scope of practice ends at 12 weeks postpartum, and midwives are only able to bill through MSP until 6 weeks postpartum. Thus, care can only be provided antenatally and in the beginning weeks of breastfeeding. Many feeding challenges start at 6 weeks or later due to physiologic maternal/parental changes.
- Scope of practice does not allow for frenotomy, breast ultrasounds, and certain medications and labs used in advanced lactation care.
- Some midwives have been trained in how to perform a frenotomy and train physician colleges, but are not able to perform themselves. Access to frenotomy in many rural communities is limited and may require hours of travel for new families.
- Historically, there has been no funding for leadership or education roles.
- Many IBCLC job postings are for RNs only, and are not accessible to midwives.
- Midwives cannot bill for male parents – this is problematic for female to male transgender folks.
- Some Midwifery offices have hired a non-MSP billing IBCLC to work in their office and pay them an hourly wage out of the office overhead. This option has traditionally been short-lived in most clinics as Midwives struggle to pay high overhead costs. Likewise, IBCLC's who work at RM offices find they are not making enough money.
- Although income would appear "on paper" to be equivalent or greater than standard midwifery care, this is not the reality experienced by providers working in this model. Overhead costs of running a feeding clinic are higher than in standard midwifery

care due to:

- Additional MOA time spent on billing codes and appointment booking.
- Appointment no-shows are more common amongst struggling new parents, and result in a lower income.
- Frequent billing code rejections.
- No access to business support funding or overhead support.

"We end up doing a lot of work for free, I'm not going to lie"

"It's not a super lucrative business, you've gotta do it because you love it"

- Consult fee codes with MSP are often rejected, and complex to navigate.
- RM's report often working for free to provide care to families over 6 weeks postpartum.
- The billing code can only be used for 12 units or equivalent to 4 hours. If another provider has used the consult code to see a family for any reason (not necessarily for breastfeeding support), then they will have less than 12 units available. By the time a parent is receiving postpartum care, all their consultative care units could have been used up. Midwives are often not aware that a consult code has been previously billed for a client and end up not being paid for appointments.

PHYSICIANS (GP)

Few physicians specialize in breastfeeding medicine. There is minimal education in medical school curriculums leaving many physicians unsure how to help breastfeeding families. Providing lactation care is seen as not being a well-compensated field. Furthermore, they are limited by short appointment times of 30mins or less which is often not enough time to observe a full feed, take a history, do an exam and create a care plan. Physicians thus make less money when taking the time to care for lactating families. The Vancouver Breastfeeding Clinic, a physician run clinic, closed its doors this year after 35 years of operation because no physicians wanted to take it over. They saw over 2000 new dyads each year, and the closure has left a huge void.

STRENGTHS

- MD's have an expansive scope of practice allowing for full spectrum care. This includes frenotomy, medications, and imaging as needed, as well as knowledge of complex medical conditions.

BARRIERS

- It is felt not many physicians specialize in infant feeding because there is a general lack of interest, there is minimal education in school, and it is not well compensated.
- The Vancouver Breastfeeding Clinic closed in March 2022 due to no physicians wanting to take it over.
- GP's are limited by shorter appointment times. Families get 30mins or less which is not enough time to watch a full feed. GP's typically see 5 patients in an hour or 12 mins per patient. Seeing both a parent and baby = 24mins.
- Physicians report making less money in breastfeeding medicine clinics vs standard physician care due to the amount of time it takes to see these families.
- There are sometimes issues with getting paid for babies because parents do not have their MSP yet.

"There are a lot of glitches in the system, so there are a lot of times we just don't get paid for babies"

"I make less but I enjoy it"

NURSE PRACTITIONERS (NP)

There is a general lack of interest in breastfeeding support amongst nurse practitioners due to a perceived lack of caring for lactating families. This is because families receive most of their antenatal and postpartum care up to 6 weeks postpartum from other providers. There are currently no NPs working in breastfeeding clinics, however there are a few that have taken a special interest in breastfeeding medicine and incorporate this into their standard practice.

