Payer Policy Guidance: Innovative Approaches to Coverage Of Breastfeeding Support, Equipment, and Supplies

Presented by the Lactation Support Provider (LSP) Constellation

a collaborative group convened by the U.S. Breastfeeding Committee

The LSP Constellation is a collaborative of twenty lactation training, mentoring, and accreditation organizations working together since 2014 to increase access to lactation care for all families, while building opportunities to diversify, strengthen, and mobilize the workforce through policy, system, and environmental change initiatives.

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Answering the Call: Role of Health Insurers in Breastfeeding Success

Breastfeeding is a primary prevention strategy that builds a foundation for life-long health and wellness, adapting over time to meet the changing needs of the growing child, while conferring protective benefits to the mother. The evidence for the value of human milk feeding to overall health is scientific, robust, and continually reaffirmed by new research.[1]

The public health case is well established, as is the gap between these population health goals, and national breastfeeding rates as further detailed below.

Key barriers to breastfeeding include limited availability lactation accommodations at workplace and community spaces, and limited access to lactation supplies, equipment and access to skilled Lactation Support Provider (LSP) to assist with lactation challenges.

Some of this gap relates to systemic conditions, must be addressed by enacting policies such as paid leave which helps to establish breastfeeding, and protected breaks for milk expression during the workday which is essential to maintaining milk supply. Yet the gap is also attributable to barriers individuals face in accessing breastfeeding support, equipment, and supplies.

Health insurers have a critical role to play in facilitating access to education, counseling, equipment, and supplies with ease throughout the breastfeeding journey.

The Affordable Care Act enacted a decade ago was intended to be a sweeping reimagining of how public health infrastructure and health care delivery might be integrated for the benefit of the citizenry. While the Women's Preventive Services designation survived the social, political, and legislative machinations that proceeded implementation, breastfeeding has been difficult for many insurers to fit into existing health care delivery models. There are several reasons for this, including:

- **Limitations of covered services**, particularly billing approaches which require a diagnosis code (thus assigning pathology) to breastfeeding, which is a physiologically normative behavior
- **Limitations of covered providers,** particularly designation of in-network provider system including geographic proximity limits, and licensure requirements
- **Limitations in access to equipment and supplies**, particularly ease of access to hospital grade breast pumps when medically indicated and access to pasteurized donor human milk

Given these limitations, many health plans are reconsidering their approach to lactation support in preparation to craft benefits packages for 2023 health plans and beyond. This is timely work, likely inspired by the rising awareness of Black maternal morbidity and mortality rates; the White House Conference call to implement Women's Preventive Service with better allegiance to the spirit of the law; and 2022 updates to the Women's Preventive Services Initiative guidelines.

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This Payers Policy Guidance for Breastfeeding Counseling, Equipment, and Supplies aims to provide health plans with the information they need while designing better approaches to lactation support. This document outlines what breastfeeding families need and when; who the lactation workforce is and how to integrate their services with insured families on the plan; and proposals on how to leverage existing payment mechanisms to significantly expand access to care and utilization of this workforce.

Public Health Case: Breastfeeding is a Primary Prevention Strategy

Human milk feeding is proven to reduce the risk of a range of illnesses and conditions for infants and mothers. Compared with commercial milk formula-fed children, breastfed infants have a reduced risk of ear, skin, stomach, and respiratory infections; diarrhea; and sudden infant death syndrome. In the longer term, breastfed children have a reduced risk of obesity, type 1 and 2 diabetes, asthma, and childhood leukemia. Women who breastfed their children have a reduced long-term risk of type 2 diabetes, cardiovascular disease, and breast and ovarian cancers.[2]

The American Academy of Pediatrics (AAP) states that breastfeeding and human milk are the normative standards for infant feeding and nutrition. The AAP recommends infants be exclusively breastfed for six months with continued breastfeeding while introducing complementary foods for as long as mutually desired by baby and parent for two years or beyond.[1]

A recent CDC study found that breastfeeding initiation reduced the risk of post-perinatal infant deaths (between 7-364 days) by 26 percent![3] Feeding babies human milk saves lives and healthcare dollars across the lifespan, and legislation and programmatic support for lactation support, supplies, and accommodations represent a powerful, wise, and humane investment in public health.

