Information Summary and Recommendations

Lactation Consultant

Sunrise Review

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THE SUNRISE REVIEW PROCESS

A sunrise review is an evaluation of a proposal to change the laws regulating health professions in Washington. The Washington State Legislature's intent, as stated in chapter 18.120 RCW, is to permit all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. Changes to the scope of practice should benefit the public.

The Sunrise Act (RCW 18.120.010) says a health care profession should be regulated or scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions, and criminal prohibitions are not sufficient to eradicate existing harm.
2. *Inspection requirements*. A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business, when a service being performed for people involves a hazard to the public health, safety or welfare.
3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the healthcare activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act (chapter 18.130 RCW).
4. *Certification.* A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.[1] A certified person is subject to the Uniform Disciplinary Act.
5. *Licensure.* A method of regulation by which the state grants permission to engage in a healthcare profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act.

[1] Although the law defines certification as voluntary, many healthcare professions have a mandatory certification requirement such as nursing assistants-certified, home care aides, and pharmacy technicians.

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EXECUTIVE SUMMARY

Background and Proposal

In April of 2016, the Chair of the House Health Care and Wellness Committee asked the Department of Health (department) to conduct a sunrise review of a proposal to license lactation consultants as a new and distinct profession. The legislative request included draft bill H-4795.1/16, which would require licensure for lactation consultants and create the lactation consultant advisory committee. The Washington Lactation Consultants Licensure Collaborative was the applicant for this proposal.

The draft bill would require the department to issue a lactation consultant license to any professional who meets specific qualifications as listed in section 3 of the bill. Licensing would allow professionals to perform lactation care and services, defined as "clinical application of scientific principles and a multidisciplinary body of evidence for evaluation, problem identification, treatment, education, and consultation to provide lactation care and services to childbearing families." It exempts certain providers like volunteer peer counselors, La Leche League leaders, and other regulated providers working within their own scopes of practice, from the licensure requirements as long as they don't call themselves lactation consultants. The bill would also form a new advisory committee of five members to advise the secretary on regulation of lactation consultant practice.

The applicant states that regulation is necessary to reduce harm to the mother and infant due to short breastfeeding duration rates. The proposal argues that limited access to proper lactation care or incorrect and conflicting information can result in premature discontinuation of breastfeeding, unnecessary maternal pain and discomfort, and poor infant outcomes.[2] The report further discusses the need for regulation in order to provide access to services for all populations statewide, increase the availability of qualified lactation consultants, create an avenue for insurance reimbursement, and create a disciplinary process for this profession.

Recommendations

The department recognizes the extensive training of International Board Certified Lactation Consultants (IBCLC) and their value within the healthcare system in helping mothers to initiate and continue breastfeeding. However, we can't support the proposal to require state licensure of lactation consultants.

Rationale:

- The proposal doesn't meet the sunrise criteria because the applicant has not provided evidence of a clear and easily recognizable threat to public health and safety from the unregulated practice of lactation consultation.
- The proposal may result in unintended harm to particular populations. Limiting the number of healthcare professionals who can provide lactation care may create barriers to access, particularly in rural and underserved areas.

[2] Applicant report, Appendix B, pp. 33-60.

- The proposal would place the burden of dual state licensure, renewal fees, and education requirements on already licensed healthcare professionals operating within their scopes of practice if they want to continue to call themselves lactation consultants.
- There are currently processes in place for the public to file complaints against practitioners who provide substandard care or commit unprofessional conduct. Since a majority of IBCLCs already hold registered nurse (RN) or registered dietitian (RD) credentials, licensing of lactation consultants for the purpose of providing oversight and discipline would be a costly and unnecessary duplication of regulation.
- The proposal would place a significant financial burden on lactation consultants, particularly in rural areas, without a corresponding increase in public protection.

The department offers an alternative proposal to the legislature that would recognize the higher level education and skills of IBCLCs and may help them to receive insurance reimbursement for services.[3] Voluntary certification by the department would be a less-burdensome option by granting recognition to lactation consultants who have met certain qualifications and would be qualified to provide lactation support to deal with complex breastfeeding issues that are outside the training of the other providers who lack lactation-specific training. Non-certified providers may perform the same tasks, but may not use "certified" in their title.

[3] Insurance reimbursement is not part of the sunrise criteria but was a major obstacle identified by the applicants.

SUMMARY OF INFORMATION

Proposal and Bill Draft

In April of 2016, Representative Eileen Cody, Chair of the House Health Care and Wellness Committee, asked the department to conduct a sunrise review of a proposal to create a new licensed profession for Licensed Lactation Consultants. The request included proposal H-4795.1/16 that would require licensure for lactation consultants and create the lactation consultant advisory committee. The Washington Lactation Consultants Licensure Collaborative (applicant) provided an applicant report addressing how the proposal meets the sunrise criteria in chapter 18.120 RCW.

The draft bill requires a license from the department before providing lactation care and services or representing oneself as a lactation consultant, licensed lactation consultant, or registered lactation consultant. It exempts certain providers like volunteer peer counselors, La Leche League leaders, and other providers working within their own scopes of practice, from the licensure requirements as long as they don't call themselves lactation consultants. It defines lactation care and services as "the clinical application of scientific principles and a multidisciplinary body of evidence for evaluation, problem identification, treatment, education, and consultation to provide lactation care and services to childbearing families."

Qualifications for licensure include:

- Board certification by a national or international certifying organization that has specific requirements, to include:
    - 90 hours of lactation-specific education;
    - 24 college-level academic credits in health professional courses; and
    - 300 hours of clinical practice; or
- Equivalent education and experience as approved by the department; and
- Passage of an examination approved by the secretary.

The applicant states that regulation is necessary to prevent potential harm—such as dehydration, weight loss, and failure to thrive—to the infant, and therefore the public, from short breastfeeding duration when mothers do not have access to lactation care and services. Inaccurate and conflicting information from health professionals without specific lactation education contributes to short breastfeeding duration. The applicant report also states that regulating lactation consultants may increase access and availability of trained lactation professionals across the state.[4]

Background

Breastfeeding is widely accepted as the best feeding option for infants for the first 12 months of life.[5] Many organizations are taking steps to increase rates of breastfeeding in the United States by supporting optimal breastfeeding practices. A couple of examples are the Surgeon General's Call to Action to Support Breastfeeding[6] and Womenshealth.gov, which provides resources to

[4] Applicant report, Appendix B, pp. 33-60.
[5] American Academy of Pediatrics recommendations, the Centers for Disease Control and Prevention (CDC), Surgeon General's Call to Action, and many more.
[6] http://www.surgeongeneral.gov/library/calls/breastfeeding/, accessed August 17, 2016.

help with successful breastfeeding that include a national breastfeeding hotline.[7] The department recognizes the importance of breastfeeding through programs like the Breastfeeding Friendly Washington Initiative,[8] which encourages hospitals and birthing centers to promote and support breastfeeding, and the Women, Infants, and Children (WIC) Breastfeeding Peer Counseling Program that offers breastfeeding support to WIC clients.

According to the Surgeon General, more than two-thirds of mothers begin using formula within three months of giving birth and more than half give up breastfeeding completely by six months. Disparities still exist in breastfeeding rates by race/ethnicity, socioeconomic characteristics, and geography.[9] Barriers to breastfeeding can include lack of information, conflicting advice from clinicians, concerns about adequate milk supply, and physical challenges with breastfeeding. If identified early, mothers can overcome many of these challenges with proper guidance and support.

According to the Academy of Breastfeeding Medicine, healthcare practices that hire professionals trained in lactation care have significantly higher breastfeeding initiation and maintenance rates.[10] The Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN) position statement on breastfeeding states that nurses and other healthcare professionals should acquire knowledge and competence to provide evidence-based breastfeeding information and support. If the provider does not possess competence to provide this support, he or she should refer the mother to a lactation specialist or other clinical expert.[11]

Current Regulation and Practice in Washington

Lactation consultation is not regulated as a stand-alone profession in Washington. There are several already-regulated professions that may provide this care under their scopes of practice, including nurses, allopathic and osteopathic physicians, midwives, registered dietitians, and others. Midwives commented that they receive extensive lactation-specific education and that lactation care is a large part of their scope of practice. There are also unlicensed individuals with various levels of lactation-specific training who provide this care including, but not limited to, volunteer peer counselors, La Leche League leaders, doulas, WIC peer counselors, and some IBCLCs.[12]

According to the applicant report, IBCLC is the only certification that prepares providers to help women address complex breastfeeding issues. Less trained providers are qualified to provide basic support for the normal course of breastfeeding, including providers like doulas and WIC peer counselors. However, when these providers encounter challenges beyond their training level, they often refer the patients to IBCLCs. In addition, the applicants state that licensed healthcare providers (including doctors and nurses) lack specialized lactation training and often

[7] http://www.womenshealth.gov/breastfeeding/, accessed August 17, 2016.
[8] http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/BreastfeedingFriendlyWashington/Hospitals, accessed 7/25/2016.
[9] "Surgeon General's Call to Action to Support Breastfeeding," 2011, pp., 6-7, http://www.surgeongeneral.gov/library/calls/breastfeeding/, accessed August 17, 2016.
[10] http://www.bfmed.org/Media/Files/Protocols/Protocol_14_revised_2013.pdf, p. 237, accessed August 17, 2017.
[11] AWHONN Position Statement, http://www.jognn.org/article/S0884-2175(15)31769-X/abstract?utm_source=awhonn.org, accessed August 17, 2016.
[12] Applicant report, Appendix B, pp. 50-51.

refer mothers and babies to IBCLCs. The applicants estimate that 86 percent of IBCLCs in Washington already hold Department of Health credentials as RNs or RDs.

Education and Training of Lactation Care Providers

The International Board of Lactation Consultant Examiners (board) provides certification for the International Board Certified Lactation Consultant (IBCLC) credential. The board's website states that IBCLCs provide expert breastfeeding and lactation care, promoting changes that support breastfeeding and help reduce the risks of not breastfeeding. It certifies IBCLCs through an examination and requires clinical practice hours based on the professional background of the applicant. IBCLCs must re-certify every five years through examination or continuing education credits and must renew their certification every 10 years through passing the certification examination.

Certification requirements include 90 hours of lactation-specific education, eight college-level health professional courses (totaling 24 credits), six health-related continuing education courses, 300 to 1,000 clinical practice hours, and an examination.[13] Costs to obtain the certification include approximately $1,000 to obtain 90 hours of lactation-specific training[14] , $1,000 to $6,000 to obtain eight college-level health professional courses[15] , and $660 for the IBCLC certification. There are also costs to obtain training in the additional six health science subjects (which may be from continuing education courses).

In addition, there are a number of other training programs for providing lactation care. Some examples include:

- Certified Lactation Specialist (CLSC) training, which is intended for nurses, physicians, midwives, dieticians, or others who wish to improve knowledge and skills in lactation support. This course is offered by the organization *Lactation Education Consultants* and taught by currently practicing IBCLCs (five-day 45-hour course that can be used as a stepping stone for IBCLC certification).
- Breastfeeding Educator Certification (BEC) training for childbirth professionals like doulas, midwives, and nurses that qualifies them to teach, support, and educate the public on breastfeeding and related issues. This course is offered through *Birth Arts International*, an international organization offering education for doulas, midwives, nurses, childbirth educators and others (120-hour online program).
- Certified Breastfeeding (Lactation) Counselor (CBC) training on how to assist women in overcoming breastfeeding difficulties like learning how to latch. This course is offered through *Childbirth International*, a team of doulas, educators and breastfeeding counselors that provides training to birth professionals to help families put mothers and babies first (10-15 month program).

[13] Applicant report and http://iblce.org/certify/eligibility-criteria/, accessed August 17, 2016.
[14] Estimate obtained from public hearing testimony.
[15] Fee estimates for 8 credits obtained from South Puget Sound Community College and University of Washington resident tuition and fees.

- Lactation Educator Counselor training program, which is intended for entry-level providers who deal with the normal process of lactation. This course is offered through the *UC San Diego Extension* (45 didactic hours on-site or 60 hours online).
- WIC Peer Counselor trainings to support mothers with basic lactation support in the absence of breastfeeding challenges. This training varies by state (30-50 hour programs).

Applicant Definition of the Problem and Why Regulation is Necessary

The applicant states regulation is necessary for a number of reasons.

First, the applicant states that families will be better protected from harm of short breastfeeding duration rates due to:

- Mothers not having access to adequate lactation care to overcome breastfeeding problems.
- Mothers receiving inaccurate information from other healthcare professionals, which may result in choosing not to breastfeed or to prematurely discontinue breastfeeding.

Second, the applicant states there is a need to standardize and ensure evidence-based care because:

- There are 14 different types of breastfeeding professions in Washington with no consistent standards for education and training.
- The applicants assert that licensed providers like physicians and nurses often feel inadequately prepared to provide lactation care. Medical doctors and nurses receive only a few hours of breastfeeding training and it often focuses on the benefits of breastfeeding, rather than on overcoming barriers.

Third, the applicant states the proposal will help to provide access to lactation care to all breastfeeding populations by:

- Providing a way to receive insurance reimbursement, which will also encourage growth of IBCLCs in Washington;
- Helping to address the shortage of lactation care providers (IBCLCs). The applicant states the Surgeon General's Call to Action recommendation of 8.6 IBCLCs per 1,000 live births, compared to only 5.65 IBCLCs per live birth in Washington. The applicant adds that outpatient clinics have up to a two-week waiting list for women in crisis to be assessed by an IBCLC.

The applicant also asserts that licensure of IBCLCs may provide a pathway to encourage growth of the profession by increasing access to mentorship programs. Currently, there are not enough IBCLCs in the state to support such a program. They are hopeful that licensure will increase the numbers of IBCLCs, who could then provide mentorship to other lactation care providers, especially in rural areas and minority populations so they can license more IBCLCs.

Other States

There are only two states that have passed legislation to regulate lactation consultants: Rhode Island in 2014 and Pennsylvania in 2016. These laws are too recent to provide us with data on outcomes related to credentialing IBCLCs.

