Lessons Learned from Hospital Leaders Who Participated in a National Effort to Improve Maternity Care Practices and Breastfeeding

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Abstract

Objectives: As a method to increase exclusive and overall breastfeeding, the Centers for Disease Control and Prevention funded the National Institute for Children's Health Quality to run a national collaborative designed to accelerate the number of Baby-Friendly–designated hospitals in the United States. A unique aspect of this project was the development of the first ever national quality improvement collaborative of hospital leaders focused on maternity care practices and breastfeeding.

Materials and Methods: Members of the Leadership Track were continually engaged and surveyed throughout the project period to provide feedback on the collaborative process and project as a whole.

Results: The Leadership Track served as a vital catalyst for change, resulting in an unprecedented number of newly designated Baby-Friendly hospitals.

Conclusions: A quality improvement Leadership Track adds value and provides lessons learned that can be applied to other complex healthcare initiatives affecting global policies and public health.

Introduction

QUALITY IMPROVEMENT (QI) SCIENCE is a mechanism to take what is already known and test it for application in varied environments to ensure the delivery of evidence-based methods meets quality standards.¹ These standards in healthcare include being safe, efficient, effective, timely, equitable, and patient centered; all concepts drawn from the 2001 Institute of Medicine report *Crossing the Quality Chasm*.²

Experts in improvement, such as the National Institute for Children's Health Quality (NICHQ), have brought together improvement advisors and healthcare organizations to facilitate change in multiple fields.³ Many of the areas of healthcare delivery targeted for improvement come from the National Quality Forum's list of recommended core measures for healthcare quality. One such measure, adopted by The Joint Commission, is exclusive breast milk feeding (EBMF).

In an effort to improve their Joint Commission core measure on EBMF, hospitals and healthcare organizations throughout the United States have focused attention on improvements in maternity care practices, an area that has been slow to join the movement of systematic hospital improvement.⁴ In 2011, while 75% of U.S. women initiated breast-

feeding, merely 15% were exclusively breastfeeding at 6 months, and 25% of breastfeeding newborns were receiving formula supplements before hospital discharge.⁵

Many of the practices in maternity care that continue to exist today were created during a time when an industrialized, technical, sterile, and formula feeding culture was prevalent.⁶ Current evidence emphasizes care that provides adequate prenatal preparation and support for breastfeeding, including expectations of an effective beginning for breastfeeding in the delivery hospital, skin-to-skin care, keeping mothers and newborn(s) together, and avoidance of unnecessary formula supplementation. These are a few of the basic tenets of the Ten Steps to Successful Breastfeeding,⁷ which were first articulated at the 1989 conference of the World Health Organization and subsequently led to the 1991 creation of the Baby-Friendly Hospital Initiative (BFHI).⁸

The BFHI is a global effort to promote, protect, and support breastfeeding through implementation of the Ten Steps as manifest in the Baby-Friendly designation.^{8,9} In 2011, merely 100 U.S. hospitals were designated as Baby-Friendly, accounting for 6.2% of the births in the United States.¹⁰ Despite publications describing the evidence and accompanying need for education to change maternity care practices, U.S. hospitals have been slow to adopt these changes.^{11–13}

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To accelerate change, the Centers for Disease Control and Prevention (CDC) funded NICHQ to lead a national collaborative to improve maternity care practices with the aim of having an additional 90 hospitals in the United States designated as Baby-Friendly.¹⁰ The project, entitled Best Fed Beginnings (BFB), was the first nationwide QI effort to facilitate Baby-Friendly designation. The aim seemed at the time to be far reaching and unprecedented, given the slow pace of change in maternity care over the previous few decades. As a result, project leaders determined that a novel aspect of technical support would be necessary to create such widespread transformational change: the creation of a Leadership Track running parallel to the collaborative.¹⁴

The Leadership Track of the BFB project was a separate yet integrated collaborative effort composed of senior administrative leaders (SALs) from each of the participating hospitals. SALs were defined as individuals who fulfilled four criteria: has the ear of the chief executive officer; resides at a level where they can make or strongly influence resource allocations (personnel and budget); has credibility and positive relationships with physicians, nurses, and administrators throughout the system; and is willing and able to dedicate 4–8 hours per month to the project. The goal of the Leadership Track was to support the BFB teams' achievement of Baby-Friendly designation within the time frame of the project. Considering the contracted timeline (~2 years from selection to the final intervention), it was imperative to engage leaders from the start.