STRENGTHS

- Nurse Practitioners have a scope of practice that is supportive of seeing breastfeeding families throughout their feeding relationship, as well as a scope of practice that allows for diagnosis, and treatment of complex challenges such as frenotomy, specialized medications and imaging.
- NPs have funding for leadership and educational activities, which is important to provide comprehensive lactation care.
- Overhead funding is in place allowing for effective clinic running.
- Appointment times can be longer on an as needed basis without salary decreasing.

BARRIERS

- Some lack of interest in the profession as a whole due to a perceived lack of seeing breastfeeding families. Families receive most of their antenatal care and postpartum care up to 6 weeks postpartum from other providers. NP's do not see breastfeeding families until after 6 weeks postpartum. Many challenges do start around this time, but there is minimal education on this in school.
- There is minimal to no breastfeeding training in school.
- NP's can occasionally do longer appointments, however it is difficult to meet patient volume quotas if doing frequent feeding support with long appointment times. Routine appointment times are 30 minutes.
- Currently there are no NP's working in feeding clinics provincially. Since many communities are also low on primary care providers and NP's help meet this need it is questioned if such a proposal would be approved. A communities need for feeding support would have to outweigh its need for primary care.

REGISTERED NURSES (RN)

Many nurses enjoy supporting breastfeeding families and are not limited by short appointment times. However, a lack of recognition for this additional skill has led to challenges within this profession. Some nurses with a special interest in breastfeeding support are not pursuing education as an IBCLC because it is costly and they have no incentive such as pay increases. Meanwhile they often have to work harder once certified as they are assigned more complex cases. This lack of incentive for training leads to inconsistencies in skill sets and service delivery. Many public health units run a breastfeeding clinic, however the IBCLC credential is not a requirement and so the level of support that families receive is highly variable. Many public health units have tried to remedy this with a dedicated IBCLC position, but few of these proposals have been accepted. Service delivery has been further interrupted with COVID. Nurses have been pulled from providing breastfeeding support to other pandemic duties. There are very few positions available for nurses wanting to work exclusively as a lactation consultant.

STRENGTHS

- Nurses are already providing care to families in the early postpartum period such as on labour and delivery units and through public health maternity care programs.
- Many nurses enjoy supporting breastfeeding families, and are highly skilled.
- Nursing funding models are salaried. This allows for long appointment times, drop-in programs, group classes, leadership duties, education and more creative models of service delivery.

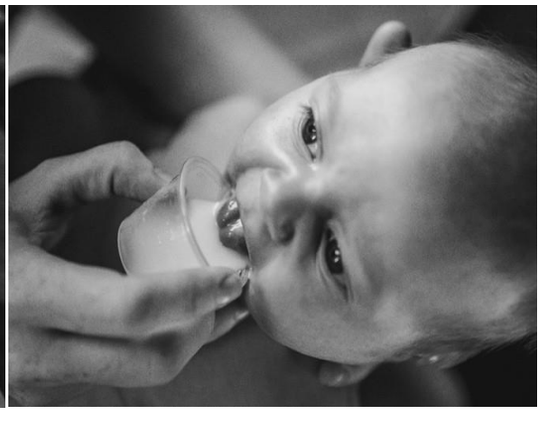
BARRIERS

- Some nurses with interest in learning more about breastfeeding are not pursuing further education as there is no incentive for them. There is no recognition of IBCLC certification as a specialization so no increase in pay, while having to work harder because they will be assigned to families with more complex challenges.
- Nurses providing breastfeeding care without the IBCLC credential have a varying skill set.
- Limited scope – RNs are not able to prescribe, diagnose, order lab work or imaging.
- Those with a passion for feeding support are doing so as a second or separate job.

"I kinda do it off the side of my desk"
"I gave away community support because it was my passion",
"I volunteer, but I can't survive on volunteer"

- Under-education on the importance of breastfeeding in school has led many managers unaware of the importance of supporting breastfeeding initiatives and leadership projects. This means RN's struggle to participate at the BFI, health authority and provincial level. This is a huge gap in stakeholder input and will directly impact the quality of work being done.
- Some RN's had approached RM and physician clinics to work there as an IBCLC with no success. Clinics struggle to fund these models as practitioners have to pay IBCLC salaries out of their own pocket.
- Those that have been successful with working in another providers office have found that "it is not cost effective," and have left the position.
- There is an identified need for more blended acute care/ community positions.
- Smaller communities have limited or no IBCLC positions.
- Nurses wanting to do exclusively lactation work are not able to do so.
    - Since COVID, many nurses that provided breastfeeding support, such as public health nurses have been pulled to other pressing duties.
    - 3 nurses in the group have gone into private practice to be able to provide breastfeeding care, but have to bill families directly as it's not a position funded by their health authority.