Public Participation and Hearing

The department received the request from the legislature to conduct this sunrise review on May 9, 2016, and received the applicant report on June 1, 2016. The department posted the proposal and all applicant materials to the sunrise webpage and notified interested parties of the public hearing scheduled for July 12, 2016. Written comments were accepted until the close of the public hearing, with an additional comment period for follow-up after the hearing. Here is a summary of the comments we received at the public hearing and in writing.

Comments regarding other professionals that provide lactation services:

- The free and discounted services that are available from midwives, doulas, and lactation consultants will end;
- Women who want to lend a helping hand should be able to;
- Current available resources will be eliminated unless providers obtain licensure;
- Lactation services will be more difficult to get in rural communities;
- Limiting licensure to experts will create a public health crisis;
- The bill is conflicting for providers performing services within their scopes of practice and could potentially infringe on other professions' scopes of practice, similar to midwives providing newborn care;
- The applicant report does not demonstrate a need for lactation consultants as a separate profession beyond healthcare providers who are currently providing these services;
- Many anecdotal stories of harm were submitted —for example, a story of a baby diagnosed with tongue tie[16] by the IBCLC after both a midwife and pediatrician had said there was not a tongue tie; and
- Poor lactation advice is given out by non-IBCLCs.

Comments regarding Insurance/Medicaid Coverage:

- Licensure will allow insurance coverage, making services more affordable and improve breastfeeding success rates;
- Medicaid and private health plans would need to enroll or contract with providers;
- Anticipate shifting distribution of services between provider types, but not an increase in visits or costs;
- Insurance rate of reimbursement is not mandated;
- The Affordable Care Act does not limit reimbursement to lactation consultants;

[16] Tongue tie (ankyloglossia) is a problem affecting some babies with a tight piece of skin between the underside of their tongue and the floor of their mouth (lingual frenulum). It can sometimes affect the baby's feeding, making it hard for them to attach properly to their mother's breast.

- Instead of integrated value-based care, reimbursement specifically for lactation services is moving backwards toward fee-for-service, and will cause higher costs for healthcare and administrative costs;
- Insurance will not cover lactation services without required licensing;
- Medicaid payment will be too low to justify IBCLC licensure and liability insurance; and
- Few families pay out-of-pocket for services because most lactation consultants are billing Medicaid under other licenses or through their employers. Others are given services as a part of their global maternity care.

Comments regarding IBCLC requirements:

- Educational and clinical opportunities to complete IBCLC are limited and it's hard to find someone to shadow for 6-8 months, especially in rural areas;
- Volunteer licensure with a larger variety of lactation training programs would allow others to serve their communities;
- Requiring IBCLC for this licensure monopolizes breastfeeding care and there is no evidence that this is necessary;
- Licensing will allow greater clarity on titles and training requirements for the various types of lactation care providers;
- Licensure requirements do not specify an educational requirement for HIPAA and privacy laws;
- Certification may not be available to all people. We must be sure the certification materials and exams are culturally sensitive and accessible to low-income individuals or those with limited-English proficiency;
- Because licensing only IBCLCs requires the highest level of breastfeeding education and specialization, it will devalue community-based peer support that often has the biggest impact on breastfeeding rates in communities of color;
- Data in the report does not demonstrate that outcomes are better with IBCLCs versus other lactation professionals; and
- Licensure for IBCLC will increase access to care for complex medical issues and does not conflict with La Leche League support.

Comments regarding the draft bill and applicant report:

- The draft bill should include an educational requirement for intimate partner violence and reproductive coercion;
- The bill needs to be very specific so third-party payors will not challenge paying for services;
- The bill should provide credit for experience and a testing-out option for existing providers;
- The report has no data to support that IBCLC licensure will increase access to services rather than decrease them;
- The report does not demonstrate a public health crisis;
- There are other pathways to achieve Medicaid reimbursement;
- Families with serious problems are already referred to higher level professionals; and

- There are concerns that the proposal will create barriers to the practice of lactation consultation and could prohibit staff RNs from providing breastfeeding support and education in the hospital.

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REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act, in RCW 18.120.010, states that a healthcare profession should be regulated or the scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

First Criterion: **Unregulated practice can clearly harm or endanger the health or safety of the public.**

The proposal doesn't meet this criterion. The applicants provided anecdotal incidents or generalized examples of harm that would not rise to the level of requiring state regulation or would not be addressed through the proposal.

Experts agree on the need to increase breastfeeding rates and durations. However, the applicant report did not provide sufficient data to demonstrate that outcomes are better when using IBCLCs over other lactation professionals. Also, it appears that most of this care involves basic assistance with the normal course of breastfeeding, and the applicants acknowledge that the providers without IBCLC certification are qualified to provide this type of care.

Restricting entry into this profession to only the highest level of lactation professionals could further exacerbate any shortage that exists. A stronger argument could be made against the licensing of lactation consultants, which may disproportionately impact rural or underserved communities.

This proposal would not help with the issue of incorrect or conflicting information allegedly being provided by licensed healthcare providers (ARNPs, MDs, etc.) who may not have adequate lactation-specific education. We cannot restrict them from doing what is already in their existing scopes of practice.

Second Criterion: The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

The proposal doesn't meet this criterion. The proposal would not reduce the incidence of most of the problems identified in the applicant report. It would restrict the provision of lactation care and services and use of lactation consultant titles to only those who are licensed. The applicant acknowledges that providers with lower level certifications and training are capable of providing lactation support for the normal course of breastfeeding. They did not provide evidence of a need for IBCLC-level education for all lactation care providers.

A large majority of IBCLCs already hold an underlying RN or RD credential. The public can already expect to receive initial and continuing professional ability from these healthcare professionals. There is already a route to report inadequate care through each profession's

disciplining authority. Healthcare providers should already refer mothers to lactation specialists when necessary.

The only part of this criterion that the proposal may address is the inability of the public to distinguish between the various levels of providers. This would be helpful when lactation support is needed to deal with complex breastfeeding issues that are outside the training of the other unlicensed lactation care providers or licensed providers without lactation-specific training.

Third Criterion: **The public cannot be effectively protected by other, more cost-beneficial means.**

The proposal doesn't meet this criterion. In most cases, it creates a duplicative process for regulation of healthcare providers who are already licensed in Washington as an RN or RD. The proposal would place a significant financial burden on lactation consultants to acquire formal training, pass an examination, and pay state licensing fees without a corresponding increase in public protection. This burden would be even higher in rural and underserved areas where training opportunities do not appear to exist. Providers living in rural areas would have more difficulties and expenses associated with drive time and expense to access training opportunities and mentor hours required for IBCLC licensure.

IBCLC certification is already available for those who wish to show a higher level of education and knowledge, and many healthcare providers already refer patients to IBCLCs for more complex breastfeeding challenges. It appears that many of the challenges cited in the applicant report could be addressed through public outreach to hospitals and healthcare providers on the qualifications of IBCLCs. Much of the literature the applicant provided recommends additional training for pediatricians and nurses so they can more adequately advise mothers on breastfeeding and assist with challenges they encounter.

In addition, there is a less-burdensome alternative to licensure. RCW 18.120.010 requires that when a decision is made to create a new health profession credential, the regulation adopted should be set at the least restrictive level consistent with the public interest to be protected. Voluntary certification by the department may be an option to recognize the higher level education and skills of IBCLCs who are qualified to provide lactation support for complex breastfeeding issues. With voluntary certification, the department grants recognition to lactation consultants meeting certain qualifications, who would be subject to the Uniform Disciplinary Act, chapter 18.130 RCW. Non-certified lactation care providers would still be authorized to perform the same tasks as long as they did not use the protected title of "certified." This alternative may help with insurance reimbursement for lactation care as well.[17]

[17] This is not part of the sunrise criteria but was a major issue identified by the applicant group.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The department recognizes the extensive training of IBCLCs and their value within the healthcare system to help mothers initiate and continue breastfeeding; however, we can't support the proposal to require state licensure of lactation consultants. The applicant has not provided evidence of a need for the state to protect the interests of the public by restricting the provision of lactation care. The proposal doesn't meet the sunrise criteria.

Rationale:

1. The applicant hasn't identified a clear and easily recognizable threat to public health and safety from the unregulated practice of lactation consultation.
2. The proposal may result in unintended harm to particular populations. Limiting the number of healthcare professionals who can provide lactation care may create barriers to access, particularly in rural and underserved areas.
3. The proposal would place the burden of dual state licensure, renewal fees, and education requirements on already licensed healthcare professionals operating within their scopes of practice if they want to continue to call themselves lactation consultants.
4. There are currently processes in place for the public to file complaints against practitioners who provide substandard care or commit unprofessional conduct. Since a majority of IBCLCs already hold RN or RD credentials, licensing of lactation consultants for the purpose of providing oversight and discipline will be a costly and unnecessary duplication of regulation.
5. The proposal would place a significant financial burden on lactation consultants, particularly in rural areas, without a corresponding increase in public protection.

In addition, there are flaws and conflicts in the proposed bill that would make it difficult to implement.

Rationale:

1. Section 6 appears to create exceptions for certain unlicensed lactation care providers, as well as licensed providers performing services within their scopes of practice. However, it conflicts with section 2 which states that no person may provide lactation care without a license.
2. Defining a specific scope of practice for lactation care and services may create challenges for other licensed providers, such as midwives, whose scopes of practice don't explicitly include lactation care. These providers routinely provide this care.
3. It is unclear what role is intended for the advisory committee.

Alternative to Consider

The department offers an alternative to the proposal that would recognize the higher level education and skills of IBCLs and may help them to receive insurance reimbursement for services.[18] Voluntary certification by the department would be a less-burdensome option by granting recognition to lactation consultants who have met certain qualifications and would be qualified to provide lactation support to deal with complex breastfeeding issues that are outside

[18] Insurance reimbursement is not part of the sunrise criteria but was a major obstacle identified by the applicants.

the training of lactation care providers who lack lactation-specific training. Non-certified providers may perform the same tasks, but may not use “certified” in the title.

REBUTTALS TO DRAFT RECOMMENDATIONS

The department shared a draft report with interested parties September 8, 2016, and invited rebuttal comments. We received two letters of rebuttal and have summarized them below along with our responses.

Applicant Rebuttal

The applicant group responded that they were disappointed with the findings in the report and remain convinced that licensure of lactation consultants using IBCLC standards is the best option for mothers and babies in Washington.

They provided the following specific rebuttals to each of the sunrise criteria:

Rebuttal - First criterion that unregulated practice can clearly harm or endanger the health or safety of the public.

The applicants disagree with the department's position that they only provided anecdotal incidents or generalized examples of harm that would not rise to the level of requiring state regulation or would not be addressed in the proposal.

The applicants cited key findings from an article in *Maternal and Child Nutrition* that show substantial impacts of suboptimal breastfeeding on maternal and pediatric health outcomes and costs. This article suggests that women's health providers require training in lactation support and management as part of preventative health for women.

Department Response: The department did not make changes to the report in response to this comment. Like the other sources the cited in the original applicant report, this article does not address outcomes related to using IBCLCs over other lactation care professionals. The department still finds that the applicants have not provided evidence of harm that would rise to the level of requiring state licensure or that would be addressed through the proposal.

Rebuttal - Second criterion that the public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

The applicant rebuttals disagreed with the department that the proposal would not reduce the incidence of most of the problems identified in the applicant report. They stated that IBCLCs are recommended and found effective to sustain breastfeeding intensity and duration and that there is no other lactation provider group that has evidence that their level of training produces these results.

The applicants also disagreed with the department's assessment that there is already a route to report inadequate care through professional disciplining authorities because most IBCLCs are already credentialed as RNs or RDs. They stated that individuals with only basic lactation care are unaware of how little they know and may not refer mothers for higher level care. Mothers are unaware of the qualifications of IBCLCs to help them overcome breastfeeding problems and don't seek assistance, resulting in the harm of premature weaning and potential acute threats to mother or infant.

Department Response:
The department did not make changes to the report in response to this comment. The department recognizes the extensive training of IBCLCs and their value within the

healthcare system to help mothers initiate and continue breastfeeding. However, the department's position has not changed with these additional comments. The applicants still have not provided evidence of a need for IBCLC-level education for all lactation care providers.

Rebuttal - Third criterion that the public cannot be effectively protected by other, more cost-beneficial means.

The applicant rebuttals state that the department failed to recognize the IBCLC as a separate profession and that only three percent of all nurses have lactation qualifications. They also stated that the only difference between the department's alternative of voluntary certification and their proposal is that the qualifications are defined in the proposal but not in the alternative option. They stated this is the only difference.

Department Response:

In response to these comments, the department revised the explanations of voluntary certification on pages 13-15. We clarified that voluntary state certification would recognize the higher level education and skills of IBCLs who are qualified to provide lactation support to deal with complex breastfeeding issues but would not require the credential for all providers who provide lactation care or who use the term lactation consultant. The major differences between the proposal and the department's alternative are that voluntary certification would not require a credential, would not protect a scope of practice for lactation consultation and there would not be a need for an advisory committee.

In addition, after further review of the voluntary certification option, the department removed the language that recommended evaluation of the qualifications for certification to determine what additional programs may be sufficient. We determined that the applicants provided sufficient evidence to recommend IBCLC-level education and training as the minimum qualifications as long as the state credential is voluntary.

Rebuttal from Melissa Slovek Bonghi, RN, IBCLC

Ms. Slovek also provided the specific rebuttals to each of the sunrise criteria:

Rebuttal - First criterion that unregulated practice can clearly harm or endanger the health or safety of the public.

Ms. Slovek stated that she sensed that proof of harm to the public will always fall short of the department's expectations. She discussed the midwives' concerns that the proposal may restrict their scope of practice, stating that is not the intent of the proposal. She added that we all agree the harm of early weaning and that all the causes would not be resolved by licensing lactation professionals, but that she hopes to ameliorate the problem by creating an additional type of healthcare provider to provide clinical lactation care.

Department Response:

The department did not make changes to the report in response to this comment. Chapter 18.120 RCW requires the department to review proposals to regulate new health professions according to specific criteria, which includes this criterion. The department

finds that the applicants have not provided evidence of harm that would rise to the level of requiring state licensure or that would be addressed through the proposal.