Members of the Leadership Track participated in prework (which included reading key manuscripts and completing surveys), webinars, remote learning and sharing, and attended the first of three face-to-face learning sessions. There were 89 SALs who participated, one from each hospital. Sixty (67%) held the title of vice presidents of product lines, directors, or chief nursing officers. The remainder (33%) included directors of lactation services, senior nurse managers, and physician leaders. Members of the Leadership Track were continually surveyed throughout the project period to provide feedback on the collaborative process and the project as a whole.

From this feedback and using our experience as project director/faculty chair, we have summarized lessons learned from the Leadership Track. Five key lessons were learned in the Leadership Track that may help guide other collaborative efforts to “cross the quality chasm” in areas of complex healthcare service delivery. Leaders ongoing engagement helped overcome strong and ingrained cultures of practice in the achievement of evidence-based care, leading to improved outcomes and better patient experiences at a neutral or even decreased cost.¹⁵ These five lessons are as follows: (1) government involvement in healthcare plays a key role in how leadership leads, (2) there are leaders in all spheres, (3) leaders need training in QI methodology, (4) leaders need support and collaboration to avoid the feeling of being alone, and (5) essential touch points can be brief (time is not the barrier).

Lesson 1: Government Involvement in Healthcare Plays a Key Role in How Leadership Leads

One of the most important revelations observed by Leadership Track participants is the key role that government

plays. As discussed in the recent commentary by Berwick et al., this is especially true with the advent of the Affordable Care Act (ACA), and healthcare leaders need to actively engage in the process of change during this critical time.¹⁶ The ACA has delineated criteria that reward good practice using measures of quality and improving the three components of the Triple Aim: better health for the population, lower cost, and better patient experience.^{17,18}

The BFHI has the potential to affect all three of these components of the Triple Aim by increasing breastfeeding, a known contributor to optimal health outcomes^{19,20}; reducing the costs associated with not breastfeeding,^{21,22} while not inflating the costs of delivering this type of care^{23,24}; and improving patient- and family-centered care and communication, a major component of patient satisfaction.²⁵ Successful leaders will leverage the opportunities and vision created by the ACA. Nevertheless, the most common challenge to the BFB cited among hospital leaders was balancing evidence-based care strategies with patients' individual choice and culturally sensitive care.

In addition to responding to the demands of the ACA, hospital leaders need to be responsive to governmental organizations responsible for public health. Leaders from the CDC Division of Nutrition, Physical Activity, and Obesity were actively engaged in the Leadership Track and provided a voice of authority with leaders from participating hospitals. When certain hospitals encountered major hurdles, such as structural reorganization, financial constraints, and public resistance, governmental leaders joined the NICHQ and other

TABLE 1. POTENTIAL PARTNERS FOR THE LEADERSHIP TRACK OF A BABY-FRIENDLY HOSPITAL COLLABORATIVE (NATIONAL AND INTERNATIONAL)

National and international nonprofit organizations

- *U.S. Breastfeeding Committee
- *Baby-Friendly USA
- *Step2 Education
- *American Hospital Association
- *The Joint Commission
- *Association of Women's Health, Obstetric, and Neonatal Nurses
- *American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American Academy of Family Physicians
- Academy of Breastfeeding Medicine

Governmental agencies

- *Centers for Disease Control and Prevention
- Executive Office of the President—Champions of Change: Let's Move
- U.S. Department of Agriculture—Breastfeeding Promotion Consortium and Women, Infants, and Children (WIC) Program
- Office on Women's Health
- Maternal and Child Health Bureau—Health Resources Services Administration
- Agency for Healthcare Research and Quality
- National Institutes of Health—National Institute of Child Health and Human Development
- Institute of Medicine (now called the National Academy of Medicine)

*Participated in the partnership of Best Fed Beginnings.

members of the Leadership Track to provide individualized technical assistance or national data for comparison and benchmarking. The CDC also worked with NICHQ and Leadership Track participants to forge national partnerships with key organizations to facilitate change (Table 1).

Despite these critical connections, participants in the Leadership Track voiced how participation from national organizations, such as the American College of Healthcare Executives, may be necessary to sustain these efforts. In the past, all relevant federal agencies under the U.S. Department of Health and Human Services convened in a federal working group to align goals and incentives to better promote, protect, and support breastfeeding. These federal partners are now working collaboratively with the U.S. Breastfeeding Committee (USBC) in a collective impact model to affect change. QI organizations and hospital leadership organizations, such as the Health Care Administrators Association and the American Hospital Association, have the opportunity to engage with federal partners through the USBC structure, if key stakeholders take the lead. A strong collective federal voice for breastfeeding care and changes in maternity care practices would sustain efforts, such as the BFB, to empower hospital leaders as the implementation of the BFHI is set as a priority.