"I am also in private practice and struggle with it, simply because I have to charge [families] and it just doesn't sit well."

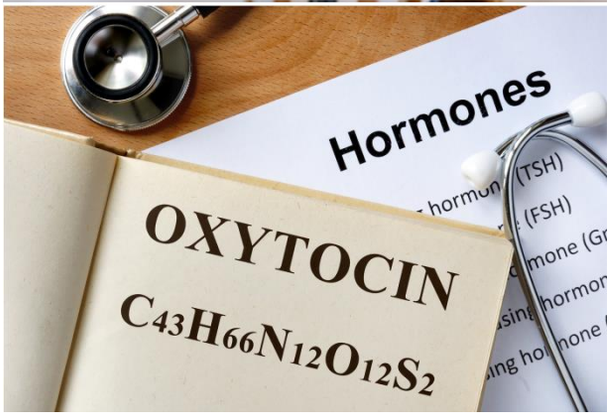


OTHER PROFESSIONAL IBCLCs (OT, Dietitian, SLP, Physiotherapist, RMT, Direct Entry)

This interdisciplinary group includes but is not limited to, occupational therapists, dietitians, speech language pathologists, physiotherapists, and those who hold the IBCLC credential without having another regulated health profession. Many of these providers work privately and bill families directly. Extended health benefits typically do not cover IBCLC support as it is not a recognized health profession and there is no industry code. There is a desire amongst this group to work in inter-disciplinary clinics, however minimal jobs are available due to a lack of funding.

STRENGTHS

- Different backgrounds make this group highly knowledgeable, motivated and with a strong interprofessional skill set.



BARRIERS

- There is a lack of jobs available to IBCLC's who are not RN's or cannot bill to MSP.
- The cost of private IBCLC consultation ranges from $100-300 per consultation depending on the community. This is not affordable for many families.

> *"We try to find a balance between what we feel our time is worth and what is realistic for families to pay because it is out of pocket."*

- Extended health benefits typically do not cover IBCLC support as it is not a recognized health profession and there is no industry code. Some coverage is available if also a physiotherapist, or occupational therapist etc., but many IBCLC's are not one of the covered professions. Typically, only very comprehensive plans or health spending accounts will cover IBCLC services.
- These professionals rely on primary care providers for prescriptions and services not in the IBCLC scope of practice.
- There is a desire to work in inter-disciplinary clinics, however minimal jobs are available due to no funding.
- There is a desire for an industry code for private practice IBCLC's so more families can use extended health benefits.

COMON BARRIERS FACED ACROSS DISCIPLINES

Lack of recognition: The added skills lactation consultants and specialized physicians have are undervalued and not well understood. Many managers, and fellow health care providers do not recognize the difference in training and skill of an International Board Certified Lactation Consultant (IBCLC) vs standard breastfeeding education, or short courses. Overconfidence in the skills of breastfeeding support leaves many families given incorrect, and sometimes dangerous advice. There are many examples of well-meaning but under-educated health care providers across all professions doing more harm than good for breastfeeding families.

Funding: Many providers had looked into sources of creative funding for clinic start-up or private practice with mixed success. Ideas included:

- Band funding for local health programs
- Chronic disease management teams
- Divisions of family practice
- Neighbourhood houses / local non-profits
- Health authorities – community development grants
- Hospital foundations – proof of concept

Reluctant Volunteering: Many providers report working without any form of compensation on a regular basis. This included appointments where MSP bills are not paid, caring for families that cannot afford to private pay, leadership activates, education etc. They continue to provide care because they are passionate about helping families, but are not funded to do so. There was a common theme of "volunteering" across professions.