Rebuttal - Second criterion that the public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

Ms. Slovek stated that it has been demonstrated that many current healthcare providers have limited training and experience in addressing breastfeeding problems. She added that there have been recommendations in place for over a decade to address this lack of training with very little change occurring. She discussed the costs of lactation consultation between lactation consultants and other providers like MDs and ARNPs. She stated that licensure will not resolve this issue, but can expand the choice of the type of provider and assure the public a specific level of knowledge and training.

Department Response:

The department did not make changes to the report in response to this comment. Voluntary certification would provide this choice without making it a requirement. The applicants have not provided evidence of a need for IBCLC-level education for all lactation care providers.

Rebuttal - Third criterion that the public cannot be effectively protected by other, more cost-beneficial means.

Ms. Slovek commented that everyone is concerned about the costs related to the establishment of a new board and administration of a new license but states she has not been given evidence from the department on what these costs would be. She added that some collaboration between health professions seems possible to reduce costs and that certification would not meet the goals of the applicant group.

Department Response:

The department did not make changes to the report in response to this comment. A majority of the costs the department expressed concerns about in this criterion were focused on formal training and the IBCLC examination being required of everyone who practices lactation consultation. However, in response to this request for more information, the costs of establishing a new healthcare credential would include rulemaking to establish licensure requirements; development of paper and online applications and other forms; recruiting and training members of a new advisory committee; member pay, per diem, and travel costs for holding committee meetings; program administration, ongoing credentialing costs; and ongoing costs to process and investigate complaints against licensees. Many of these costs remain, but may be less costly, under a voluntary certification.

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Appendix A

Request from Legislature and Draft Bill

STATE REPRESENTATIVE
34th DISTRICT
EILEEN CODY, R.N.

State of
Washington
House of
Representatives

HEALTH & WELLNESS
CHAIR
HEALTH & HUMAN SERVICES
APPROPRIATIONS
WAYS & MEANS

April 28, 2016

John Wiesman, Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Wiesman,

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would create a new licensed profession: Licensed Lactation Consultants.

A copy of the proposal (H-4795.1/16) is attached and my office can provide you with an electronic copy. The House Health Care and Wellness Committee would be interested in an assessment of whether the proposal meets the sunrise criteria for creating a new regulated health profession in Washington. The proponent for this proposal is the Washington Lactation Consultants Licensure Collaborative (contact: Kim Rechner—KimRechnerRN@gmail.com; 360-480-2319).

I appreciate your consideration of this application and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

Eileen L Cody

EILEEN CODY, Chair
House Health Care and Wellness Committee

Cc: Tim Farrell, Washington State Department of Health
Kim Rechner, Washington Lactation Consultants Licensure Collaborative
Jim Morishima, Office of Program Research

LEGISLATIVE OFFICE: JOHN L. O'BRIEN BUILDING, PO BOX 40600, OLYMPIA, WA 98504-0600 • 360-786-7978
E-MAIL: cody.eileen@leg.wa.gov
TOLL-FREE LEGISLATIVE HOTLINE: 1-800-562-6000 • TDD: 1-800-635-9993

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-4795.1/16

ATTY/TYPIST: KS:akl

BRIEF DESCRIPTION: Concerning lactation consultants.

AN ACT Relating to lactation consultants; amending RCW 18.120.020 and 18.130.040; adding a new chapter to Title 18 RCW; creating new sections; prescribing penalties; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Department" means the department of health.

(2) "Lactation care and services" means the clinical application of scientific principles and a multidisciplinary body of evidence for evaluation, problem identification, treatment, education, and consultation to provide lactation care and services to childbearing families.

(3) "Lactation consultant" means a person licensed under this chapter to provide lactation care and services.

(4) "Secretary" means the secretary of health.

NEW SECTION. **Sec. 2.** No person may provide lactation care and services or represent himself or herself as a lactation consultant, licensed lactation consultant, or registered lactation consultant unless he or she is licensed under this chapter.

NEW SECTION. **Sec. 3.** (1) The secretary shall issue a lactation consultant's license to any person who meets the following qualifications:

(a)(i) Board certification by a secretary-approved national or international certifying organization that, at a minimum, requires the following for board certification:

(A) Ninety hours of lactation-specific education;

(B) Twenty-four college-level academic credits in health professional courses; and

(C) At least three hundred hours of clinical practice; or

(ii) Equivalent education and experience approved by the secretary;

(b) Passage of an examination approved by the secretary;

(c) Good moral character;

(d) The physical and mental capability to safely provide lactation care and services;

(e) Submission of application on a form provided by the department; and

(f) Payment of an application fee as determined by the secretary under RCW 43.70.110 and 43.70.250.

(2)(a) The secretary shall adopt rules specifying the requirements for renewal of a lactation consultant's license, including, but not limited to:

(i) Reasonably appropriate evidence of competency, as long as such requirements are uniform as to application, are reasonably related to the measurement of qualification, performance, or competence, and are desirable and necessary for the protection of public health; and

(ii) Continuing education requirements consistent with the requirements of the certifying organization approved under subsection (1)(a)(i) of this section. The rules must allow an applicant to successfully complete a criterion-referenced examination approved by the secretary in lieu of the continuing education requirements.

(b) The secretary shall establish administrative procedures, administrative requirements, and fees for renewal or late renewal as provided in RCW 43.70.250 and 43.70.280.

NEW SECTION. **Sec. 4.** An applicant holding a license in another state may be licensed as a lactation consultant in this state without examination if the secretary determines that the other state's

licensing standards are substantially equivalent to the standards in this state.

NEW SECTION. **Sec. 5.** A lactation consultant licensed under this chapter may perform lactation care and services, including, but not limited to:

(1) Lactation assessment through the systematic collection of subjective and objective data;

(2) Analysis of data and creation of a plan of care;

(3) Implementation of a lactation care plan with demonstration and instruction to parents and communication to the primary health care provider;

(4) Evaluation of outcomes;

(5) Provision of lactation education to parents and health care providers;

(6) The recommendation and use of assistive devices; and

(7) Other lactation care and services authorized in rule by the secretary.

NEW SECTION. **Sec. 6.** (1) Except as provided in subsection (2) of this section, nothing in this chapter prohibits:

(a) A person licensed under this title performing services within his or her scope of practice;

(b) A person performing functions in the discharge of official duties on behalf of the United States government, including, but not limited to, the armed forces, the coast guard, public health service, veterans' bureau, or bureau of Indian affairs;

(c) A person acting as a paid or volunteer peer counselor, la leche league leader, doula, or childbirth educator;

(d) A person providing lactation care and services provided through the federal special supplemental nutrition program for women, infants, and children; or

(e) The practice of lactation care and services by students, interns, or persons preparing for the practice of lactation care and services under the qualified supervision of a lactation consultant or any licensed professional.

(2) A person providing lactation care and services under subsection (1) of this section may not represent himself or herself as a lactation consultant, licensed lactation consultant, or registered lactation consultant.

NEW SECTION. **Sec. 7.** (1) The lactation consultant advisory committee is created, consisting of five members appointed by the secretary. The members of the committee must be residents of this state. Three of the committee members must be board certified by the organization approved by the secretary under section 3(1)(a)(i) of this act. The remaining two members must be members of the public at large who are unaffiliated, directly or indirectly, with lactation consultants. Initial members of the committee must serve staggered terms as follows: One member appointed for a term of one year, two members appointed for a term of two years, and two members appointed for a term of three years. Subsequent members are appointed for a term of three years.

(2) The secretary may remove any member of the committee for cause as provided by rule. In case of a vacancy, the secretary shall appoint a person to serve for the remainder of the unexpired term.

(3) The advisory committee must meet at the times and places designated by the secretary and must hold meetings during the year as necessary to provide advice to the secretary. The committee may elect a chair and a vice chair. A majority of the members currently serving constitutes a quorum.

(4) Each member of the advisory committee must be reimbursed for travel expenses as authorized in RCW 43.03.050 and 43.03.060.

(5) The secretary, members of the advisory committee, and individuals acting on their behalf are immune from suit in any action, civil or criminal, based on any credentialing proceedings, disciplinary proceedings, or other official acts performed in the course of their duties.

NEW SECTION. **Sec. 8.** An applicant with military training or experience satisfies the training or experience requirements of this chapter unless the secretary determines that the military training or experience is not substantially equivalent to the standards of this state.

NEW SECTION. **Sec. 9.** The uniform disciplinary act, chapter 18.130 RCW, governs the issuance and denials of credentials, unauthorized practice, and the discipline of persons credentialed under this chapter. The secretary is the disciplining authority under this chapter.

Sec. 10. RCW 18.120.020 and 2016 c 41 s 17 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant group" includes any health professional group or organization, any individual, or any other interested party which proposes that any health professional group not presently regulated be regulated or which proposes to substantially increase the scope of practice of the profession.

(2) "Certificate" and "certification" mean a voluntary process by which a statutory regulatory entity grants recognition to an individual who (a) has met certain prerequisite qualifications specified by that regulatory entity, and (b) may assume or use "certified" in the title or designation to perform prescribed health professional tasks.

(3) "Grandfather clause" means a provision in a regulatory statute applicable to practitioners actively engaged in the regulated health profession prior to the effective date of the regulatory statute which exempts the practitioners from meeting the prerequisite qualifications set forth in the regulatory statute to perform prescribed occupational tasks.

(4) "Health professions" means and includes the following health and health-related licensed or regulated professions and occupations: Podiatric medicine and surgery under chapter 18.22 RCW; chiropractic under chapter 18.25 RCW; dental hygiene under chapter 18.29 RCW; dentistry under chapter 18.32 RCW; denturism under chapter 18.30 RCW; dental anesthesia assistants under chapter 18.350 RCW; dispensing opticians under chapter 18.34 RCW; hearing instruments under chapter 18.35 RCW; naturopaths under chapter 18.36A RCW; embalming and funeral directing under chapter 18.39 RCW; midwifery under chapter 18.50 RCW; nursing home administration under chapter 18.52 RCW; optometry under chapters 18.53 and 18.54 RCW; ocularists under chapter 18.55 RCW; osteopathic medicine and surgery under chapters 18.57 and 18.57A RCW; pharmacy under chapters 18.64 and 18.64A RCW; medicine under chapters 18.71 and 18.71A RCW; emergency medicine under chapter 18.73 RCW; physical therapy under chapter 18.74 RCW; practical nurses under chapter 18.79 RCW; psychologists under chapter 18.83 RCW; registered nurses under chapter 18.79 RCW; occupational therapists licensed under chapter 18.59 RCW; respiratory care practitioners licensed under chapter 18.89 RCW; veterinarians and

veterinary technicians under chapter 18.92 RCW; massage therapists under chapter 18.108 RCW; East Asian medicine practitioners licensed under chapter 18.06 RCW; persons registered under chapter 18.19 RCW; persons licensed as mental health counselors, marriage and family therapists, and social workers under chapter 18.225 RCW; dietitians and nutritionists certified by chapter 18.138 RCW; radiologic technicians under chapter 18.84 RCW; nursing assistants registered or certified under chapter 18.88A RCW; reflexologists certified under chapter 18.108 RCW; medical assistants-certified, medical assistants-hemodialysis technician, medical assistants-phlebotomist, and medical assistants-registered certified and registered under chapter 18.360 RCW; and licensed behavior analysts, licensed assistant behavior analysts, ((~~and~~)) certified behavior technicians under chapter 18.380 RCW; and lactation consultants licensed under chapter 18.--- RCW (the new chapter created in section 14 of this act).

(5) "Inspection" means the periodic examination of practitioners by a state agency in order to ascertain whether the practitioners' occupation is being carried out in a fashion consistent with the public health, safety, and welfare.

(6) "Legislative committees of reference" means the standing legislative committees designated by the respective rules committees of the senate and house of representatives to consider proposed legislation to regulate health professions not previously regulated.

(7) "License," "licensing," and "licensure" mean permission to engage in a health profession which would otherwise be unlawful in the state in the absence of the permission. A license is granted to those individuals who meet prerequisite qualifications to perform prescribed health professional tasks and for the use of a particular title.

(8) "Professional license" means an individual, nontransferable authorization to carry on a health activity based on qualifications which include: (a) Graduation from an accredited or approved program, and (b) acceptable performance on a qualifying examination or series of examinations.

(9) "Practitioner" means an individual who (a) has achieved knowledge and skill by practice, and (b) is actively engaged in a specified health profession.

(10) "Public member" means an individual who is not, and never was, a member of the health profession being regulated or the spouse of a member, or an individual who does not have and never has had a

material financial interest in either the rendering of the health professional service being regulated or an activity directly related to the profession being regulated.

(11) "Registration" means the formal notification which, prior to rendering services, a practitioner shall submit to a state agency setting forth the name and address of the practitioner; the location, nature and operation of the health activity to be practiced; and, if required by the regulatory entity, a description of the service to be provided.

(12) "Regulatory entity" means any board, commission, agency, division, or other unit or subunit of state government which regulates one or more professions, occupations, industries, businesses, or other endeavors in this state.

(13) "State agency" includes every state office, department, board, commission, regulatory entity, and agency of the state, and, where provided by law, programs and activities involving less than the full responsibility of a state agency.

Sec. 11. RCW 18.130.040 and 2016 c 41 s 18 are each amended to read as follows:

(1) This chapter applies only to the secretary and the boards and commissions having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter does not apply to any business or profession not licensed under the chapters specified in this section.