Leadership was also responsive to recommendations set forth by the U.S. Surgeon General. In 1984, C. Everett Koop convened the first Surgeon General's Workshop on Breastfeeding and authored a report outlining six key actions needed to improve breastfeeding rates in the United States.²⁶ These steps included establishing and promulgating policy, offering professional consultation and technical assistance to providers, supporting professional training, conducting research, implementing the delivery of services, and sponsoring public education. Many of these recommendations continue to be relevant since adoption of these recommendations was slow.

Nearly 15 years transpired before the government released another key publication, the Blueprint for Action.²⁷ The Environmental Health Policy Committee, responding to concerns about environmental health and breastfeeding and recognizing the need for a more comprehensive approach and opportunity to partner with the Office on Women's Health, conducted a thorough and contemporary review of breastfeeding in the United States. This document drew attention to the issue of disparities, especially the very low rate of breastfeeding among African Americans in the United States. The U.S. Surgeon General highlighted the key role of hospital leaders in eliminating disparities in maternity care practices, especially among the underserved.

About a decade later, the CDC, the Office on Women's Health, and the Office of the Surgeon General published *The Surgeon General's Call to Action to Support Breastfeeding* (SGCTA), which describes in detail how individuals and organizations can contribute to the health of mothers and their children through promotion, protection, and support of breastfeeding in clinical, home, public, research, and work settings.^{28,29} The SGCTA outlines key stakeholders and recommendations that served as the platform to fund and organize the BFB project. Table 2 outlines these recommendations for healthcare, as well as key recommendations for other stakeholders that affect hospital leadership. Hospital leaders agreed that many of the recommendations highlighted in Table 2 were

TABLE 2. KEY RECOMMENDATIONS FROM THE SURGEON GENERAL'S CALL TO ACTION TO SUPPORT BREASTFEEDING (2011) IMPLEMENTED WITH EFFECTIVE LEADERSHIP

Actions for mothers and families

- Give mothers the support they need to breastfeed their babies
- Develop programs to educate fathers and grandmothers about breastfeeding *and integrate these classes free of charge with prenatal classes offered by hospital*

Actions for communities

- Strengthen programs that provide mother-to-mother support and peer counseling *and permit establishment of these relationships to begin while in the delivery hospital*
- Use community-based organizations to support breastfeeding *and coordinate care at discharge*
- Ensure that the marketing of infant formula is conducted in a way that minimizes its negative impacts on exclusive breastfeeding *by implementing the International Code of Marketing of Breast-Milk Substitutes at the hospital and all its affiliated clinics*

Actions for healthcare

- Ensure that maternity care practices throughout the United States are fully supportive of breastfeeding
- Develop systems to guarantee continuity of skilled support for lactation between hospitals and healthcare settings in the community
- Provide education and training in breastfeeding for all healthcare professionals who care for women and children
- Include basic support for breastfeeding as a standard of care for midwives, obstetricians, family physicians, nurse practitioners, and pediatricians
- Ensure access to services provided by the International Board Certified Lactation consultants
- Identify and address obstacles to greater availability of safe banked donor milk for fragile infants

Actions for employment

- Work toward establishing paid maternity leave for all employed mothers, *including all employees of the hospital system*
- Ensure that employers establish and maintain comprehensive, high-quality lactation support programs for their employees *and go beyond provisions of the Affordable Care Act to encourage employees who are new parents to breastfeed according to the recommendations issued by the American Academy of Pediatrics, exclusive for about 6 months and continued with complementary foods to at least one year*
- Expand the use of programs in the workplace that allow lactating mothers to have direct access to their babies *by creating local or onsite child care opportunities*

(Italics Added by Author.)

within their reach. As stated by one of the participants, "... the leader's job is to remove the boulder from stream—often it was easy." Therefore, if goals are evident and leadership is engaged, barriers to change may be overcome.

Lesson 2: There Are Leaders in All Spheres

Leaders for this kind of initiative can be found in many different roles and settings. Some of the participants in the

Leadership Track were CEOs, Directors of Lactation Services, or unit managers. However, the majority were service line managers, such as directors of maternal and child services. We observed that the key determinant of how much impact each leader had with respect to change initiatives was not their “level” of leadership but rather their role in the culture of their organization.