Access to clinical training: Lactation training is often limited to a small proportion of perinatal placements. This is a small exposure and students are being trained by health care providers who may not have much knowledge in infant feeding themselves. UBC has expressed a desire to fund more placements with lactation consultants, however there are very few breastfeeding clinics in this province able to take on learners. *More opportunities for breastfeeding specific placements are needed for all professions.*

Appointment booking: Due to the urgent nature of breastfeeding challenges families need to be seen quite quickly following referral. Practitioners cannot book clinic ahead and have to keep spaces open for urgent needs. Many days end up being under booked, while other days cannot meet capacity. This is a particular challenge for practitioners who are paid by the hour or bill MSP. *Practitioners felt that salaried positions would allow for more flexible appointment scheduling, group care options, drop-in clinics and other models to accommodate urgent appointments as well as time for leadership and educational roles.*

Need for urgent care provision such as a 24/7 phone line: Care providers expressed a need for access to 24/7 virtual support. One provider tried to establish this through Telus Health, but was not successful. *Provincially, there is a desire amongst professionals to include a Lactation Consultant position at 811 or an alternate phone line. A line that professionals can call for consultation is also needed.*

BC INFANT FEEDING CLINICS

This is not an exhaustive list of breastfeeding clinics or care providers in British Columbia. The clinics included below are those with a larger patient roster or a focus on interprofessional care and innovative models.

Vancouver Breastfeeding Clinic – CLOSED

Closed at the end of March 2022, after 35 years of operation due to the owner retiring and no one wanting to take over.

- A network of breastfeeding medicine physicians providing virtual care across the province as well as in- person supports locally.
- Staffed by physicians with special training in lactation medicine. Some physicians were IBCLC's but not all.
- In 2021 saw over 2000 new dyads and over 4000 follow-up cases

BC Women's Hospital (Vancouver)

MODEL

- Clinic running for at least 20 years.
- RN/IBCLC led.
- Funding through the Health Authority. Positions are only open to RN/IBCLCs.
- Primarily see inpatients 5 days a week.
- They provide mentorship to own RN staff as required for Baby Friendly Initiative designation.
- Also run an outpatient clinic 2 days a week.
- Pre-pandemic was seeing ~9patients a week in outpatient clinic. With COVID, clinic stopped offering services for a time, then did virtual only care. Now offering a blend of virtual and in-person care.
- Hour- long appointments. Pre-booked appointments. No referral required.
- Sees all families with infants under 12 months. Most commonly seeing babies within first 6 months.

BARRIERS

- 1-4 week wait for appointments
- The focus is on the inpatient program with the outpatient clinic being smaller and not able to handle the full volume of inpatient follow-up.
- Desire for there to be more systemic supports available. IBCLC's report feeling like an island. They wish more support was given in hospital prior to discharge, and follow-up from public health or in the community setting. Nurses often don't know what to tell families about breastfeeding support after discharge because there is not much out there.

"More breastfeeding support needs to be a priority."

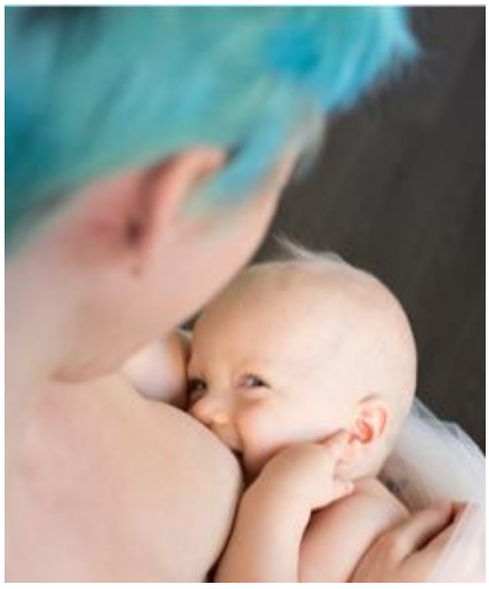
Breastfeeding Solutions (Victoria)

MODEL

- Physician-led Infant feeding clinic located in 2 Neighborhood houses in Victoria, BC. Pre- COVID had group care model. Currently uses multiple rooms at a time and GP +2 lactation counselors rotate through the rooms.
- Lactation counselors (not IBCLC's) spend the most time with families and provide latching support, while the GP rotates through the rooms to evaluate babies medically and provide needed treatments and diagnoses.
- Focus is on supporting young or marginalized families through the Neighborhood house. "We take all-comers."
- Runs 2 days a week.
- Option of virtual or in person visits.
- Bills regular GP codes plus physician extender funding to pay for lactation counselors. This was a program through Divisions of Family Practice that provided additional funding to work with non-physicians.