(2)(a) The secretary has authority under this chapter in relation to the following professions:

(i) Dispensing opticians licensed and designated apprentices under chapter 18.34 RCW;

(ii) Midwives licensed under chapter 18.50 RCW;

(iii) Ocularists licensed under chapter 18.55 RCW;

(iv) Massage therapists and businesses licensed under chapter 18.108 RCW;

(v) Dental hygienists licensed under chapter 18.29 RCW;

(vi) East Asian medicine practitioners licensed under chapter 18.06 RCW;

(vii) Radiologic technologists certified and X-ray technicians registered under chapter 18.84 RCW;

(viii) Respiratory care practitioners licensed under chapter 18.89 RCW;

(ix) Hypnotherapists and agency affiliated counselors registered and advisors and counselors certified under chapter 18.19 RCW;

(x) Persons licensed as mental health counselors, mental health counselor associates, marriage and family therapists, marriage and family therapist associates, social workers, social work associates—advanced, and social work associates—independent clinical under chapter 18.225 RCW;

(xi) Persons registered as nursing pool operators under chapter 18.52C RCW;

(xii) Nursing assistants registered or certified or medication assistants endorsed under chapter 18.88A RCW;

(xiii) Dietitians and nutritionists certified under chapter 18.138 RCW;

(xiv) Chemical dependency professionals and chemical dependency professional trainees certified under chapter 18.205 RCW;

(xv) Sex offender treatment providers and certified affiliate sex offender treatment providers certified under chapter 18.155 RCW;

(xvi) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205;

(xvii) Orthotists and prosthetists licensed under chapter 18.200 RCW;

(xviii) Surgical technologists registered under chapter 18.215 RCW;

(xix) Recreational therapists under chapter 18.230 RCW;

(xx) Animal massage therapists certified under chapter 18.240 RCW;

(xxi) Athletic trainers licensed under chapter 18.250 RCW;

(xxii) Home care aides certified under chapter 18.88B RCW;

(xxiii) Genetic counselors licensed under chapter 18.290 RCW;

(xxiv) Reflexologists certified under chapter 18.108 RCW;

(xxv) Medical assistants-certified, medical assistants-hemodialysis technician, medical assistants-phlebotomist, and medical assistants-registered certified and registered under chapter 18.360 RCW; ((~~and~~))

(xxvi) Behavior analysts, assistant behavior analysts, and behavior technicians under chapter 18.380 RCW; and

(xxvii) Lactation consultants licensed under chapter 18.--- RCW (the new chapter created in section 14 of this act).

(b) The boards and commissions having authority under this chapter are as follows:

(i) The podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic quality assurance commission as established in chapter 18.25 RCW;

(iii) The dental quality assurance commission as established in chapter 18.32 RCW governing licenses issued under chapter 18.32 RCW, licenses and registrations issued under chapter 18.260 RCW, and certifications issued under chapter 18.350 RCW;

(iv) The board of hearing and speech as established in chapter 18.35 RCW;

(v) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vi) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

(vii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapters 18.57 and 18.57A RCW;

(viii) The pharmacy quality assurance commission as established in chapter 18.64 RCW governing licenses issued under chapters 18.64 and 18.64A RCW;

(ix) The medical quality assurance commission as established in chapter 18.71 RCW governing licenses and registrations issued under chapters 18.71 and 18.71A RCW;

(x) The board of physical therapy as established in chapter 18.74 RCW;

(xi) The board of occupational therapy practice as established in chapter 18.59 RCW;

(xii) The nursing care quality assurance commission as established in chapter 18.79 RCW governing licenses and registrations issued under that chapter;

(xiii) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW;

(xiv) The veterinary board of governors as established in chapter 18.92 RCW;

(xv) The board of naturopathy established in chapter 18.36A RCW; and

(xvi) The board of denturists established in chapter 18.30 RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny

licenses. The disciplining authority may also grant a license subject to conditions.

(4) All disciplining authorities shall adopt procedures to ensure substantially consistent application of this chapter, the uniform disciplinary act, among the disciplining authorities listed in subsection (2) of this section.

NEW SECTION. **Sec. 12.** The secretary of health may adopt any rules necessary to implement this act.

NEW SECTION. **Sec. 13.** This act may be known and cited as the lactation consultant practice act.

NEW SECTION. **Sec. 14.** Sections 1 through 9 of this act constitute a new chapter in Title 18 RCW.

NEW SECTION. **Sec. 15.** Sections 1 through 11 of this act take effect January 1, 2019.

--- END ---

Appendix B

Applicant Report and Follow Up

A Sunrise Review: licensing lactation consultants

Applicant Report Outline/Instructions
Proposal to Regulate a New Health Profession

Proposals to regulate a health profession shall have the exclusive purpose of protecting the public interest. Applicants must demonstrate (RCW 18.120.010(2)):

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

Evidence and Data

- Provide quantitative evidence, if available, from studies or other sources (with citations) to support your assertions.
- Provide enough detail to fully support your claims.
- Provide citations to specific portions of educational curricula, rather than attaching entire curricula.

The outline and instructions on the following pages will assist you in preparing your applicant report.

A Sunrise Review: licensing lactation consultants

Draft Legislation Bill REQ. # H-4795.1/16

- Profession seeking licensure:
  - "Lactation Consultants" in the bill called "Lactation Consultant Practice Act".
- Approximate number of individuals practicing in Washington:
  - About 500 currently board certified as an International Board Certified Lactation Consultant (IBCLC).

- Organization name / contact person: Washington Lactation Consultants Licensure Collaborative/ Kim Rechner
- Number of members in the organization: 20

- Name(s) and address of national organization(s) with which the state organization is affiliated:
  - United States Lactation Consultant Association (USLCA)
    - Marsha Walker, RN, IBCLC
      Public Policy Director
      4410 Massachusetts Ave. NW, #406
      Washington, DC 20016
      Telephone: 1-800-729-2776
      Fax: (919) 459-2075
      E-mail: marshalact@gmail.com
  - International Board of Lactation Consultant Examiners Serving North America
    - Elizabeth Stehel, MD, FAAP, IBCLC Chair
      6402 Arlington Blvd, Suite 350
      Falls Church, VA 22042 USA
      Phone: 703-560-7330
      Fax: 703-560-7332
      Email: iblce@iblce.org

- Name(s) of other state or national organizations representing the profession:
  - There is no affiliated state organization.

A Sunrise Review: licensing lactation consultants

- List the states that regulate this profession:
    - Rhode Island- bill passed July 2014; Pennsylvania- bill sent to sunrise review; Georgia- bill passed 2016, Minnesota- bill introduced, New Jersey- bill introduced, New York- bill introduced

Factors to Address

Address the following (RCW 18.120.030):

(1) A definition of the problem and why regulation is necessary:

Regulation is necessary because of the potential harm to the public in the extent to which there is a threat to public health and safety. Harm comes from short breastfeeding duration rates when mothers do not have access to proper lactation care to overcome breastfeeding problems. Shorter duration of breastfeeding negatively impacts the lifelong health of the mother and infant. Harm also comes when mothers receive inaccurate information from other health professionals who have lactation education but are not board certified.

Incorrect and conflicting information given to mothers and families can result in premature discontinuation of breastfeeding, unnecessary maternal pain and discomfort, and poor infant outcomes. Currently in the U.S. there are 14 different lactation titles and certifications. Only one of these, the IBCLC, requires a certification including supervised clinical hours, college course requirements and an exam. In Washington State anyone can use the title "lactation consultant". For example when a person providing breastfeeding consultation uses the title "Lactation Consultant" the mother does not know if she's receiving care from a possibly unqualified individual who may not have the knowledge and skills required to assist her with the problem and may do harm.

For the infant improper breastfeeding management can result in risks such as dehydration, hyperbilirubinemia, weight loss, allergic reactions to cow's milk or soy based formulas, failure to thrive, premature discontinuation of breastfeeding, child abuse and even death.

For the mother poor breastfeeding management can result in painful breast engorgement, plugged milk ducts, mastitis, breast abscess, nipple trauma, bacterial and candida infections, increased postpartum depression, and early weaning.

For insurers, hospitals, employers, families with these negative outcomes lead to increased health care costs and hospital readmissions.

Premature discontinuation of breastfeeding exposes infants to increased health risks is well documented high quality medical literature. While not every mother will choose to breastfeed, it is important that qualified assistance be readily available and identifiable so that women desiring to breastfeed have access to the proper level of care that they require.

(a) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession;

The primary benefit of regulation would be assuring an identifiable, interdisciplinary health professional workforce providing all segments of the population access to qualified health care professionals who can deliver appropriate health care services. Regulation assures persons delivering lactation care and services have been trained, undergone an accredited examination, and conform to standards designed for patient safety, and a code of ethics.

The availability of trained lactation consultants results in positive health outcomes including, but not limited to, an increased duration of breastfeeding. The relationship between qualified lactation care and improved breastfeeding outcomes has been demonstrated by numerous studies and meta-analyses. Research shows when IBCLCs provide care, it has a positive effect on breastfeeding success ***(Appendix 2&3).***

In our state there is a critical shortage of outpatient lactation services provided by qualified lactation professionals. The Surgeon General's Call to Action recommends 8.6 IBCLCs per 1,000 births to ensure adequate long term breastfeeding rates. Currently, our state has 5.65 IBCLCs per 1000 live births, falling short of the national recommendation. Licensure will provide an avenue for insurance reimbursement for IBCLCs, increasing the public's access to this much needed lactation support. This will also provide incentive for hospitals and independent IBCLCs to provide evidence-based services to breastfeeding families.

(b) The extent of autonomy a practitioner has, as indicated by:

(i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and

Clinical lactation services are provided by lactation consultants. This refers to the clinical application of evidence-based practices for evaluation, problem identification, treatment, education, and consultation in providing lactation care and services to childbearing families.

Clinical lactation services include one or more of the following activities: lactation assessment through the systematic collection of data and information which may include maternal and infant health history, social history, physical assessment, observation of feeding and milk production; analysis of collected information; creation of lactation care plans; implementation of lactation care plans, including but not limited to providing demonstration and instruction to parents and recommending the use of assistive devices when appropriate.

Medical documentation and record keeping, communication with the primary health care provider and evaluation of outcomes.

(a) The extent to which practitioners are or would be supervised;

Lactation consultants would be able to work autonomously and independently in hospitals, physician practices, public health agencies, community healthcare, private practice and other settings with the requirement to report to the primary care physician.

(2) The efforts made to address the problem:

(a) Voluntary efforts, if any, by members of the health profession to establish a code of ethics;

Currently lactation consultants certified by IBLCE (or licensed as IBCLC) must adhere to professional standards including Code of Conduct, standards of Practice, and Disciplinary Procedures.
The IBCLC Professional Standards can be found at:
http://iblce.org/resources/professional-standards/

This document contains detailed information regarding skills and functions performed by IBCLC professionals, professional obligations and sanctions, and testing of knowledge. The Standards include:

- IBLCE Exam Blueprint
- Clinical Competencies for IBCLC Practice
- Code of Conduct for IBCLCs
- IBLCE Disciplinary Procedures
- Scope of Practice
- Standards of Practice

(b) Help resolve disputes between health practitioners and consumers; and recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem;

Currently there are Disciplinary Procedures for any IBCLC by the International Board of Lactation Consultant Examiners. Health practitioners and the public can report complaints against a lactation consultant. These procedures can be found at:
http://iblce.org/resources/disciplinary-procedures/

(3) The alternatives considered:

(a) Regulation of business employers or practitioners rather than employee practitioners;

The Affordable Care Act (ACA) requires insurance plans to cover certain preventive services (including breastfeeding support, supplies, and counseling) without any cost-sharing. The ACA does not prescribe who should provide these services; however, Medicaid regulations prohibit unlicensed providers. Additionally, most private insurance companies require state licensure as the standard for provider credentialing and reimbursement. This eliminates IBCLCs who do not hold another license (ARNP, or MD) from getting third party reimbursement for their services. Families must pay out of pocket for lactation services and many cannot afford to do so. This creates disparity a large in care for many middle income families and most low income families. .

(b) Regulation of the program or service rather than the individual practitioners;

The International Board of Lactation Consultant Examiners (IBCLE) determines the education and clinical experience prerequisites, and examination of IBCLCs. We suggest DOH use this existing credential of IBCLCs. This allows IBCLE to continue to oversee all of the requirements and testing of IBCLCs. IBCLE investigates practice and ethics violations of those using the IBCLC title and implements sanctions. See Disciplinary Procedures at: http://iblce.org/wp-content/uploads/2013/08/disciplinary-procedures.pdf

(c) Registration of all practitioners; See above.

The IBLCE maintains a registry of International Board Certified Lactation Consultants on their website, which is accessible to the public, for verification of certification. The registry can be searched under by zip code, name or IBCLC certification number. The registry webpage at: http://www.ilca.org/why-ibclc/falc

(d) Certification of all practitioners;

Appendix 1 lists a variety of training programs and certificates that are designed to equip individuals with knowledge to provide basic lactation support for the normal course of breastfeeding. The primary outcome of these programs is to provide prenatal education and postnatal support in the absence of breastfeeding challenges. Breastfeeding problems beyond the skill level of these providers are referred to the IBCLC. In most cases, non-IBCLC lactation support providers are meant to be supervised by IBCLCs. Despite the vast differences in training, any of these individuals can currently call themselves a "lactation consultant".

(e) Other alternatives;

Providing lactation services is within the scope of practice for a number of licensed healthcare professionals such as midwives, physicians, nurses, and others. However, lactation management training is not in the standard curriculum for these practitioners. For example, only 3% of all nurses report having any lactation training. A minority of the licensed practitioners, have pursued education in breastfeeding and human lactation, but most of these practitioners do not offer lactation services.

(f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest;

As stated above, licensed primary care providers have the health science and medical knowledge, but they lack specific in depth training in breastfeeding management. Breastfeeding coursework is not required in medical nor nursing schools.

(g) Why licensing would serve to protect the public interest;

Families looking for a lactation consultant do not know the difference in the education and skill level of the various lactation support personnel cited in section 3(d). There is also no recourse for negative outcomes from poor service for those who are not IBCLC certified but claim to be a lactation consultant. State licensing will help to protect the public health and safety by creating the ability to distinguish the IBCLC as a clinical lactation service provider. This will also enable insurance reimbursement so families can afford this essential preventive care.

Market forces potentially will enable increased access to qualified lactation professionals.

(4) The benefit to the public if regulation is granted:

Regulating IBCLCs would assure persons delivering lactation care and services receive standard training, an accredited examination, and conform to standards that are evidence based and designed for patient safety.