Some participating organizations tended to operate in a top-down, executive-driven culture, which depended on high-level leaders to bring about change. These institutions worked best when their executive leaders were visible, understood day-to-day operations, and could communicate change effectively in a cascading manner. In many of these organizations, this role was played by a service line director, which is an executive position in many cases, and leaders in these positions often had the opportunity to continuously inform top executives in the hospital while staying in touch with unit managers and frontline personnel. Many of these service line directors were nurses by training with advanced practice degrees who understood the culture and what it would mean to change practices at the front line.

The culture in other participating organizations was more driven by the front line, and in these cases, leaders from unit managers and lactation were effective at bringing about change. Leadership from within permitted accountability, synergy between data collection, and responsiveness to gaps because management level leaders collected process and outcome measures. In addition, these managers could permit early adopters to be recognized as great examples and allow naysayers to voice opinions without derailing the process.

Physicians served as leaders, too. In general, physicians were the most resistant group among all the stakeholders needing to change practice for Baby-Friendly designation. This resistance came from both pediatric and maternal providers, and it varied considerably between hospitals. Having a physician champion was critical for gaining the buy-in for change in each hospital. In some cases, it was necessary to have two physician champions, one from maternal care and one from pediatric care. The physician–SAL dyad was deemed the most effective arrangement of leadership for change,³⁰ each bringing their own strengths and expertise that when united as a dyad led to more than the sum of their individual efforts. Physicians often possess the clinical authority to advise safe and effective change strategies, while administrative leaders are skilled in communicating change and providing metrics to measure and track.

Lesson 3: Leaders Need Training in QI Methodology

One common thread among successful leaders in this work is a thorough knowledge of QI methods and tools, especially as they apply to maternity care practices. Early on in the BFB project, NICHQ invited hospital leaders who had previously led their hospital to Baby-Friendly designation to serve as adjunct faculty in the Leadership Track. These leaders were all well versed in QI as well as the Ten Steps and therefore able to articulate the leadership role in using a QI approach to achieve designation. Investing time and energy to educate leaders about how QI is different from translational research and involves its own set of rules and techniques helps elevate

the leaders’ effectiveness and credibility in the work. For example, leaders with a QI mind-set will emphasize run chart data with relevant annotation, as opposed to dashboard statistics from a single point in time. Dashboard results, which generally include only data from before and after project implementation, may mislead those working on changes to over- or underestimate progress.³¹

To be effective in improvement initiatives, leaders also need to have some understanding of the specific content area. While hospital leaders do not need to understand all the nuances of the BFHI or clinical management of breastfeeding, they do need to know the basic tenets of the Ten Steps and understand what clinical changes will take place and what challenges and barriers to expect. Participants in the Leadership Track created “personal leadership action plans” to stay on track with the BFHI leadership requirements. Plans included strategies for budgeting for change, organization-wide communications with the senior management team, changes in the health system interface (such as health information technology), changes in the professional provider interface (such as meetings with employees and physicians in private practice), and changes in the community interface (such as marketing and public relations). These plans also included a timeline, “SMART” (specific, measurable, achievable, realistic, and timely) goals, and a detailed work plan for each goal.

Finally, participants in the Leadership Track were educated in the pitfalls of transformational change using Kotter’s eight points of transformational change and why such efforts

TABLE 3. HOW LEADERSHIP CAN FACILITATE ADOPTION OF THE BABY-FRIENDLY HOSPITAL INITIATIVE

1. Develop the case for urgency about changing maternity care practices, especially with regard to equity, morbidity, mortality, and each of the elements of the Triple Aim
2. Create a powerful guiding coalition, budget resources to create a task force or steering committee, and incentive regular meetings and progress
3. Create a vision of what a Baby-Friendly hospital looks like and how patients will experience care in this new setting
4. Communicate this vision effectively by strategic use of resources, marketing, and public relations. Involve the community and patient relations department
5. Empower all members of the team to act on the vision by creating seamless methods of care and documentation, including revisions of the electronic health record, and organizing regular huddles and rounding
6. Use Plan–Do–Study–Act small cycles of change to create short-term wins, particularly around delivery and skin-to-skin care, with knowledgeable clinicians and willing patients, then share their stories
7. Consolidate improvements to create more change necessary to reach the 80% threshold, by not declaring victory too soon. Audit processes regularly and round to monitor changes that ensure full adoption and integrity of implementation
8. Hardwire/anchor the changes into policies, staff expectations, and the culture of the institution such that practices, including mother–baby separation, bottle feeding, and delivery room care without skin-to-skin, become unnatural and uncomfortable for staff

may fail.³² Implementation of the BFHI may either stall or fail on any of Kotter's points that were uniquely adapted for this project (Table 3).