Despite these proven health benefits, the U.S. has many barriers to establishing and maintaining the human milk feeding relationship. While most (83.2%) babies born in the United States start out being breastfed, around half (55.8%) are still receiving some breast milk at six months, and less than a quarter of infants (24.9%) are exclusively breastfed.[4] Research shows that this drop-off is not a choice most families are making willingly, but rather a default decision in the current social context where families are under-supported by public policy. Six out of ten breastfeeding mothers report that they stopped nursing their babies earlier than they intended.[5] This is not due to the personal capacity of the parent, but rather because policies and systems that surround and shape our lives are not in alignment with human physiology, including lactation.

Babies typically require 8 to 12 feedings a day, and ready access to nutrition is critical to their survival. A robust infrastructure for infant nutrition security includes comprehensive lactation support in all policies, systems, and environments where babies and parents interact. Without that infrastructure, many are forced onto painful, difficult, and sub-optimal paths of infant feeding and care. Structural and environmental barriers can make it difficult or impossible for families to establish an adequate milk supply to sustain human milk feeding at medically recommended levels. For many families, rather than being a matter of personal choice, infant feeding practice is determined by circumstance.

Infant feeding practices have such a profound impact on population health outcomes that increasing breastfeeding rates and creating lactation-friendly environments have been identified as critical public health priorities nationally as well as globally. In the U.S., breastfeeding rates are included in a variety of national initiatives, including the Healthy People initiative, The Surgeon General's Call to Action to Support Breastfeeding, the 2020-2025 Dietary Guidelines for Americans White House Blueprint for Addressing the Maternal Health Crisis, and the Biden-Harris Administration National Strategy on Hunger, Nutrition, and Health.[6, 7, 8, 9]

Individual Experience: What to Expect in Common Course(s) of Breastfeeding

Although breastfeeding is natural and part of the reproductive process, it is usually challenging, especially within the first few months after birth. While every breastfeeding experience is unique, we

can anticipate and prepare to support the typical phases of the experience. In preparation for this journey, lactation education during pregnancy, and access to prenatal support during pregnancy help to guide families toward success. Knowledge of common infant behaviors and anticipated physical changes following birth readies and empowers parents to provide this essential first food for their babies.

Throughout the course of breastfeeding, many events are likely to occur. And with their occurrence, a family is expected to require support in the following areas:

> **Prenatal education and relationships with lactation support help** build a foundation for establishing feeding goals, provide anticipatory guidance, and approaching breastfeeding with optimism.
>
> **Establishing a deep and comfortable latch from the start** is paramount for establishing a milk supply that matches the infant's nutritional needs. Support with comfortable latching techniques and positions from a trained Lactation Support Provider can help minimize discomfort and aid in the postpartum recovery process.
>
> **Learning the infant's unique feeding cues** brings the dyad together as they synergistically meet their needs for milk removal and the provision of critical nutritional sustenance. Research shows that the removal of milk on a regular and unobstructed basis supports human milk feeding until the common course of feeding has waned.
>
> **The return to work or school** will often shift goals and priorities around breastfeeding. Parents require education about breastfeeding supplies such as pumps and their accessories, feeding supplies such as bottles and the supportive mechanisms that help to protect the feeding relationship, and support with scheduling and caregiver concerns. Parents often require additional assistance addressing common causes of setbacks during this time.
>
> **Teething and other developmental experiences** can be uncertain times for families as infants engage with their environments in new ways and develop unique forms of communication with their caregivers. Skilled Lactation Support Providers can help to educate and provide families with resources that help to build nurturing and intuitive parenting skills over a lifetime.
>
> **Approaching readiness to begin exploring solid foods** is pivotal in an infant's physical and neurological development. Education and support around safe food handling and preparation, access to healthy and nutritional complementary foods, and age-appropriate guidance regarding portion sizing and human milk security must not be an afterthought.
>
> **The natural course of breastfeeding** may close at different times for each unique family. Several factors come into play that influences a family's decision to approach this transitional time, many of which may have come to light because of receiving quality lactation support. A care and assistance system throughout this journey increases the chances of optimal health outcomes for all involved.