The primary benefit of regulation would be assurance of an identifiable, interdisciplinary health professional workforce that provides access to qualified lactation services to all segments of the population. Regulating lactation professionals will also provide an avenue for third party reimbursement for lactation support provided by IBCLCs. Currently there is a critical shortage of outpatient lactation services provided by qualified lactation professionals. This shortage of qualified lactation providers leads to a shorter duration of breastfeeding and increased healthcare costs for mothers, infants and increased societal

costs[1]. Insurance reimbursement will increase the public's access to needed evidence based lactation support.

(a) The extent to which the public can be confident that qualified practitioners are competent:

Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections;
There are economies of scale that would be beneficial if the Department of Health (DOH) would combine the lactation consultant advisory committee with another committee. We would also like DOH to consider using the Scope of Practice for International Board Certified Lactation Consultant (IBCLC) *published* by the International Board of Lactation Consultant Examiners, as a guideline for the licensed lactation consultant's scope of practice in our state. Should this not be feasible, we have included recommendations for a board in our draft bill Section 8 quoted below.

Sec. 8. (1) The lactation consultant advisory committee is created, consisting of five members appointed by the secretary. The members of the committee must be residents of this state. Three of the committee members must be board certified by the organization approved by the secretary under section 4(1)(a)(i) of this act. The remaining two members must be members of the public at large who are unaffiliated directly or indirectly with lactation consultants. Initial members of the committee must serve staggered terms as follows: one member appointed for a term of one year, two members appointed to a term of two years, and two members appointed to a term of three years. Subsequent members will serve terms of three years.

(2) The secretary may remove any member of the committee for cause as specified by rule. In case of a vacancy, the secretary shall appoint a person to serve for the remainder of the unexpired term.

(3) The advisory committee must meet at the times and places designated by the secretary and must hold meetings during the year as necessary to provide advice to the secretary. The committee may elect a chair and a vice chair. A majority of the members currently serving constitutes a quorum.

(4) Each member of the advisory committee must be reimbursed for travel expenses as authorized in RCW 43.03.050 and 43.03.060. Members

[1] Information accessed at: http://www.ers.usda.gov/media/329098/fanrr13_1_.pdf

of the committee must be compensated in accordance with RCW 43.03.240 when engaged in the authorized business of the committee.

(5) The secretary, members of the advisory committee and individuals acting on their behalf are immune from suit in any action, civil or criminal, based on any credentialing proceedings, disciplinary proceedings, or other official acts performed in the course of their duties.

(b) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date;

We proposed the following in the draft bill: Page 4 section 9:

Section 9. An applicant with military training or experience satisfies the training or experience requirements of this chapter unless the secretary determines that the military training or experience is not substantially equivalent to the standards of this state.

This could potentially be removed from the bill and would require everyone to obtain an IBCLC prior to state licensure. We are recommending that all applicants meet and pass the IBCLC certification exam prior to applying for licensure in Washington State and continue to be IBCLCs in good standing in order to keep their Washington license.

(c) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions;

The standards we are proposing are similar to Rhode Island, one of the two states that have implemented "rules and regulations for licensing of lactation consultants".

(d) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions;

The IBCLC is an internationally recognized credential. Anyone holding this credential in another state may be entitled to reciprocity. We proposed in the draft bill page 3 sections 5:

Section 5. An applicant holding a license in another state may be licensed as a lactation consultant in this state without examination if the secretary determines that the other state's licensing standards are substantially equivalent to the standard in this state.

(e) The nature and duration of any training including, but not limited to:

(i) Whether the training includes a substantial amount of supervised field experience; Include options for this.

There are three pathways to eligibility for the IBCLC certification examination. These pathways require candidates to meet criteria for education and clinical experience. To review the pathways see IBCLC Pathways.

Supervised field and other experience can be gained through paid or volunteer hours in a number of settings. These include: WIC clinics, La Leche League Leadership, hospitals, and outpatient settings.

(ii) Whether training programs exist in this state;

There numerous options to obtain the required hours of didactic lactation-specific education. Options include face-to-face training and courses in our state and in other states, as well as online courses.

Required health-related college level academic courses are available at most colleges or state and private institutions of higher learning.

(iii) If there will be an experience requirement;

We believe the clinical experience requirement as proscribed in the pre-requisites for the IBCLC examination is *essential* training for a clinical lactation care provider and a licensed practitioner.

(iv) Whether the experience must be acquired under a registered, certificated, or licensed practitioner;

Clinical experience hours must be completed as supervised under Pathway 1 or directly supervision by an IBCLC for Pathways 2 and 3.

(v) Whether there are alternative routes of entry or methods of meeting the prerequisite qualifications;

There are 3 Pathways for to becoming an IBCLC.

a. All pathways require the same didactic education which includes 90 hours of lactation-specific education, 8 college level health professional academic courses, and 6 health related continuing education courses. Depending on the candidate's pre-existing preparation they must have clinical experience:

b. Pathways 1 for "Recognized Health Professions" require 1000 hours of supervision working in a healthcare setting or as an accredited volunteer breastfeeding counselor.

c. Pathways 2 and 3 from IBLCE require 300 and 500 directly supervised hours respectively. The IBLCE definition of "directly supervised" requires the supervisor to be an IBCLC who is nearby and able to step in to assist. The process involves gaining experience first through observation of the IBCLC which is not counted as directly supervised hours. Only after an observation period does the aspiring IBCLC graduate to practicing with the mentor nearby. Those hours are counted as directly supervised hours.

(vi) If an examination is required, by whom it will be developed and how the costs of development will be met.

The examination has existed since 1985 and is administered by the International Board of Lactation Consultant Examiners serving North America twice a year. The legislation also ties licensure to the attainment of the IBCLC credential eliminating the need for an additional licensing examination to be administered by Washington, and significantly reducing the cost of providing licensure.

(vii) What additional training programs are anticipated to be necessary to assure training accessible statewide?

The college-level academic courses needed for entering health care professions that are required by IBCLCs can be obtained through most post-secondary education institutions. These courses include:

- Biology
- Human Anatomy
- Human Physiology
- Infant and Child Growth and Development
- Nutrition
- Psychology or Counseling or Communication Skills
- Introduction to Research
- Sociology or Cultural Sensitivity or Cultural
- Anthropology

Healthcare related continuing education is currently available throughout the state on online for healthcare professionals and includes:

- Basic Life Support
- Medical Documentation
- Medical Terminology
- Occupational Safety and Security for Health Professionals
- Professional Ethics for Health Professionals.
- Universal Safety Precautions and Infection Control

IBCLC exam candidates can obtain continuing education credits by attending conferences or courses online and in person around the country or by contracting with an IBCLC in their area for mentoring.

(viii) A description of how training programs will meet the needs of the expected workforce, including reentry workers, minorities, and place bound students, and others;

While education courses are readily available at the present time it is difficult to obtain the supervised and directly supervised clinical experience necessary to qualify for taking the examination. Licensure can improve this in two ways.

a. By licensing IBCLCs so that they can work independently there should be an increase in the number of IBCLCs in Washington State. This provides more opportunities for the mentorships needed to gain the required hours.
b. Secondly, post-secondary institutions may be more willing to incorporate a degree program for a professional who can get a job in their field of study. Academic institutions can offer the education component, and already have the system in place to provide clinical experience for students in healthcare professions, thus increasing availability of clinical training hours.

(f) Assurance of the public that practitioners have maintained their competence:

(i) Whether the registration, certification or licensure will carry an expiration date;

As per usual in the state of Washington we would expect licensure renewal to be annual. IBCLCs must renew their certification every five years. The recertification requirements depend upon the last method by which an IBCLC achieved or renewed their certification.

Table below: Optional methods for recertification.

Last Method of Certification	Recertification Options
Exam	Continuing Education or Exam
Continuing Education	Exam Only

Recertification by Exam
Every ten years, IBCLCs must renew their certification by taking and passing the certification exam. Recertification by exam is an option that is always open to IBCLCs who must renew their certification. In other words, recertification by continuing education is not mandatory.
IBCLCs that are renewing their certification by exam are not required to demonstrate completion of continuing education. However, IBLCE recommends that all IBCLCs keep their knowledge and practice up-to-date through continuing education.

Recertification by Continuing Education
An IBCLC who passed the exam five years ago may choose to recertify by continuing education recognition points (CERPs). CERPs are the continuing education units awarded by IBLCE to education that meets the educational needs of IBCLCs. The three types of CERPs awarded by IBLCE are described in the table below.

CERP Type	Description
L	Education that is specifically about human lactation and breastfeeding
E	Education that is specifically about professional ethics for IBCLCs
R	Education that is related and relevant to the lactation consultant profession but not specifically about human lactation or ethics

When recertifying by CERPs, IBCLCs must demonstrate that they have completed 75 hours of CERP-approved education. These 75 hours of CERP-approved education must have been completed over the five years since last passing the exam. In addition, the continuing education must meet the following minimum requirements:
At least 50 hours of L-CERP education
At least 5 hours of E-CERP education
At least 20 hours of education that has been approved for L, E or R CERPs

(5) Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement;

When the IBCLC certification is valid, the licensee can pay the fee to receive a new license. If the IBCLC certification has expired, the license will no longer be valid.

(6) The extent to which regulation might harm the public:

We believe this regulation will benefit the public. At the present time lactation consulting is an unregulated profession and anyone can use the title even if they have very little or no training. In the healthcare delivery system, an individual who is licensed is known to have a determined minimum level of education and experience in order to practice. The licensed individual must satisfy ongoing requirements which assure certain knowledge and skills.

(a) The extent to which regulation will restrict entry into the health profession:

We recommend that Washington adopt current standards and specifications for education, knowledge, and experience required for licensure as a lactation consultant will be the criteria established by the International Board of Lactation Consultant Examiners (IBLCE). We believe the recognition of the credential and enabling third party reimbursement for services will increase entry into the profession.

(i) Whether the proposed standards are more restrictive than necessary to insure safe and effective performance; and

We believe the educational coursework and clinical hours required by IBLCE to earn the IBCLC credential are essential qualifications for rigorous and skilled clinical practice. The International Board of Certified Lactation Consultant is nationally as the expert credential for provision of breastfeeding care and services.

(ii) Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same manner as state applicants for registration, certification, and licensure when the other jurisdiction has substantially equivalent requirements for registration, certification, or licensure as those in this state; and

We suggest that Department of Health only issue a lactation consultant license to an individual who successfully passes the Lactation Consultant Certifying Exam conducted by the International Board of Lactation Consultant Examiners (IBLCE). Licensure regulations in Rhode Island and in Georgia include reciprocity language

For the proposed legislation in Washington we suggest language that recognizes lactation consultants licensed in other states as follows,

> "An applicant holding a license in another state may be licensed as a lactation consultant in this state without examination if the secretary determines that the other state's licensing standards are substantially equivalent to the standards in this state."

(b) Whether there are similar professions to that of the applicant group which should be included in, or portions of the applicant group which should be excluded from, the proposed legislation;

There are other healthcare professions which provide services to lactating mothers and breastfeeding infants and children. However, none of them routinely or extensively trained in breastfeeding management as are IBCLCs. There are a small minority who have special interest and seek out this training on their own beyond the requirements of their credential. It is the IBCLC as the member of the healthcare team who is uniquely suited to provide breastfeeding and lactation support. The other healthcare professionals would continue to be able to provide this support if they are trained and desire to do so within their licensed scope of practice.

There are also numerous other short courses or certificates for breastfeeding support providers who do not meet the advanced level of qualifications as the IBCLC, but who provide rudimentary breastfeeding support and encouragement. These are provided in ***Appendix 1.***

For both of these groups we propose exemptions within a licensure bill so that they can continue their valuable work on behalf of mothers and babies.

(7) The maintenance of standards:

(a) Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics; and

There are no legally enforceable regulations in Washington to govern the activities of IBCLCs. IBCLCs agree to be governed by the Code of Professional Conduct and by the IBLCE Disciplinary Procedures for any violations of the Code. IBLCE is responsible for the implementation of these Procedures. Pursuant to the IBLCE Bylaws, IBLCE has a standing Ethics & Discipline Committee. The Chair of the Board of Directors appoints the Chair of the Ethics & Discipline Committee. The Chair of the IBLCE Board of Directors is responsible for ensuring that these procedures are implemented and followed.

IBLCE depends on employers, clients, IBCLCs and the public to report incidents which may require action by the IBLCE Ethics and Discipline Committee. Complaints must be signed and submitted to the Executive Offices of IBLCE International. Inquiries or submissions other than complaints may be reviewed and handled by IBLCE at its discretion.

For more information see:
Code of Professional Conduct for IBCLCs
Code of Professional Conduct for IBCLCs FAQs

(b) How the proposed legislation will assure quality:

(i) The extent to which a code of ethics, if any, will be adopted; and

The IBLCE examination is the premier, nationally recognized certification for lactation consultant practice. Licensure is an essential policy change needed to enable all families to have access to IBCLC services. The IBCLC certification assures referring healthcare providers, families, insurers, and policy makers the ability to recognize and to garner the services of a qualified and trained lactation care provider.

(ii) The grounds for suspension or revocation of registration, certification, or licensure;

We recommend this be deferred to the Washington state disciplinary authority for licensed professions in the proposed licensure bill language, "The uniform disciplinary act, chapter 18.130 RCW, governs the issuance and denials of credentials, unauthorized practice, and the discipline of persons credentialed under this chapter. The secretary is the disciplining authority under this chapter."

(8) The expected costs of regulation:

(a) The impact registration, certification, or licensure will have on the costs of the services to the public;

IBCLC licensure will make it possible to receive third party reimbursement, which should not increase the consumer's cost of services. For those who are economically advantaged and can currently afford to pay for services, it could decrease their out-of-pocket costs. For those with no access to care (including those on Medicaid insurance), it is expected that IBCLC services would be reimbursed by third party insurers, creating access to services not currently available.

The payment to IBCLCs varies depending on their specific background and credentials, as well as the work setting and the type of insurance held by the clients they see.

Removing financial barriers to receiving lactation services will increase successful breastfeeding and breastfeeding duration. The government insurers; the Centers for Medicare and Medicaid Services (CMS) set policies and precedent for much of the third party payment system that are also used by private insurers. Because CMS does not permit reimbursement for unlicensed providers this removes the ability to receive lactation services for many families.