BARRIERS

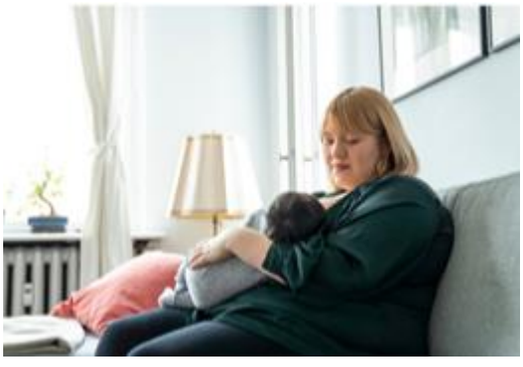
- GP makes less money than in regular practice and lactation counselors make healthy authority rate for non- credentialed professionals (~33/hr).
- The physician extender funding program has been discontinued.



Richmond Breastfeeding Centre (Richmond)

MODEL

- Midwife-run breastfeeding clinic in Richmond.
- A "rapid access" clinic with 2 locations.



BARRIERS

- A proposal to be housed at the Richmond hospital was turned down due to space limitations
- The clinic is made up of 2 RM/IBCLCs working together. There is a desire to include GP's to work around scope limitations, however there has been no interest to date.
- MSP covers services only until 6 weeks postpartum. Private pay options are available beyond 6 weeks. A large number of people are willing to do private pay.
- Struggle to keep on top of number of referrals.

St Paul's Hospital (Vancouver)

MODEL

- Physician-run clinic. Opened in June 2021 with 1 day per week, increased to 2 days in Feb 2022.
- Hospital working towards BFI designation and was welcoming of creating a breastfeeding clinic.
- 1 physician seeing 12-14 families daily. 30min appointments. Families are followed for an average of 2-3 appointments.
- Average age is 2 weeks but sees families from 1 day old to 6 months.
- Located on L+D unit. They have 2 "extra" L+D rooms that were not being used as patient rooms.
- Unit clerk for L+D does bookings and checks patients in.
- Compensation through MSP with a referral. Consult fees are used for patients that are not part of family practice. No overhead payments as in hospital which makes the clinic far more sustainable as not loosing money with additional expenses. Makes a similar amount of money as in regular family practice because of no overhead.

BARRIERS

- There is 1 part-time IBCLC on the unit who is also a L+D nurse. Idea was to have collaboration with IBCLC, but in practice this has been challenging. The IBCLC is not always there on the same days, is busy seeing families on the floor, and is often pulled to other labour and delivery duties.
- The room is used by other providers (telehealth, overflow staff room) on other days so have to pack up stuff at the end of each day. Not a cozy, inviting environment and no wait room for patients.
- It previously took an average of 1 week to get an appointment, but now with Vancouver clinic closure are seeing 3 week waits as cannot keep up with demand.
- Challenges reported: navigating the hospital systems, sharing a physical space, not enough rooms to be in family practice area, no wait room, no room for group care, difficult to collaborate with IBCLC as busy on floor and pulled to other duties.
- Vision: A new hospital is being built and the hope is to move the breastfeeding clinic into the outpatient space with the family practice maternity clinic where there can be more interprofessional collaboration. Offering more comprehensive postpartum care, including group support and drop-ins in a multidisciplinary clinic.

The Milk Clinic (Penticton)

MODEL

- Midwife-led, interdisciplinary infant feeding clinic staffed by 1 RM/IBCLC and 1 GP who is actively pursuing IBCLC certification.
- Provides continuous care from antenatal preparation, inpatient rounds, and postpartum support.
- RM and GP bill to MSP for consultative care. Both pay 25% overhead for running of clinic.
- Hospital has no IBCLC on staff so IBCLCs from The Milk Clinic do inpatient rounds 4-6 mornings a week.
- RM and GP complement each other's scopes and limitations – RM has long appointments and can do lots of latching support, but limited in scope and can only see families to 6 weeks. GP can see older infants and provide prescriptions, imaging and frenotomy that RM cannot.