The adage, "expect the best and prepare for the worst" applies to health plans. Breastfeeding is a learned behavior for both the infant and new mother, and as such, families deserve supportive, culturally congruent community care to facilitate best-case scenarios unfolding even amidst typical challenges.

Even with ample support, however, families experience differing layers of complexities that may enhance the need for skilled help. Health plans must be prepared to build a structure sufficient to support the needs of *all* infants, regardless of intricacy or medical diagnoses.

Breastfeeding is classified as a preventive service for both the individual lactating and the infant receiving human milk, and exclusive breastfeeding for at least six months influence health outcomes for a lifetime. Meeting public health goals is only possible when individuals' needs are anticipated and met with minimal barriers to care. Both support and access to services, equipment, and supplies are critical for supporting generational health and easing the weight of the medical system as a whole.

Workforce: Mobilizing the Existing Trained Workforce Throughout Communities

Certification in breastfeeding-specific training is critical to the provision of breastfeeding support services. Lactation Support Providers (LSPs) include Lactation Consultants, Breastfeeding Counselors, Peer Counselors, and Lactation Educators that are present in communities throughout the United States. All of these providers play a valuable role in breastfeeding support. This is a workforce prepared and longing to be mobilized to support the nation's families in establishing and maintaining breastfeeding and/or donor human milk as the first nutrition for all infants.[10]

Lactation support services can also be provided by health professionals who have completed breastfeeding-specific training to augment their practice, including certified midwives, certified nurse-midwives, certified professional midwives, dieticians, doulas, nurses, occupational therapists, nurse practitioners, mental health professionals, physical therapists, physician assistants, and physicians. While these health professionals have great potential to support families, health care providers typically receive inadequate pre-service breastfeeding education.[11] Many report feeling they have "insufficient knowledge about breastfeeding and that they have low levels of confidence and clinical competence in this area."[7] UNICEF & WHO state: "It should not be assumed…that health care professionals are inherently skilled in breastfeeding counselling, as the amount of specific training received is typically inadequate."[11]

Hence, breastfeeding-specific training, not training or licensure in another, even allied, field is critical to the provision of adequate care. Families report difficulty accessing preventive services with no cost sharing, in part due to insurance company failure to provide up-to-date lists of eligible (covered) lactation support services.[12] If insurers shift from an emphasis on licensure, to an emphasis on identifying providers with breastfeeding-specific training, there is immense potential to expand access to care.

Due to the necessity of breastfeeding-specific training, it is not appropriate to substitute other providers for trained lactation support providers. The emerging practice to offer services "in lieu of" lactation support is not sufficient to meet family needs and public health goals.

Lactation Support Providers should be respectful and appropriately patient centered, demonstrating cultural humility and linguistic competence. Cultural humility demonstrates behaviors and attitudes congruent with valuing diversity and managing the dynamics of difference, to enable effective cross-cultural work. Patients and clients thrive when served by a culturally reflective provider. Where not possible, the cultural humility model provides a crucial framework in the cases providers do not match the identify, background, and/or community of those served. [13, 14]

Lactation Support Providers must demonstrate sensitivity to those who are having difficulty with breastfeeding, regardless of the cause, including infant loss. After an infant loss, many parents choose to continue lactation as part of the grieving process, and/or need assistance to safely stop their milk

production. Therefore, parents facing this tragic circumstance should be recognized within health plan coverage, lest they be overlooked as a population in need of lactation support services.