Additionally, in 2013, Washington Medicaid covered 39.2% of births in the state, and after birth, the infant is then covered by Medicaid for pediatric care. Because IBCLCs are not currently licensed, low income families on Medicaid often cannot access lactation services outside the hospital. WIC clinics provide Peer Counselors to aid with simple lactation services. However, they do not provide support for clinical breastfeeding needs usually provided by IBCLCs. Because Medicaid does not reimburse for services unless licensed, those on WIC are unable to receive access to much needed clinical lactation support.

Most IBCLCs work in hospitals leaving few IBCLCs who work in the outpatient setting. These IBCLCs mainly bill individuals for their services as an out-of-pocket self-pay expense because of the insurance dilemma. This results in lack of access to care for most families. The average middle class family, and especially the most at-risk, lower socio-economic populations cannot afford to pay for these services.

At this time, the costs of IBCLCs and other breastfeeding support in the hospital setting is rolled into the dollars allocated in the global fee the hospital charges. Therefore the actual cost of lactation support to the individual is largely unknown in these settings. Theoretically, hospitals appear to be giving these services "free of charge" to patients. They are not "really" free, as the lactation specialists are typically hired employees of the OB Department, and are paid a salary.

Finally, it is expected that covering the IBCLC services, which increases breastfeeding duration will ultimately be a cost savings to families, insurers and the government. The North Carolina Child Fatality Taskforce estimated a $2.3 million annual savings to Medicaid on lower respiratory infections, gastroenteritis and necrotizing enterocolitis would result after covering the costs of lactation services for state Medicaid insured infants. http://bit.ly/1iyluS0 A Georgia Health Policy Center analysis estimated a $15 million annual savings to Medicaid on otitis media, lower respiratory infections and necrotizing enterocolitis after deducting the costs of lactation care for its Medicaid insured infants. http://bit.ly/1LPVHw2

(b) **(This information should be provided by the Department of Health.)**

(c) The cost to the members of the group proposed for regulation for the required education, including projected tuition and expenses and expected increases in training programs, staffing, and enrollments at state training institutions.

- We recommend that IBCLC be regulated by an existing healthcare board in order to contain licensure fees. Ideally, legislation creating licensure of IBCLCs under an existing board will enable the lowest costs for licensees and the state.

- With the IBCLC examination as the qualifying criteria for licensure this will also negate additional costs for the licensee or the state either.

- We expect that DOH will verify the IBCLC certification prior to renewing licenses which can be done by accessing the verification tool on the IBLCE website.

A Sunrise Review: licensing lactation consultants

APPENDIX 1: Lactation training programs

TITLE	TRAINING TIME	SKILLS
International Board Certified Lactation Consultant (IBCLC)	Approximate 5 years, of preparation	▪ 90 hours lactation specific education, ▪ 8 college level health professional courses (24 academic credits) ▪ 6 health related continuing education courses, ▪ 300-1000 clinical practice hours ▪ Pass a criterion-reference exam The International Board Certified Lactation Consultant possesses the necessary skills, knowledge, and attitudes to provide quality breastfeeding assistance to babies and mothers. IBCLCs specialize in the clinical management of breastfeeding which includes: preventive healthcare, patient education, nutrition counseling, and therapeutic treatment. http://iblce.org/certify/eligibility-criteria/
Certified Lactation Specialist/ Breastfeeding Specialist	45 hours	Designed for the aspiring lactation consultant or nurses, physicians, midwives, dieticians, breastfeeding assistants or others desirous of improving their knowledge base and skills in working with the breastfeeding dyad. This certification is a stepping stone to the IBCLC credential. http://www.lactationeducationconsultants.com/course_clsc.shtml
Lactation Educator Counselor	45 hours	This university based program trains participants to be Lactation Educator Counselors. Lactation Educator Counselors are typically entry level practitioners and deal primarily with the normal process of lactation. This course is the required prerequisite to the Lactation Consultant course. http://breastfeeding-education.com/home/clec-2/
Breastfeeding Counselor	10-14 months, Provide 30 hours of support	2-3 day workshop, self-evaluation, one written paper & case studies, read and review 5 books, submit one survey on breastfeeding support available in your community, open book online tests (multiple choice) to cover physiology & anatomy. http://www.childbirthinternational.com/courses/breastfeeding_counselor.php
Lactation Educator	120 hours online study, includes 50 hours health science 75 hours self-directed study/mentorship	Qualified to teach, support, and educate the public on breastfeeding and related issues and policies. Workbook activities, required reading materials, attend 8 breastfeeding meetings, research paper, submit a class presentation, work for clients in their community. Prepares for the IBCLC exam. www.birtharts.com/lactation-educator-certification.htm
Community Breastfeeding Educator	20 hours	"Does not issue Lactation Consultant status. For community workers in maternal child health, focuses on providing services to pregnant women to encourage the initiation and continuation of breastfeeding." http://www.healthychildren.cc/Education.htm#Lactation
Certified	45 hours	"This comprehensive, evidence-based, breastfeeding management course

Lactation Counselor (CLC)		includes practical skills, theoretical foundations and competency verification." Certification is accredited by the American National Standards Institute. http://www.healthychildren.cc/clc.htm
Baby Friendly Curriculum	Approximate 20 hours	Used by facilities to strengthen the knowledge and skills of their staff towards successful implementation of the Ten Steps to Successful Breastfeeding http://www.babyfriendlyusa.org/get-started
WIC Peer Counselor	30-50 hours, Varies by state, some states have quarterly training	Peer counselors are mothers who have personal experience with breastfeeding and are trained to provide basic breastfeeding information and support to other mothers with whom they share various characteristics, such as language, race/ethnicity, and socioeconomic status. In WIC, peer counselors are recruited and hired from WIC's target population of low-income women and undergo training to provide mother-to-mother support in group settings and one-to-one counseling through telephone calls or visits in the home, clinic, or hospital. Refer mothers to IBCLCs who have challenging questions and concerns. https://lovingsupport.fns.usda.gov/content/about-wic-breastfeeding-peer-counseling
Certified Lactation Educator	20 hours total, some have 8 hours clinical	Qualified to teach, support, and educate the public on breastfeeding and related issues. Complete course training, attend support group meetings, observe consultation or videos, review research studies and other requirements, including a test. http://www.icappa.net/events/EventDetails.aspx?id=638578&hhSearchTerms=%22lactation+and+educator%22
La Leche League Peer Counselor (volunteer)	18-20 hours	Have successfully breastfed their infants for 6 months. Program developed to provide support systems within targeted communities that will provide ongoing access to breastfeeding information and support. http://www.llli.org/llleaderweb/lv/lvaugsep99p92.html
La Leche League Leader (volunteer)	About 1 year of self-study training	An experienced breastfeeding mother, familiar with research and current findings dealing with breastfeeding, who offers practical information and encouragement to nursing mothers through monthly meetings and one-to-one help. http://www.lalecheleague.org/lad/talll/faq.html.#howlong

APPENDIX 2: Recommendations for Utilization of IBCLC Services

1. American Academy of Family Physicians Breastfeeding Advisory Committee. Breastfeeding, Family Physicians Supporting (Position Paper) (2014) American Academy of Family Physicians. "When challenges exceed the expertise of the family physician, patients should be referred to someone with a higher level of expertise, such as an International Board Certified Lactation Consultant."

http://www.aafp.org/about/policies/all/breastfeeding-support.html

2. American Association of Health Plans & U.S. Department of Health and Human Services, Office of Women's Health (2001) **Advancing Women's Health: Health Plans' Innovative Programs in Breastfeeding Promotion, U.S. Government Printing Office, Washington, DC.**
"Health plans have key role to play in encouraging women and their families to initiate and maintain breastfeeding." "Overall Lessons Learned: Utilize certified lactation consultants"
http://permanent.access.gpo.gov/lps23476/default.pdf

3. American Public Health Association (2013) An Update to A Call to Action to Support Breastfeeding: A Fundamental Public Health Issue.
"APHA recommends consistent reimbursement strategies for independently accredited lactation professionals both to reduce inequities among lactation care providers and to reduce inequities in access to care."
"Urges public and private insurers (including the Centers for Medicare & Medicaid Services, the National Association of Insurance Commissioners, and America's Health Insurance Plans) to cover appropriately trained and qualified lactation counseling and consultation, which is independently accredited and thus protects consumers; recommends that third-party payers institute reimbursement scales commensurate with training credentials and state licensure where possible; urges insurance companies to cover breastfeeding supplies that are appropriate for a mother's clinical situation; and urges state Medicaid offices to include reimbursement for IBCLCs and other independently accredited lactation providers who offer lactation care and services within their appropriate scopes of practice."
http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/15/26/an-update-to-a-call-to-action-to-support-breastfeeding-a-fundamental-public-health-issue

4. Association of Women's Health Obstetric and Neonatal Nurses (2015) Breastfeeding Journal of Obstetric, Gynecologic, & Neonatal Nursing, 44: 145–150.
"Recommendations- Expansion of insurance coverage for the services of lactation specialists … in private and public health insurance plans…"
http://onlinelibrary.wiley.com/enhanced/doi/10.1111/1552-6909.12530/

5. Campbell, K.P., editor. *Investing in Maternal and Child Health: An Employer's Toolkit.* Washington, DC: Center for Prevention and Health Services, National Business Group on Health; 2007. Available at
https://www.businessgrouphealth.org/pub/f3004374-2354-d714-5186-b5bc1885758a

6. Grawey, A. E., Marinelli, K. A., Holmes, A.V. & the Academy of Breastfeeding Medicine, 2013 Academy of Breastfeeding Medicine Protocol Committee. (2013) ABM Clinical Protocol #14: Breastfeeding-Friendly Physician's Office, Part 1: Optimizing Care for Infants and Children, Revised 2013. Breastfeeding Medicine 8(2), 237-242.
"Insurance coverage for lactation consultant services would greatly enhance breastfeeding care at many levels."
http://www.bfmed.org/Media/Files/Protocols/Protocol_14_revised_2013.pdf

7. Lessen, R. & Kavanaugh, K. (2014) Practice Paper of the Academy of Nutrition and Dietetics: Promoting and Supporting Breastfeeding. Academy of Nutrition and Dietetics.
"Education regarding how to accurately assess insufficient milk supply, as well as encouragement to seek expert assistance (such as an International Board Certified Lactation Consultant) when faced with lactation issues, should continue, with efforts amplified in at risk populations."
http://www.andjrnl.org/article/S2212-2672(14)01876-0/pdf

8. National WIC Association (2016) Enhancing Breastfeeding Support in WIC: The Case for Increasing the Number of International Board Certified Lactation Consultants.
"However, the International Board Certified Lactation Consultant is most qualified to provide clinical care of the breastfeeding dyad and address complex lactation problems." "Integrating and IBCLC into a local WI"C agency can have an enormous impact."
https://s3.amazonaws.com/aws.upl/nwica.org/ibclc-cc.pdf

9. United States Department of Health and Human Services. (2011) The Surgeon General's Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.
"IBCLC certification helps ensure a consistent level of empirical knowledge, clinical experience, and professional expertise in the clinical management of complex lactation issues. Evidence indicates that, on discharge, rates of exclusive breastfeeding and of any breastfeeding are higher among women who have delivered their babies in hospitals with IBCLCs on staff than in those without these professionals. Further, employment of IBCLCs in neonatal intensive care units increases the percentage of a particularly vulnerable infant population—those born at other facilities and transferred to neonatal intensive care units—who leave the hospital receiving human milk." "Provide reimbursement for International Board Certified Lactation Consultants (IBCLCs) independent of their having other professional certification or licensure."
http://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf

APPENDIX 3: Evidence for Effectiveness of IBCLC Services

1. Andaya, E., Bonuck, K.A., Barnett, J., & Lischewski-Goel, J. (2012) Perceptions of Primary Care-Based Breastfeeding Promotion Interventions: Qualitative Analysis of Randomized Controlled Trial Participant Interviews. Breastfeeding Medicine 7(6), 417-422.

"Our findings affirm women's perceptions of the utility of combined prenatal and postpartum provider and LC interventions in reinforcing breastfeeding intention and duration, especially when faced with lack of support from family or medical professionals, and in addressing early postpartum lactation difficulties. They thus underscore the need for breastfeeding interventions across the continuum of care."
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3523239/pdf/bfm.2011.0151.pdf

2. Bonuck, KA., Lischewskai J, Brittner M. (2009). Clinical translational research hits the road: RCT of breastfeeding promotion interventions in routine prenatal care. *Contemporary Clinical Trials*, 30(5), 419-426.
"The rationale for the LC intervention is based upon a systematic review showing the effectiveness of combined pre-and postnatal interventions, and individual – level professional support. Face-to-face, sustained, technical assistance the LC's provide is highly effective. "
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2752285/pdf/nihms-122982.pdf

3. Bonuck, K., Stuebe, A. Barnett, J., Labbock, M. H., Fletcher, J. & Bernstein, P. S. (2014**) Effect of Primary Care Intervention on Breastfeeding Duration and Intensity**
American Journal of Public Health, 104(S1), S119–S127.
"We found that a combined pre-and post-natal breastfeeding support intervention integrated into routine primary care increased breastfeeding intensity and duration in a diverse, low -income population. These differences were achieved with an average of 3 hours of LC [lactation consultant] time per participant, suggesting a full-time LC could deliver our protocol to more than 600 mother-infant dyads per year."
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4011096/pdf/AJPH.2013.301360.pdf

4. Bonuck, K.A., Trombley, M., Freeman, K. & McKee, D. (2005) Randomized, Controlled Trial of a Prenatal and Postnatal Lactation Consultant Intervention on Duration and Intensity of Breastfeeding up to 12 Months. Pediatrics, 116, 1413-1426.
"This 'best practices' intervention was effective in increasing breastfeeding duration and intensity."
http://pediatrics.aappublications.org/content/116/6/1413.long

5. Brent N.B., Redd, B., Dworetz, A., D'Amico, F., & Greenberg, J.J (1995). Breast-feeding in a low-income population. Program to increase incidence and duration. Arch Pediatr Adolesc Med, 149(7), 798-803.
"This lactation program increased the incidence and duration of breast-feeding in our low-income cohort."
http://archpedi.jamanetwork.com/article.aspx?articleid=517608

6. Buckner, E, & Matsubara, M. (1993). Support network utilization by breastfeeding mothers. *Journal of Human Lactation*, *9*(231), 231-235.
"Lactation consultants were the most utilized resources for providing expert information and answering questions."
http://www.ncbi.nlm.nih.gov/pubmed/8260055

7. Castrucci, B.C., Hoover, K., L., Lim, S., & Maus, K., C. (2006) A Comparison of Breastfeeding Rates in an Urban Birth Cohort. Journal of Public Health Management, 12(6), 578-585

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http://www.ncbi.nlm.nih.gov/pubmed/?term=Castrucci%2C+B.C.%2C+Hoover%2C+K.%2C+L.%2C+Lim%2C+S.%2C+%26+Maus%2C+K.%2C+C.+(2006

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"Our findings underscore the importance of integrating IBCLCs into routine pre- and postpartum care because they provide critical support that effectively addresses early postpartum barriers to breastfeeding."
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"A routine post-discharge outpatient lactation visit coordinated within a primary care practice improved breastfeeding initiation and intensity. This effect was sustained for 9 months."
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"Similarly, participants of PC agencies with an IBCLC were more likely to initiate breast-feeding compared with participants of PC agencies without an IBCLC."
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Sunrise Review - Licensure of Lactation Consultants Follow Up Questions to Applicant Report
June 20, 2016

1. The applicant report references inaccurate and conflicting information about lactation care being provided to mothers and families by healthcare professionals. Please provide examples.