BARRIERS

- Attempted to house clinic in hospital (2 proposals submitted) with shared-care maternity group and in partnership with public health RN/IBCLCs, however proposal rejected, as hospital did not want to "medicalize" breastfeeding.
- 1-3 week wait for appointments.
- Partnership with public health nurses:
  - Original plan for clinic to be in partnership between RM/IBCLC and Public Health Maternity Care IBCLC's
  - Due to hospital site rejection, and PHN's being pulled to COVID duties, clinic started in a community site with a solo RM/IBCLC.
  - PHN's support the clinic by taking overflow referrals and families over 6 weeks of age that need longer appointment times for latching support. Public Health is trying to prioritize their 2 staff members with IBCLC credential to see these families, however are not always able to do so. Service delivery is inconsistent.
  - It has also proven confusing to the public to be seen by different providers at different locations.
  - Public health nurses are not able to see families at The Milk Clinic office as they have a different funding model that would not contribute to the overhead costs of running an additional 1-2 days a week of clinic.
- When RM/GP on maternity leave or holidays there are very few locums available with specialized training, and the community is left with reduced supports, such as funded care only until 6 weeks postpartum.
- A smaller community means there is a lower volume of patients and clinic volume fluctuates widely based on recent births. This translates to lower pay.
- GP billings are 2.5 times more than RM billings. There is significant pay inequity between the professions for equal work.
- Unable to pay RN or other IBCLC hourly wage out of overhead as RM fee codes do not provide significant funding.

Tri-Cities Infant Feeding Clinic (Port Moody)

MODEL

- A midwife-led, interdisciplinary infant feeding clinic in Port Moody, BC.
- Group of 3 RM/IBCLC, 3 RN/IBCLC, and 2-GPs who are not IBCLCs but are breastfeeding medicine specialists who worked at the Vancouver Breastfeeding Clinic.
- Blend of virtual and in-person visits. Home visits not available.
- Babies older than 6 weeks postpartum are booked with GPs to work around limitations to RM scope.
- RM's and GP's bill MSP through consult codes, and pay overhead to the clinic. RN and RM's are paid an hourly wage to work at clinic out of overhead fund. GP pays 25% overhead and keeps 75% of billings.
- From April 2021 to Jan 2022 saw >300 dyads.

BARRIERS

- Initially, 80% of RM consult bills were rejected, this has improved now, but many still do get rejected.
- Challenging to accommodate urgent referrals – if gaps left in day practitioners who bill MSP will not make enough money to want to stay on, and business will lose money if paying providers by the hour. Some days end up overfull and appointment times are shorter to accommodate.
- Overhead costs are higher than a typical midwifery practice. Practitioners are being paid a lower hourly wage than if working independently due to high overhead. Some RM's working at Tri-cities also have their own private infant feeding practice because of this.
- Concern that with the closure of the Vancouver Breastfeeding Clinic, will not be able to keep up with demand.

RECOMMENDATIONS

Participants had a number of suggestions to be implemented at the provincial and health authority level that would allow for health care providers to better support breastfeeding families. Below are the suggestions that were brought forward.

Standardize Health Care Provider Education:

- Develop and implement educational competencies for all healthcare providers and promote the Baby Friendly Initiative. This will create a standard for breastfeeding knowledge amongst health care providers in BC, reducing incorrect and dangerous advice from well-meaning but under-educated and over-confident health care providers.
- Create a University Education Program for lactation training
    - Advance Douglas college and BCIT programs to higher level education
    - Could include IBCLC credential, but regulated for BC.
    - Could include direct entry pathway (bachelors) or as an upgrade for health care professionals (masters) across disciplines.
- Create more clinical learning opportunities focused specifically on breastfeeding. Breastfeeding clinics need to be supported to be able to provide learners with a high enough patient volume.

Collect Meaningful Statistics:

- Collect comprehensive breastfeeding data in keeping with other countries. Consider the social determinants of health and reconciliation in data collection.

Improve Social Media Presence:

- Review and enhance provincial resources for patient facing breastfeeding education. This includes prenatal classes, web resources, social media presence, and apps.