The USBC-Affiliated LSP Constellation has worked for years to understand and better articulate each certification program's scope of practice, code of conduct, code of ethics, and standards of practice. It is toward these ends that the Constellation published the LSP Descriptor Chart, provided at the end of this document. [10] Lactation Support Providers from certified programs appropriately care for families, and refer as needed, matching complexity in cases served to the skill set of available providers.

It is the responsibility of lactation training organizations (such as noted on LSP Descriptor Chart)[10] to ensure knowledge of their trainees, and that they are meeting the standards of their training program. These organizations maintain lists of active members in good standing.

This workforce has mutual accountability and a shared value for holding families in care.

Outline of Support Counseling: Timing, Place(s) of Service(s), Duration and Impacts

Lactation support services include consultation, counseling and psychosocial support, education, and breastfeeding equipment and supplies. Lactation support services should be delivered and provided regardless of complexity across the antenatal, perinatal, and postpartum periods to ensure successful preparation, initiation, and continuation of breastfeeding with deliberate care to reduce barriers that drive disparities in breastfeeding rates. [15, 16, 17]

All visits, regardless of complexity, need to be processed with no cost sharing to reduce barriers that drive disparities in breastfeeding rates. [16, 17]

Role of breastfeeding support in reaching exclusive breastfeeding 6 month goals: According to the AAP, women who are supported in breastfeeding are 2.5 times more likely to exclusively breastfeed for 6 months. This support includes maternity care practices that support breastfeeding, home visits, health care staff education, and trained peer support in communities, including through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[1]

Number of visits: Although the clinical trials of interventions including recommended 5-8 in-person visits across antenatal, perinatal, and postpartum periods to promote and support breastfeeding showed benefit.[18] Lived experience of Lactation Support Providers working in communities find that 9-12 visits are more reasonable to accommodate beyond routine perinatal care, including psychosocial counseling for breastfeeding, responsive to the needs of each individual family.[18, 19, 20, 21, 22]

Place(s) of service(s) include: Common settings include but are not limited to hospitals (all units), birth centers, home visits, health care provider offices and/or clinics, WIC clinics and Health Departments, community settings, support groups (in person or online), and telehealth (including audio and/or video). Families access care in a variety of settings which must be recognized as culturally appropriate.[18, 19, 20, 21, 22]

Duration of covered benefit: The WHO (2018) stipulates "Breastfeeding counselling should be provided in both the antenatal period and postnatally, and UP TO 24 MONTHS OR LONGER."[23] (p. 4, emphasis added).

Impact of limiting care: Meanwhile, the National Women's Law Center reported insurers tend to provide coverage for services at in-patient setting at time of birth, while others cover services only

during first 2 months, and one insurer covered a single visit. Lactation challenges occur throughout the breastfeeding experience. Limiting the timeframe for lactation care will limit breastfeeding duration.[23, 12]

Equipment & Supplies: DME Needs and Approach

Covered equipment and supplies should include: Breastfeeding equipment and supplies, as agreed upon by the client and their Lactation Support Providers, include but are not limited to:

- **Purchase of a single-user, double-electric breast pump** (or purchase of a manual pump only if the enrollee requests a manual pump based on preference or need such disaster relief).
    - The coverage policy should not require documentation of medical necessity, prior authorization, or a prescription for the breast pump.
    - The pump shall be of sufficient power and durability to establish and maintain milk supply for the duration of breastfeeding.
    - Coverage of repair or replacement of the pump if necessary.
    - **Related to timeliness of *anticipated need* (such as inducing lactation, building milk supply, anticipated separation, etc.) and distribution of a single-user breast pump:**
        - In the case of anticipated need as described above, single user breast pumps and related supplies are needed within 48 hours of request, including in the case of fetal loss when the parent wishes to express and donate milk to a nonprofit milk bank.
        - These are typically acquired through the following sources: Local DME suppliers, DME suppliers who can ship, WIC offices, and stores and online retailers.
        - In all of these cases, costs for pumps and equipment sufficient to maintain milk supply should be covered by the health plans within their usual and customary allowance.
- **Purchase or rental of a multi-user breast pump** (commonly known as “hospital grade breast pump”) on the recommendation of an LSP or health care provider.
    - **Related to timeliness of *immediate/emergent need* (such as premature birth, ill baby, ill parent, fetal demise, etc.) and distribution of a multi-user breast pump:**
        - In the case of emergencies as described above, multi-user rental breast pumps and related supplies are needed are needed within 12 hours of request.
        - These are typically distributed through the following means: hospitals, WIC offices, local DME supplies, and DME supplies with overnight shipping capacity.
        - In all of these cases, all of the costs related to rapid delivery of the multi-user pumps should be covered by health plans as part of their provision of infant nutrition security feeding plans.
- **Coverage of breastfeeding equipment** including two breast pump kits per birth event, as well as appropriate size breast pump flanges.
    - Additional covered equipment should include nipple shields, at-breast supplementers, and breast milk storage supplies.[19, 24, 25, 26, 27]
- **Who is the covered insured:** Lactation supplies are often cost prohibitive for families. Providing care with no cost sharing and responsive to urgent need, reduces barriers. Human milk feeding includes a variety of experiences, including non-birthing parents. Additionally, not all lactating parents identify as female. Gender nonconforming and intersex individuals suffer discrimination when denied “gender specific” care. Inclusive language of all types of human milk feeding facilitates care providers and insurance companies’ coverage of lactation support services and supplies for all individuals.[24, 25]

Coverage of Pasteurized Donor Human Milk

As stated throughout, human milk optimizes the health and well-being of all infants. Human milk is absolutely essential for infants born prematurely or ill. For these medically fragile infants, an all or near all human milk diet provides powerful, unparalleled protection against serious complications that can lead to longer hospitals stays, multiple procedures, readmissions, life-long disability, or even death.

Unfortunately, up to 70% of mothers who have infants in the neonatal intensive care unit (NICU) are unable to provide all of their baby's needs,[28] at least initially, despite adequate lactation support and effort. There are several factors that can initially delay copious milk production, cause temporary or long-term supply issues, or even make breastfeeding contraindicated. Examples of such factors include premature birth, cesarean section, medication use, diabetes, drug abuse, obesity, use of fertility treatments, and hypothyroidism.

Mother's milk has unique properties tailored to her own child's needs and is always the best nutrition with rare exceptions. When mother's own milk is unavailable, the use of Pasteurized Donor Human Milk (PDHM) for necessary supplementation is a proven, cost-effective way to improve health outcomes and lower health care costs.

While premature infants and those being cared for in the NICU are the primary recipients of PDHM, other infants require human milk to thrive as well. Outpatient and inpatient infants with acquired or congenital gastrointestinal or cardiac conditions, severe allergies, immunological issues, malabsorption issues, or other circumstances greatly benefit from donor milk too.

Coverage recommendation: PDHM should be provided on the basis of a medical prescription.

Barriers to Accessing Care: How Current Fee-for-Service Models are Failing

Federal guidance makes clear that "if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service."[12]

A decade of post-ACA lived experience by the LSP Constellation reveals the implementation breakdowns between what *should* happen, and what is *actually* happening for families. This includes:

- **Compliance patchwork:** Not all states opted into the ACA, creating a patchwork of compliance frameworks.[29] Add to this the perpetual legal challenges, and many affected industries seem to have adopted an approach of skirting minimum requirements, rather than fulfilling the spirit of the law. Preventive services improve health outcomes which should be something for which we all have a stake.
- **Limitations of in-network providers:**
  - **Licensure:** Many plans require lactation providers to be "otherwise licensed", for example an RN/IBCLC or an MD/CLC, etc. This excludes the vast majority of Lactation Support Providers [10] who are trained and prepared to support families, but excluded from in-network rolls.
- **Geography:** Many plans limit in-network providers to one per geographic area of any given type. It is extremely unlikely that one Lactation Support Provider can meet the needs of all breastfeeding families in a geographic area. Given that breastfeeding support is needed within 24 hours of request there is not time to appeal for coverage of an out of network provider.