There are a number of other health care professionals that provide outpatient lactation services. They are listed in appendix 1. Also listed in that appendix are the education requirements for each profession. It is clear that the levels of training are vastly different among those listed professions, creating the possibility that providers will not possess the skills needed to address basic breastfeeding issues. Even advanced medical professionals such as MDs, PAs, CNMs, ARNPs, LPMs, may not receive the focused training to be able to address breastfeeding issues. Most medical students complete a six week pediatric rotation; however, any teaching about breastfeeding is about the benefits of breastfeeding, not practical clinical skills to help mothers overcome barriers.

Research to support application:

Radzyminski, S. Callister, L. (2015). Health Professionals' Attitudes and Beliefs About Breastfeeding. *The Journal of Perinatal Education*, *24*(2), 102–109, http://dx.doi.org/10.1891/1058-1243.24.2.102

This article speaks to health care professional's beliefs about breastfeeding. The researchers interviewed various health care professionals, including Obstetricians, Pediatricians, Nurses and Nurse Midwives. Although those interviewed in this article were able to clearly describe the benefits of breastfeeding, every profession interviewed stated that they often lacked the knowledge to help a mother in crisis. One pediatric resident in the study stated "I have never seen a woman breastfeed, and frankly, I don't want to. I would not even know what to look for. The nurses here are experts in this area, and they handle any problems the mother might have." (pp. 106). However, even the nurses state that they often feel unprepared for complex breastfeeding issues. Finally, this article states that part of the concern for referring lactation consultants is that there is no formal method to ensure that a lactation consultant has the proper training as there is currently no regulation in place to ensure they are providing evidence based care for complex breastfeeding.

LB Feldman-Winter et al. (2008). "Pediatricians and the promotion and support of breastfeeding." *Arch Pediatric Adolescent Medicine*, 162(12), 142-1149.

This article compares pediatrician's view of breastfeeding in 2004 from a research article published in 1995. While there had certainly been some cultural changes since 1995, the authors found that, unfortunately, in some aspects, pediatricians beliefs about breastfeeding had become more negative. In fact, the researchers found that more pediatricians in 2004 reported issues such as immaturity of the mother, inconvenience, low milk supply, and infected nipples as reasons to recommend against breastfeeding. At the time of this study, twenty-five (25%) percent of pediatricians recommended against breastfeeding because they felt like the mother was too immature. This is in comparison with only 6.7% of pediatricians recommending the same in 1995. They also found that 24.1% (6.7% in 1995) of pediatricians recommend formula based on the mother's perception that her milk supply was not enough and 14.6% (3.7%) recommended formula because the mother felt like breastfeeding was inconvenient or too time consuming. All of these recommendations were made without exploring any further options to help these mothers overcome their breastfeeding challenges.

Yardaena BO et al. (2011) Breastfeeding Education and Support Services Offered to Pediatric Residents in the US. *Academic Pediatrics*; 11(1), 75-79.

The purpose of this study was to get an idea of just how much time was devoted to breastfeeding in pediatric residency programs across the nation. There were 132 pediatric program directors interviewed in this study. On average, residents only received about nine (9) hours of breastfeeding training in their three years of medical school. Furthermore, twenty-five (25%) percent of respondents stated that they actually offered less than six (6) hours devoted to breastfeeding education. Of this six (6) to nine (9) hours, the majority of teaching focused on the benefits of breastfeeding in the classroom. Only two (2) hours were spent in the clinical setting. Finally, researchers also found that zero (0)hours were spent with a lactation consultant, even though the residents were taught that lactation consultants were the expert in breastfeeding.

AM Nelson (2007). "Maternal-newborn nurses' experiences of inconsistent professional breastfeeding support," *Journal of Advanced Nursing*; 60(1), 29-38.

This article provides insight into the inconsistencies of breastfeeding support in maternal care. The qualitative study focused on the foundation that nurses used to educate their patients about breastfeeding. Researchers found that the majority of nurses relied more on their personal or professional experience rather than evidence-based practice. If they personally formula fed their children, they were more apt to recommend and initiate formula feeding when a mother would get exhausted or feel unsure their babies were getting enough milk. Nurses also stated that, in areas where there were lactation consultants on staff, that they mostly deferred to lactation consultants to provide breastfeeding education to their patients because of their IBCLC training and certification.

R Cricco-Lizza, (2009). "Formative Infant Feeding Experience and Education of NICU Nurses," *The American Journal of Maternal/Child Nursing*; 34(4) 236-242.

This article describes nurses feeling about breastfeeding based on their exposure to the same. The stated that, while nurses in this article had increased exposure to varied feeding methods during their adulthood, a majority of them stated that breastfeeding was often associated with difficulties among their families and friends. The nurses in this study also recounted minimal exposure to breastfeeding in nursing school. The study also states that nurses' personal experiences with breastfeeding were often laden with strong emotional reactions intertwined with their feelings about motherhood.

Clinical examples to support application:

Example 1:

As an RN, IBCLC I am called in to see clients by their healthcare providers. As an IBCLC I am identified as having the additional clinical training, certification, and skill to handle complicated breastfeeding issues.

Referred by the client's pediatrician to see dyad for feeding difficulties:

I performed my initial assessment and care of the patients. In doing my exam and breastfeeding instruction I noticed that the baby had a very weak and disorganized suck and was unable to transfer milk at the breast. I noticed that the baby was just not falling into a typical feeding issue clinically. I called the MD and obtained a referral to Children's OT. I called the intake at Children's and an OT who is also an IBCLC called me back and stated that with what I was describing she would see the baby that same day for a feeding evaluation. Because of her clinical experience as an IBCLC and that fact the baby's condition had worsened from my visit only a few hours earlier she could see that this baby needed to be seen by an MD ASAP and sent her down to the ER. Shortly after arriving at the ER the baby coded. If it had not been for our

clinical expertise as an IBCLC to recognize that this was not just a feeding issue but something more this outcome could have had a much worse outcome. This baby did survive and was discharged home after her medical problem was dx and treated.

Example 2:

I run a breastfeeding support group twice a week. It is a way for mom's to have a lactation consultation in a group setting and connect with other moms that are having similar issues as them.

Mom came to group complaining of plugged ducts. I provided breastfeeding and instruction and assessment. I referred her back to her ND for a referral to Physical Therapy for ultrasound therapy to relieve her plugged duct. I told her to call me if things were not getting better or it she had any further questions. She called me back a 1 ½ weeks later stating that things just seemed to be getting worse. She had seen PT 3 times with very little relief, her ND started her on herbs and when those did not seem to help she went to urgent care and they started her on ABO's. When she called me she stated that she was still not feeling better after 2 days on ABO's and that the MD and her ND stated that it would take a few days to kick in and give it time. I asked her to describe and send me a picture of what the red area looks like on her breast. She described that the skin looked like an orange peel and her temp was now up to 102.0. I instructed her to go the ER and called ahead with my concerns for this mom. The client called me from the ER stating that she had to fight for a U/S and that it looked like she might be getting an abscess. She stated that she was instructed to follow up with a general surgeon if her symptoms did not improve in 2 days. She had a PT appoint the next morning so I called over and said that everyone is missing something and this client needs to be seen ASAP by a breast specialist. The PT manager walked her over to the breast care center for dx and they discovered that she did indeed have an abscess and was scheduled for surgery where they removed an abscess the size of an orange. Again a problem was caught before it became any more serious because of the additional training and expertise I have as an IBCLC.

Personal Example for application:

My name is Christina Kressin. I am a mother of two beautiful children and a Registered Nurse working mainly in an ICU environment. I am also very passionate about breastfeeding and hope to become a lactation consultant one day. The reason I am so passionate about breastfeeding comes from my own experience as a new mom. My two childbirth/breastfeeding experiences were vastly different.

I had my first child a few months before nursing school and knew very little about childbirth and breastfeeding. I can remember wanting so desperately to breastfeed but terrified that I would not be able to succeed or provide enough milk for my child. It was difficult from the very first time that my son latched. He did not latch correctly and it was very painful. The

nurse's explanation was to "make a sandwich and shove him on" while manhandling my breast and my son. This did not work well and I quickly developed sores on my nipples. Because my son was on the smaller side, the pediatrician became very concerned about any lost weight and strongly encouraged me to supplement with formula. Because I was determined, I volunteered to come in daily for weight checks but asked for help. My pediatrician's only advice was to supplement. La Leche League never returned my calls, and the nurse helpline from the hospital went to voicemail. It was such a dark time. I cried every time he latched and my husband was frustrated at his helplessness in the situation. Eventually, after two excruciating months, my son learned to latch and he gained weight; however, I struggled with my insecurities daily for the next 9 months.

There wasn't a day that I didn't worry about my supply or his weight. At every appointment, although my son was growing and meeting developmental milestones, I was encouraged to supplement (I later learned that he was using the CDC growth chart based on formula instead of the WHO growth chart based on breastfeeding). These feelings continued until my I started my OB rotation in nursing school. My professor was an IBCLC trained lactation consultant. Through her evidence-based advice and her compassion, I finally learned what was normal for my son's growth and development, how to confidently assess my son was receiving enough milk, and how to overcome the barriers I had struggled with for so long. It was through her counseling that I finally gained confidence in breastfeeding and relaxed enough to enjoy my relationship with my son.

I am happy to say that my daughter's experience was much easier because I had confidence from the very first moment that my milk was enough and I had the tools needed to teach her how to latch from the very beginning. While my story has two happy endings, I have heard this exact scenario so many times from moms who have given up and my heart breaks for these mothers. This is why I am so passionate about this legislation; why we need more IBCLC trained lactation consultants who can give the right advice long before these mothers give up. If we are to meet our Healthy People 2020 goal for long term breastfeeding, we need to provide these mothers with the right support to overcome challenges so that more moms can continue in their breastfeeding relationship.

2. The applicant report references types of potential harm for infants or mothers from improper breastfeeding management. Have there been studies, complaints or other published information indicating that the harm is related to health care practitioners giving incorrect or conflicting information? If yes, please provide examples.

The state of Washington does not have a complaint process for lactation consultants. There is no clear definition of who can call themselves a lactation consultant and no laws to allow for disciplinary actions to those that have caused harm to women or infants.

Gwen Marshall is working on gathering data from IBCLE to be able to share IBCLC complaints and disciplinary procedures in Washington state and national. Gwen will send information directly to sherry Thomas at DOH once she obtains the information.

3. The applicant report references a critical shortage of outpatient lactation services provided by qualified lactation professionals. Are there health care professionals in addition to IBCLCs currently providing outpatient lactation services?

Yes, there are currently ARNPs and some midwives who will continue to offer services. ARNPs that currently offer lactation services are often also IBCLCs. There are also a number of other health care professionals that provide outpatient lactation services. They are listed in appendix 1. Also listed in that appendix are the education requirements for each profession. It is clear that the levels of training are vastly different among those listed professions, creating the possibility that providers will not possess the skills needed to address basic breastfeeding issues. Even advanced medical professionals such as MDs, PAs, CNMs, ARNPs, LPMs, may not receive the focused training to be able to address breastfeeding issues.

4. Please address the apparent conflict between the intended scope of practice discussed in the applicant report and the scope of practice proposed in the draft bill.

We ask that the Scope of practice outlined by the IBCLE be used for scope of practice in both the draft bill and the application. Any conflict between the two should resolve with this solution and it is the standard that all IBCLCs must follow to maintain certification. Below is the scope of practice taken from the International Board of Lactation Consultant Examiners:

Scope of Practice for IBCLCs Page 1 of 2 Final September 15, 2012 (Previously adopted March 8, 2008)

Scope of Practice for International Board Certified Lactation Consultant (IBCLC) Certificants

International Board Certified Lactation Consultant® (IBCLC®) certificants have demonstrated specialized knowledge and clinical expertise in breastfeeding and human lactation and are certified by the International Board of Lactation Consultant Examiners® (IBLCE®).

This Scope of Practice encompasses the activities for which IBCLC certificants are educated and in which they are authorised to engage. The aim of this Scope of Practice is to protect the public by promoting that all IBCLC certificants provide safe, competent and evidence-based care. As this is an international credential, this Scope of Practice is applicable in any country or setting where IBCLC certificants practice.

