Bringing Baby-Friendly to the Indian Health Service: A Systemwide Approach to Implementation

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Abstract
The Baby-Friendly Hospital Initiative (BFHI) increases exclusive breastfeeding. Breastfeeding protects against obesity and diabetes, conditions to which American Indians and Alaska Natives are particularly prone. As part of the First Lady’s Let’s Move! in Indian Country initiative, the US Department of Health and Human Services’ Indian Health Service (IHS) began implementing the BFHI in 2011. The IHS administers 13 US birthing hospitals. There are 5 tribally administered hospitals in the lower 48 states that receive IHS funding, and the IHS encouraged them to seek Baby-Friendly designation also. In the 13 federally administered hospitals, the IHS implemented a Baby-Friendly infant feeding policy, extensive clinician training, and Baby-Friendly compatible medical records. All hospitals also became compliant with the World Health Organization’s International Code of Marketing of Breast-Milk Substitutes. Strategies and solutions were shared systemwide via webinars and conference calls. Quality improvement methods, technical assistance, and site visits assisted with the implementation process. Between 2011 and December 2014, 100% (13 of 13) of IHS federally administered hospitals gained Baby-Friendly designation. The first Baby-Friendly hospitals in Arizona, New Mexico, North Dakota, Oklahoma, and South Dakota were all IHS sites; 6% of all US Baby-Friendly hospitals are currently IHS hospitals. One tribal site has also been Baby-Friendly designated and 3 of the 5 remaining tribally administered hospitals in the lower 48 states are pursuing Baby-Friendly status. Baby-Friendly Hospital Initiative implementation systemwide is possible in a US government agency serving a high-risk, underprivileged population. Other systems looking to implement the BFHI can learn from the IHS model.

Keywords
Baby-Friendly Hospital Initiative, breastfeeding, Native American, Indian Health Service

Background
The World Health Organization and UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) in 1991 to improve hospital maternity care and breastfeeding rates worldwide. In 2011, fewer than 5% of all US birthing hospitals were Baby-Friendly. To become designated in the United States, hospitals must meet the Ten Steps to Successful Breastfeeding; adhere to the International Code of Marketing of Breast-Milk Substitutes (the Code), including paying fair market value for formula; and pass an onsite assessment by Baby-Friendly USA.

The BFHI increases breastfeeding rates in all types of populations.1-5 American Indians (AIs) and Alaska Natives (ANs) bear a disproportionate burden of morbidity and have below-average life expectancy and particularly high rates of certain chronic illnesses, including obesity and type 2 diabetes.6-9 Exclusive breastfeeding protects against obesity and type 2 diabetes in mothers10,11 and children12 and has been associated with reduced obesity and diabetes in the AI/AN population. A study of the Pima Indians found a direct correlation between being breastfed as an infant and lower rates of obesity and type 2 diabetes in adulthood13 and hypothesized that “the
increase in prevalence of diabetes in some populations may be due to the concomitant decrease in breastfeeding.”

The Indian Health Service (IHS) is an agency within the US Department of Health and Human Services, responsible for providing health services to 2.2 million members of 566 federally recognized AI/AN tribes. The IHS is centrally administered from its headquarters (HQ) in Rockville, Maryland, and divided into 12 geographically administered areas. Of the hospitals within this system that provide birthing services, 13 are federally administered hospitals and 12 are tribally administered (5 in the lower 48, 7 in Alaska). In total, the system accounts for approximately 8000 births to AIs and ANs per year. This article focuses on the federally administered IHS hospitals.

The 13 federal sites are located in Arizona, New Mexico, Montana, North Dakota, Oklahoma, and South Dakota. Three are in urban settings and the remainder in rural locations, many of which are long distances from major population centers. None of the hospitals has a newborn intensive care unit, and 4 do not perform cesarean sections.