- **Billing and payment for services:**
  - **Expense:** Given the above two limitations, families are often driven to either pay out of pocket for help if they can afford to or seek care from volunteer community resources. With these fundamental barriers, of course many turn to breast milk substitutes such as commercial milk formula, despite desire and intention to breastfeed.
  - **Inaccurate claims:** Current billing practices require a diagnosis code, which is not appropriate or applicable for providing breastfeeding counseling, such as help with positioning and comfortable latch, and anticipatory guidance about growth spurts and cluster feeding, etc. Requiring diagnosis codes for provision of basic support pathologizes normal physiology and human behavior. The requirement also creates inaccurate claims, which corrupts data.
- **Over-reliance on volunteer organizations without renumeration:**
  - In the absence of adequate in-network rolls, many plans have defaulted to telling their insured to call community volunteer organizations. While these organizations offer a valuable community service, it is not appropriate for health plans to a) do this in lieu of providing access to LSPs who deserve to earn a living wage, or b) not renumerate the organizations, which while volunteer run, still have operating expenses.

Proposed Payer Solutions: Models to Support Families and the LSP Workforce

The Lactation Support Provider (LSP) Constellation recommends the following approach to improve access to care for all families; expand and compensate the pool of trained Lactation Support Providers; and support community-based organizations providing culturally congruent peer support.

Connecting New Babies and Families to Their Communities: Growing Membership in Community Breastfeeding Organizations

- Acknowledging the role of volunteer breastfeeding peer counseling organizations across the nation, and the importance of continuity of care, health plans can connect families with new babies to the community breastfeeding organizations, through a membership model. Such a program would mimic the popular “silver sneakers” (aka fitness club membership voucher) type programs, by providing covering membership dues for families.
- The family would receive a ticket from their health plans to cover membership dues or donations at community-based breastfeeding organizations to offset operating expenses of that organization.
- Examples of volunteer organizations with trained breastfeeding peer counselors include but are not limited to: BabyCafe, BSTARS, Black Mothers Breastfeeding Association, Breastfeeding USA, HealthConnect One, Indigenous Lactation Counselors, LaLeche League, Mom2Mom Global, Nursing Mothers Counsel, and ROSE (Reaching Our Sisters Everywhere).
- Critically, families would not be limited to seek support only from the organization where they became a member, and the volunteer organizations would not be limited to providing services to those who had given these donations. But the “currency” would make a valuable contribution to underwrite phone lines, print costs, governmental filings, and other basic operating expenses that every organization incurs, and from which every community *and health plan* benefit.
- These organizations provide incredibly valuable services to their communities, including phone support, telehealth, support groups, and in-person visits when available.

In addition to the above, the LSP Constellation recommends all health plans also implement:

An Infant Nutrition Security Payment Model Related to Supporting Human Milk for Human Babies

Beyond in/out Network Limitations & Medical Diagnosis for Normative Infant Feeding

- **Component one: Leverage CAQH to verify Lactation Support Providers are trained**
  - CAQH is an industry leader in credentialing providers.
  - Individual Lactation Support Providers (LSPs) would register with CAQH.
  - LSP training and credentialing organizations would support their trainees with this registration, verifying their qualifications quarterly or as requested by CAQH.
  - *Advantages:* centralizes provider verification with CAQH while mobilizing LSP training and credentialing organizations as the verification source. Leverages the availability of culturally congruent, trained breastfeeding care that exists in communities throughout the nation.
- **New Lactation Services Superbill**
  - The LSP Constellation proposes creation of a new Lactation Services Superbill that emphasizes time and complexity while anticipating the support needs in a typical course of breastfeeding, as well as the complications that at times occur. Each provider works within their scope, referring as appropriate.
  - Individual LSPs would provide service, complete the form, and submit to the health plan for reimbursement.
  - Upon verification with CAQH, the health plan would remit payment to the LSP based on time and complexity.
  - *Advantages:* normalizes breastfeeding support while significantly easing access to care. Empowers families to work with trained LSPs of their choosing based on training, geography, culture, language, availability, and other factors at their discretion. Equips LSPs to refer to one another and/or to a health care provider with breastfeeding-specific training, as case complexity dictates. This mobilizes the workforce while creating continuity of care.