Lesson 4: Leaders Need Support and Collaboration to Avoid the Feeling of Being Alone

The creation of a peer group proved invaluable to participants in the Leadership Track. The creation of the Leadership Track stemmed from comments shared at the first expert meeting of the BFB project convened by NICHQ in March 2012, which brought together breastfeeding experts, improvement advisors, and leaders from hospitals that had successfully achieved Baby-Friendly designation to provide the strategies for undertaking a project of this magnitude. Hospital executives shared their own personal stories about transformational change and explained how their efforts would have been streamlined if they had collaborative partners in similar organizations working on similar tasks. They also offered the perspective of what the BFHI journey looks like from the executive level and what messages were necessary to convince hospital administration that the journey was desirable and achievable within a specified time frame.

Essential data were necessary to lay the groundwork, but it was the emotional story that carried the energy to convince leadership it was worth the investment. Some leaders explained how the Baby-Friendly designation process helped strengthen their organization not only for the purpose of designation but also as a method to increase staff engagement and morale. One CEO shared that his organization was on the brink of a shutdown due to Medicaid compliance issues, but the journey toward Baby-Friendly designation helped unify processes, rectify some of the deficiencies cited, and most importantly helped rally employees around a positive message. They received the positive news about Baby-Friendly designation shortly before hearing the news that remediation efforts for Medicaid were also successful.

Leadership peers supported each other to effectively deal with the many myths and miscommunications surrounding the BFHI.³³ Many clinicians do not recommend policies and practices congruent with the Ten Steps unless they have had their own personal breastfeeding experience.³⁴ Some incorrectly believe mothers who deliver in a Baby-Friendly hospital will be mandated to breastfeed, infants will not be given infant formula even if requested or medically necessary, and the mother's decision-making authority will be taken away. Some of these myths may stem from a misunderstanding of how hospitals seeking Baby-Friendly designation must handle the free infant formula and marketing conducted by infant formula companies. Most hospitals in the United States continue to accept free infant formula and contribute to the marketing of infant formula despite policies that recommend against this practice^{35,36}; however, hospitals seeking Baby-Friendly designation must implement the International Code of Marketing of Breast-Milk Substitutes.³⁷

Hospital leaders learned about the process of negotiating fair market value for infant formula and developed an understanding about how best to communicate this process with purchasing officers. The collaborative process proved to be more effective than hospitals attempting to navigate this change alone. Furthermore, many hospitals are now aligned in large health systems, which require high-level oversight in the ne-

gotiation for fair market value of infant formula as it affects multiple hospitals under one contract. Hospital leaders provided each other moral support as well as elucidated potential pitfalls and effective strategies in negotiating fair market value.

Lesson 5: Essential Touch Points Can Be Brief (Time Is Not the Barrier)

Hospital leaders are busy individuals. Participants in the Leadership Track were continuously challenged by time constraints. Project faculty and staff quickly learned, however, that essential touch points for the leaders did not have to take much time. By creating frontline resources and access to improvement data and archived webinars, leaders could avail themselves of collaborative learning to help them throughout the BFB journey.

Activities of the Leadership Track were consolidated to maximize the effect with fewer webinars, only one face-to-face meeting, and surveys from key informants. Despite the brief number of leadership track activities, the mere involvement of hospital leaders as learners in the project empowered the hospital project teams to make substantial transformational change. Senior leaders were also coached to present team progress, including data and key pieces of information to executive leadership using concise and effective meetings. The Leadership Track was a "motivated team that was ready to change a culture—Best Fed really kept us on track."

The most common feedback from leaders was that sharing of compelling stories was very helpful in motivating change. Sharing the Baby-Friendly experience through the lay press, promotional videos, and social media helped spread awareness about the positive effects and dispel any myths about the BFB journey. What motivates a leader to engage in transformational change is most often the same thing that compels them to be in healthcare in the first place, and that is the desire to help people. While changes associated with national healthcare reform, such as paying for performance, improving on core measures, and containing costs, may help decision makers lead a hospital through the Baby-Friendly designation process, it is the patient experience that has the most potential to drive change.³⁸ As one leader reported, "when you empowered the patient to make decisions about their own baby there was a real change—this was often the turning point."

Conclusion

One key element of the CDC-funded, 3-year national collaborative engaging 89 hospitals to seek Baby-Friendly designation—known as the BFB—was a Leadership Track. The Leadership Track allowed hospital leaders to learn and support each other throughout the process of transformational change at their facilities. As a result, leaders played a key role in the success of BFB, and an unprecedented number of newly designated Baby-Friendly hospitals were created as part of this one national collaborative.

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