The IHS prioritizes reduction of chronic conditions like obesity, diabetes, and asthma and emphasizes preventive care for the health of future generations. The IHS has proactively promoted breastfeeding and the BFHI as a best practice since 2009. US First Lady Michelle Obama’s Let’s Move! campaign is “dedicated to solving the problem of obesity within a generation” and includes “creating a healthy start for children” as 1 of its 5 pillars.14 In 2011, as part of Let’s Move! in Indian Country, the agency’s Chief Medical Officer launched the IHS Baby-Friendly Initiative at Northern Navajo Medical Center in Shiprock, New Mexico, with the aim of designating all 13 federal sites. At the same time, the IHS encouraged tribally managed birthing hospitals to seek designation.

**Methods**

**Administration**

In 2011, the IHS held an in-person launch of the BFHI at Northern Navajo Medical Center, bringing in staff and stakeholders from all 13 federally funded sites and conducting a train-the-trainer event. The IHS committed to centralized payment for almost all direct costs associated with the BFHI, including clinician training, payments to Baby-Friendly USA, onsite assessments, and ongoing Baby-Friendly fees. Individual sites were responsible for paying for infant formula. To support these commitments, the IHS administered payment structures, created directives, engaged an online education contract, and, in 2012, hired a consultant, initially funded by an interagency agreement from the US Centers for Disease Control and Prevention, to provide technical assistance and content expertise. Although HQ played a pivotal role, IHS area offices and hospital employees engaged intensively in regional and hospital team leadership, communication, policy development, and technical assistance.

**Early Adopter: Great Plains Area**

The Great Plains Area, covering much of North and South Dakota, contains 3 of the federally funded IHS hospitals and emerged as an early adopter within the system, under the leadership of the area maternal child health consultant. The Great Plains Area formed a task force to examine key perinatal issues, with the Ten Steps being the inaugural issue. This task force included nurses, dietitians, administrators, and lactation consultants and built alliances with the local Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) office, home visiting programs, and local maternal child health nonprofit organizations. A universal training program and marketing strategy were created and implemented at all 3 hospitals to educate community stakeholders and garner community support. The nurse training curriculum consisted of 20 hours of didactic training and 8 hours of clinical training. This included education on the Code, focusing primarily on health care providers’ responsibility for ensuring ethical marketing at the facility, and an overview of public health consequences when marketing practices undermined ethical practices. A 5-hour training course went beyond the 3 hours required by Baby-Friendly USA and was used for all physicians and advanced practitioners; at 2 of the 3 hospitals, the CEOs required all clinicians, even those not working directly with mothers and babies, to complete this. In addition, 100% of staff at all 3 hospitals, including nonclinicians, completed a 1-hour in-service on the Initiative and the Code.

The Great Plains Area began paying for formula, closed their nurseries to facilitate rooming-in, removed pacifiers from distribution outside of circumcision, and created model policies and medical record templates that were later adopted by all other areas. The area maternal child health consultant established regular webinar and call-in sessions for the 3 hospitals, which allowed leadership to meet virtually, discuss problems, share solutions, and provide additional technical assistance, such as policy review.

**Implementation across the System**

With leadership from IHS HQ under then Acting Director Yvette Roubideaux, MD; Chief Medical Officer Susan Karol, MD; and the Division of Nursing, the other 10 federal IHS hospitals collaborated to follow the Great Plains’ lead. At the national level, webinars and virtual conferences were held systemwide on adaptation of specific steps and implementation strategies such as Plan, Do, Study, Act (PDSA) cycles. Areas also collaborated; for example, the Navajo Area nurse consultant created a Navajo Area task force that met monthly by telephone or in person for Arizona and New Mexico IHS hospitals. At the individual hospital level, each site created an interdisciplinary Baby-Friendly task force to work on
policy and process. Public health nurses supported transitions of care into the community by providing breastfeeding support and partnering with WIC. As designation timelines approached, senior staff from HQ visited many hospitals in person to address onsite barriers, provide physician training, and offer strategic planning, medical record review, intensive technical assistance, and mock Baby-Friendly assessments.