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Standard disclaimer for collaborative work:
Specific details contained herein do not necessarily represent the views of each organization within the USBC-affiliated Lactation Support Provider Constellation.

Lactation Support Provider (LSP) Constellation:
The LSP Constellation has been Stewarded by USBC Deputy Director Amelia Psmythe Seger and co-facilitated with Dr. Kimberley Broomfield Massey since its inception, yet the work direction and outcomes are owned by the participants. To read more about the U.S. Breastfeeding Committee-affiliated Lactation Support Provider (LSP) Constellation, see: www.usbreastfeeding.org/lsp-constellations

U.S. Breastfeeding Committee Constellation Model:
To read more about the U.S. Breastfeeding Committee Constellation Model for Collaborative Change, and download the Constellation Formation Pathway see: www.usbreastfeeding.org/constellations

Lactation Support Provider (LSP) Descriptors

Category	Descriptions	Training	Credentials & Programs
Lactation Consultants	Referral to these health professionals is appropriate for the full range of breastfeeding care, particularly involving high acuity breastfeeding situations.	**90-95 didactic hours**, and additional training requirements and exam for each title. Often work clinically as part of the healthcare team in both inpatient and outpatient settings; may also work in private practice.	**International Board Certified Lactation Consultant® (IBCLC®)** Program accreditation by Nat'l Commission for Certifying Agencies (NCCA) ○ Health professionals and individuals with 14 college level health science courses (6 can be continuing education) ○ 95 lactation-specific didactic hours ○ 300 to 1000+ hours of clinical practice, depending on pathway **Advanced Lactation Consultants (ALC®)** ○ Certification as a CLC® or IBCLC® ○ Plus 2 college credits in *Maternal and Infant Assessment* and 3 college credits in *Advanced Issues in Lactation Practice* **Advanced Nurse Lactation Consultants (ANLC®)** ○ Current RN license and certification as a CLC® or IBCLC® ○ Plus 3 college credits in *Advanced Issues in Lactation Practice*
Breastfeeding Counselors	Individuals who hold these certifications or similar have the skills to provide breastfeeding counseling, address normal breastfeeding in healthy term infants, and to conduct maternal and infant assessments of anatomy, latch, and positioning, while providing support.	**45-54.5 hours** of classroom training and exam. Often provide support to families in the hospital and community settings. Counselors may have additional competencies to assist families with breastfeeding difficulties.	**Certified Breastfeeding Specialists (CBS®)** ○ 54.5 didactic hours earning 3 college credits **Certified Lactation Counselors (CLC®)** Program accreditation by American Nat'l Standards Institute (ANSI) ○ 52 didactic hours; ANSI accredited exam earning 3 college credits **Certified Lactation Educators (CLE®)** ○ 45 didactic hours and exam
Breastfeeding Peer Counselors	Breastfeeding peer support organizations equip these LSPs to meet the needs of the families they serve, focusing primarily on individual and community support.	Personal breastfeeding experience and approximately **20 hours** of training through various community models, except for the La Leche League Leader program, which has **90 hours** of training.	Peer support organizations equip these LSPs to meet the needs of the families they serve, focusing primarily on individual and community support. Examples of national breastfeeding peer counselor organizations in the U.S. include: ○ **Breastfeeding USA** ○ **HealthConnect One** ○ **La Leche League (LLL)** ○ **Reaching Our Sisters Everywhere (ROSE)** ○ **Women, Infants, and Children (WIC)**
Lactation Educators	A Breastfeeding Educator is qualified to support and educate the public on breastfeeding and related issues but does not perform clinical care.	Generally, **20 hours** of training.	**Childbirth and Postpartum Professional Association (CAPPA)**

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