Increase Provincial Breastfeeding Supports:

- Establish IBCLC care as part of 811 in keeping with other provinces.
    - 811 or a similar provincial infant feeding phone line to be staffed by an IBCLC 24/7 as well as a line for healthcare providers to be able to consult directly with an IBCLC.
- Create a BC recognized Lactation/ Infant Feeding credential – This could be a regulated profession or specialization
    - A specialization would allow for nurses to be compensated for extra work that comes with the education.
    - There is a case to be a regulated profession to reduce the amount of incorrect and dangerous advice being given. There is concern about the number of babies undergoing surgical procedures such a frenotomies, lip and buccal tie releases in the absence of good lactation care.
- IBCLC positions
    - Every public health center,hospital Maternity unit and NICU needs at least 1FTE IBCLC that will not be pulled to other duties. This work may be both clinical and leadership/ educational

- RM/IBCLC's can do "rounds" or inpatient consultations for postpartum inpatients and NICU and bill directly to MSP. This can alleviate some funding demands from health authorities, and is useful in smaller communities; however, leadership and educational roles are still needed at each site and are not covered by MSP.
- Ideal positions are a blend of acute and community care as well as clinical, education and leadership.
- Every Health Authority needs an IBCLC lead
- Positions are not limited to RN designation

Increase Funding to Breastfeeding Programs:

- Fund IBCLC positions in birthing hospitals, NICUs, community health centers, First Nations communities as desired by community centered goals, breastfeeding clinics and regional positions.
- Re-evaluate funding models so nurses, midwives and physicians choosing to specialize in lactation are not making less money.
  - Consider Salaried positions. Salaried positions would allow for more flexible appointment scheduling, group care options, drop-in clinics and other models of care to accommodate urgent appointments as well as time for leadership and educational IBCLC roles
  - Provincially funded overhead coverage for breastfeeding clinics. Clinics that are not able to be located in hospital struggle with paying overhead and this is a major expense that results in practitioners making less money than they would in their regular practice. This expense is also a barrier to interprofessional collaboration – eg RM and public health nurses struggle to work together in the community because RNs don't pay into overhead.

Explore New Models-of-Care and Expand Existing Scopes of Practice:

- Review and expand scope and billing limitations for midwives, nurse practitioners and physicians to allow for comprehensive breastfeeding support from primary care providers.
- Perinatal care networks
  - Create "*perinatal* care networks" based on primary care networks that allow all perinatal care providers from different funding models to work together in one space. This would allow all disciplines that support breastfeeding to work together more easily and save money. Eg midwives, physicians, nurses, mental health professionals, physiotherapists, IBCLC's, dieticians, pediatricians.
  - Could be located in hospitals or community
  - Salaried funding model with overhead coverage to allow for different professionals to collaborate
  - Could provide well parent and well baby assessments for unattached families
- Since many RM's (20% of new graduates) are interested in doing lactation support – look at better supporting this profession to fill in the gaps that currently exist with their model and funding.
  - Expand MSP funding beyond 6 weeks, and scope past 12 weeks postpartum so Midwives can care for all breastfeeding dyads to a year or beyond
  - Expand scope to allow for frenotomy, breast ultrasounds, and medications required for complex feeding situations
  - Funding for education and leadership roles which can consume as much of half of an IBCLC's day.
  - Increase office support funding and billing code fees so not making less money than standard midwifery care.
  - Pay equity in line with family physician providing consults for breastfeeding dyads

The answer to the question: ***Why are there so few breastfeeding clinics and dedicated lactation care services in British Columbia?*** is complex. Lack of compensation, recognition, education, and scope and model limitations restrict professionals in providing lactation care. Even motivated individuals with the education and desire to work with breastfeeding families face significant barriers in doing so.

Information and recommendations of this report are just skimming the surface. Each community, profession and clinic have their own unique challenges. Interdisciplinary models are promising as a way to address some barriers, however there still exists limitations, especially for smaller communities. All providers report they make less money and often volunteer their work to provide breastfeeding support. It is the recommendation of the BCLCA, that a full review of breastfeeding care and compensation models takes place. Families in BC urgently need more breastfeeding support.