Results

By December 1, 2014, 13 of 13 IHS federally administered birthing hospitals were Baby-Friendly designated. Rosebud Indian Hospital in South Dakota was the first Baby-Friendly IHS hospital; all 3 Great Plains hospitals, accounting for 800 births per year, were designated by December 2012. They were the first 3 Baby-Friendly hospitals in the Dakotas and, at the time of writing, remain the only 3 Baby-Friendly hospitals in those states. In June 2013, Claremore Indian Hospital (200 births per year) became the first Baby-Friendly hospital in Oklahoma. The IHS also had the first Baby-Friendly hospital in New Mexico. At the time of writing, all Baby-Friendly hospitals in Arizona are IHS hospitals, and 6% of the 229 currently designated US Baby-Friendly hospitals are IHS facilities.

Discussion

The IHS implemented the BFHI across 100% of federal sites in approximately 3 years. This was achieved by a combination of HQ leadership directive, regionally administered outreach and technical assistance from the area level, and quality improvement and detail-oriented change by each hospital.15

Strengths

Certain aspects innate to the IHS contributed to this success. Status as a government agency led to early, universal compliance with the Code, with which many private hospitals struggle. The IHS used its well-established distance learning techniques and information technology to communicate effectively with remote facilities. Sharing practical resources, successes, and challenges across a mission-driven system transcended geographic collaborative norms. Hospital employees reached out to help other facilities with hands-on help and advice, fostering a broad team spirit and collaborative effort. In addition, the relatively small size of IHS facilities meant that the system had relatively few employees to train, although almost all facilities went beyond the BFHI training requirements and some trained all nursing staff and physicians. Once 50% of sites had become designated, peer pressure and expectations also played into the equation.

Barriers

The IHS serves a disadvantaged, impoverished population with high medical need, often in geographically remote areas. Whereas average per capita health care spending in the US is $7329, the IHS budget is funded at just $2643 per person per year.16 As an overburdened, underfunded system, the IHS faces tremendous staffing and operational challenges on an ongoing basis. In addition, hospitals encountered barriers common to non-IHS hospitals, such as initial lack of physician buy-in, and resistance to change.

Benefits

Many benefits emerged, including a growing sense of accomplishment, from senior leadership through on-the-ground clinicians, as the agency systematically gained designation. Newly designated hospitals were featured on the IHS website, and local leadership was honored with service awards and employee recognition programs. Many IHS hospitals were trailblazers in their states and as such received honors from state health departments. It was important that many tribes served by IHS hospitals expressed appreciation for the evidence-based care, which, with its focus on demedicalization of the hospital experience, was often in alignment with traditional birthing practices in local culture.

No data have yet been analyzed to assess the effect of designation on IHS populations. Data collection would be highly beneficial to assess the effect of the BFHI on breastfeeding rates among AI/AN populations in general, and at IHS facilities in particular.

Conclusion

The IHS suffers from many challenges associated with a government system serving an underprivileged population bearing a disproportionate burden of chronic disease. Despite this, within a relatively short period of time, the IHS implemented the BFHI at 100% of federally operated hospitals in a nation where fewer than 10% of hospitals are designated. The IHS now describes Baby-Friendly as the standard of care for AI/AN and predicts increased rates and improvements in long-term health outcomes. Breastfeeding rates in these populations have already begun to increase.17 This example sends a strong message to hospitals in Western nations that claim that Baby-Friendly designation is too difficult, too expensive, or too politically problematic to achieve. Other institutions and systems should adopt a can-do attitude, invest in the initiative, and follow the IHS example.

Authors’ Note

The authors prepared the article within the scope of their employment with the Indian Health Service, US Department of Health and Human Services. Accordingly, the content of this article is a US government work and in the public domain within the United States.

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