IBCLC certificants have the duty to uphold the standards of the IBCLC profession by:

• working within the framework defined by the IBLCE Code of Professional Conduct and the Clinical Competencies for IBCLC Practice

• integrating knowledge and evidence when providing care for breastfeeding families from the disciplines defined in the IBLCE Exam Blueprint

• working within the legal framework of the respective geopolitical regions or settings

• maintaining knowledge and skills through regular continuing education

IBCLC certificants have the duty to protect, promote and support breastfeeding by:

• educating women, families, health professionals and the community about breastfeeding and human lactation

• facilitating the development of policies which protect, promote and support breastfeeding

• acting as an advocate for breastfeeding as the child-feeding norm

• providing holistic, evidence-based breastfeeding support and care, from preconception to weaning, for women and their families

• using principles of adult education when teaching clients, health care providers and others in the community

Scope of Practice for IBCLCs Page 2 of 2 Final September 15, 2012 (Previously adopted March 8, 2008)

IBCLC certificants have the duty to provide competent services for mothers and families by:

• performing comprehensive maternal, child and feeding assessments related to lactation

• developing and implementing an individualized feeding plan in consultation with the mother

• providing evidence-based information regarding a mother's use, during lactation, of medications (over-the-counter and prescription), alcohol, tobacco and street drugs, and their potential impact on milk production and child safety

• providing evidence-based information regarding complementary therapies during lactation and their impact on a mother's milk production and the effect on her child

• integrating cultural, psychosocial and nutritional aspects of breastfeeding

• providing support and encouragement to enable mothers to successfully meet their breastfeeding goals

• using effective counselling skills when interacting with clients and other health care providers

• using the principles of family-centered care while maintaining a collaborative, supportive relationship with clients

IBCLC certificants have the duty to report truthfully and fully to the mother and/or infant's primary health care provider and to the health care system by:

• recording all relevant information concerning care provided and, where appropriate, retaining records for the time specified by the local jurisdiction

IBCLC certificants have the duty to preserve client confidence by:

• respecting the privacy, dignity and confidentiality of mothers and families

IBCLC certificants have the duty to act with reasonable diligence by:

• assisting families with decisions regarding the feeding of children by providing information that is evidence-based and free of conflict of interest

• providing follow-up services as required

• making necessary referrals to other health care providers and community support resources when necessary

• functioning and contributing as a member of the health care team to deliver coordinated services to women and families

• working collaboratively and interdependently with other members of the health care team

• reporting to IBLCE if they have been found guilty of any offence under the criminal code of their country or jurisdiction in which they work or is sanctioned by another profession

• reporting to IBLCE any other IBCLC who is functioning outside this Scope of Practice

5. Page 5 of the applicant report indicates that lactation consultants would work autonomously and independently with "the requirement to report to the primary care provider." Please describe examples of situations when a lactation consultant should be required to report or refer to a primary care provider.

IBCLC's would work autonomously, however they would consult and report their findings and plan of care back to the primary care provider per the scope of practice outlined by the IBCLE. Examples of these situations occur when a health care provider consults with lactation consultants for infants who are having difficulties with breastfeeding. In a different arena, this would be no different than primary care provider consulting with a registered dietician to help their diabetic patient control and maintain healthy weights and blood sugars.

See the following scope of practice bullet points from www.ibcle.org:

Principle 4: Report accurately and completely to other members of the healthcare team
Every IBCLC shall:
4.1 Receive a client's consent, before initiating a consultation, to share clinical information with other members of the client's healthcare team.
4.2 Inform an appropriate person or authority if it appears that the health or safety of a client or a colleague is at risk, consistent with Principle 3

Also included is the following:

• making necessary referrals to other health care providers and community support resources when necessary

• functioning and contributing as a member of the health care team to deliver coordinated services to women and families

• working collaboratively and interdependently with other members of the health care team

6. How can we ensure that services will not be reduced in rural areas where there may not be IBCLCs to provide lactation care?

There will be no change in the current scope of other lactation services available. Licensure will not take away from any current services provided to those in rural areas. Unfortunately there is no research to ensure IBCLCs will increase as there has not been enough time to produce evidence based research. However, currently there are areas with no IBCLC support because Medicaid does not reimburse. This bill may eliminate that barrier and provide IBCLC access to areas that currently have no support.

7. Page 6 of the applicant report indicates that the IBCLE determines education/experience prerequisites, examines IBCLCs, and investigates practice and ethics violations. Please describe how regulation by the department would provide greater public protection than already provided by the IBCLE.

Regulation would ensure that every member that calls themselves a "Lactation Consultant" has met the education requirements to provide the services at hand. The IBLCE certification is voluntary. Without licensure anyone can call themselves a lactation consultant, even if they have no or minimal training such as 10, 20 or 40 hours with no other health care background and without ever having seen a breastfeeding mother and baby. Licensure assures a person who says they are a "lactation consultant" (when that title is protected by law) has a minimum standard of training and education. Licensure also ensures that the public has a means of recourse if the lactation provider is negligent or harmful. It also guarantees that lactation consultants, who work with a very vulnerable population, have undergone a background check.

Finally, regulation gives the public a means of reporting malpractice. Without regulation the public has no means to report individuals who may cause undo harm to a vulnerable population. There is no current formal process to file complaints in the state of Washington regarding lactation services. There is currently a formal process through IBCLE for those that are certified, however the public is not often aware that this regulatory body exists. Even then,

although the IBLCE retains the right to “discipline” or remove a certification from someone who is negligent, there is no legal process involved. An individual disciplined by IBCLE has no legal limits on their ability to still practice (albeit negligently) without licensure.

Appendix C

Public Hearing Summary

Lactation Consultant Sunrise Review
Public Hearing Summary
July 12, 2016

Andy Fernando, Rules and Legislative Implementation Manager in the Health Systems Quality Assurance Division of Department of Health, called the hearing to order and provided rules for the hearing. He also introduced staff, Sherry Thomas, Sunrise Review Coordinator, and Brandy Ragsdale and Jennifer Greene, staff assisting with the hearing.

He then introduced the hearing panel members, whose job was to ask questions and make sure the department has all the information necessary to make a sound recommendation. Panel members were:

- Nancy Elliott is an RN who specialized in emergency medical services as a paramedic, emergency room nurse, Air Force flight nurse on worldwide flight status, & civilian helicopter chief flight nurse. Nancy is currently a policy analyst here at the department, supporting rulemaking activities for the Nursing and Chiropractic Commissions.
- Chris Gerard obtained law degrees from the University of Cambridge, England and the University of Washington. He is a staff attorney at the department, providing legal support for the Boards of Optometry and Nursing Home Administrators, Pharmacy Commission, and the public records unit.
- Julie Tomaro has her Bachelor of Science degree in nursing and a master's degree in public health. She began her nursing career in the emergency room before transitioning into government public health. Currently, Julie is the program manager for hospitals and residential treatment facilities and also works as a school nurse for a rural Washington school district.
- Micah Matthews is the Deputy Executive Director of the Medical Commission. He started with the medical commission in 2011 as the Performance and Outreach Manager and was promoted to deputy in 2014. Micah's focus areas include legislation, budget, telemedicine, international regulatory trends, licensure, human resources, communications, and IT.

Mr. Fernando stated that there will be a 14 day written comment period for participants to provide additional information for topics brought up today, to clarify things they may have said, and for those who could not attend in person to submit information on the proposal. He next introduced the applicant group, Kim Reichner and Christina Kressin, and invited them up to present their proposal.

Applicant Presentation

Kim Reichner introduced herself as an emergency room nurse and a very passionate advocate for issues surrounding breast feeding. She stated she is not an IBCLC, but is training to become one. She said that everyone in the room has the same goal to support breastfeeding and enhance initiation and duration of breastfeeding for the health of the mother and the baby. She provided an example of a mother and baby with a breastfeeding issue who visits a walk-in clinic and are

seen by a physician assistant, who cannot help with the problem and refers to a primary care doctor, who cannot treat the issue and refers on to a specialist in this area.

She stated that this is exactly what the applicants are trying to do, not to replace existing resources or restrict anyone's existing practice. Licensing lactation consultants will ensure patients receive the highest standard of evidence based care.

Christina Kressin presented next. She introduced herself as a registered nurse with a specialty in ICU and breastfeeding. She said she is very passionate about breastfeeding moms. She is also not a lactation consultant. She stated they are a group of professional women that includes IBCLCs, registered nurses, business women, and mothers who have a passion to support breastfeeding moms and their goals. They want to ensure that anyone who calls themselves a lactation consultant has an IBCLC certification. They do not wish to change the scope or inhibit anyone providing lactation consults from their present practice.

She said she would cover three main topics regarding why they are proposing licensure for lactation consultants:

- Providing access to care to all breastfeeding populations,
- To protect families from harm; and
- To standardize and ensure evidence-based care.

Ms. Kressin provided information on the evidence of harm, which shows that there is harm to mothers and babies from early weaning. She discussed the Healthy People 2020 objectives for the next 10 years in regards to breastfeeding, which include increasing the proportion of infants who are breastfed in the early postpartum to 81.9 percent. The national average is 80% and Washington State is rocking it and 93.6 percent. She stated that moms want to breastfeed, however when you get to the bottom of the chart in her PowerPoint (attached at end of hearing summary), infants who are breastfed exclusively for six months, Washington is well below the national average of 25.5 percent with 15.3 percent . She said we are doing something wrong and women are being failed. Ms. Kressin discussed other issues with early weaning such as Mastitis, abscesses, worsened post–partum depression, child abuse, and death. She stated it can also create an increased long term risk of breast and ovarian cancer and type 2 diabetes, and many more.

The International Board of Lactation Consultant Examiners (IBCLE) is a regulating body that has a system in place to report concerns about IBCLC members. However the public is not aware of this resource, and there are no regulations to stop someone who loses their IBCLC certification from continuing to practice even if they have brought harm to the community.

Licensure would provide standardization to ensure evidence-based care. She stated that every category of lactation care provider (referring to slides 8-9), is vital and important and necessary to empower women to be successful. It takes a village. Licensure is a way to recognize a standard to ensure safety for consumers by making it easy to identify lactation services, similar to a primary care doctor consulting with a cardio surgeon after you have had a heart attack.

She stated that current providers often feel inadequate to provide proper lactation care. Medical doctors receive six to nine hours of breastfeeding training in medical school, with only two hours in clinical practice, and only schools with baby friendly hospitals receive one to two hours with breastfeeding professionals such as IBCLC. The majority of a doctor's education is focused on the benefits of breastfeeding, not overcoming barriers. Nurses also receive minimal training and research shows they base their views on breastfeeding on their personal experience, or family members' experience with breastfeeding. Midwives offer excellent, evidence-based lactation support. Their education is comparable to that of an IBCLC. Midwives often consult with IBCLCs for complex issues, but there are often more patients than IBCLCs available.

There is a lack of IBCLS' in Washington, and outpatient clinics have up to a two week waiting list for women in crisis. The Surgeon General recommends 8.6 IBCLCs per 1,000 patients.

Ms. Kressin discussed the three pathways to become an IBCLC:

Pathway 1

- Most common pathway for Registered Nurses or Registered Dieticians
- Must complete 14 health science classes or possess an RN or RD degree, 90 hours of lactation specific education and 1000 hours of clinical practice.

Pathway 2

- Attend a IBCLE approved program to obtain certification (there are currently only 5 programs that qualify)
- This program includes the 14 health science classes, at least 90 hours of didactic education in human lactation and breastfeeding and a minimum of 300 hours of directly supervised clinical practice in lactation and breastfeeding care

Pathway 3

- Considered a mentorship program with a current IBCLC holder
- Must complete 14 health science classes or possess an RN or RD degree, 90 hours of lactation specific education and 500 hours of directly supervised clinical practice in lactation and breastfeeding care

She added that because IBCLC's cannot sustain themselves they often have to have other employment. She is hoping that through licensure there will be an increase in Washington IBCLC's. Those IBCLC's can mentor those other the other lactation care categories.

Ms. Kressin closed her presentation by stating that licensure for IBCLCs would provide protection for all Washington breastfeeding families, a standard of care for anyone stating they are a "lactation consultant," and increased access to care where there is currently very little or no access.

Panel Questions

Panel Question (Q): How are the 500 IBCLC's dispersed in the state?

Response (R): They are congregated in areas like King County. Eastern Washington has very few to none.

Q: In the area where there are few to no IBCLC's, is there no lactation support? Or who is it being provided by?
R: Their lactation support is being provided by peer counselors, midwives, and those with lactation education. The WIC program usually supports the rural areas.

Q: Are the 500 primarily working in hospitals or clinics or are they going back and forth between the two?
R: The majority of them are in hospitals or are working for WIC.

Q: Does everyone who works for WIC have IBCLC certification?
R: No. They have about 20 hours of schooling and most of them are breastfeeding mothers themselves. They are wonderful advocate to have for the new mother. If the WIC counselor is unable to assist, this is where the IBCLC would come in and assist.

Q: Are they doing that already?
R: They try, but then you get referred to a doctor or pediatrician.

Q: Are you saying that for the most part they are trying to refer to IBCLCs, but their resources are limited?
R: Correct.

Q: Are they trying to provide care that may be questionable whether they should be providing it?
R: They try to help you the best way that they can.

Q: Are members of the public asking about qualifications of who is providing lactation care?
R: They don't know.

Q: Can you talk a little about the cost of becoming an IBCLC?
R: The person responding stated she attended a conference and took an online course that included 90 hours of lactation consultant training that cost about a $1,000. The IBCLC exam cost $660.

Q: In the application it states that this service can be reimbursed by insurance companies. Are there some insurance companies already reimbursing for these services even if the individual is not certified?
R: Some insurance companies do. Aetna covers for services by IBCLCs. Others must pay out-of-pocket.

Q: How much does a visit cost from an IBCLC?
R: The range is currently from $175.00 to $225/$250 for an in-home visit. If they can come to the office, it is usually less, $120 to $150.

Q: A few questions were asked regarding hospital resources for IBCLCs in rural and underserved areas and reimbursement in hospitals for lactation services.
R: The hope is that Medicaid can support reimbursement and that reimbursement would help support IBCLCs in rural and underserved areas.

Q: Rural areas have small populations, so how many people in those areas are going to be in need of the lactation consultants?
R: That answer is unknown because they have very little data to reflect that.

Q: Has the theory that licensure will increase access been demonstrated in Rhode Island?
R: Unsure.

Q: How can perspective IBCLC's that live in rural areas meet the criteria?
R: Telemedicine should help with this where populations don't support full-time specialists.

Q: How will rural areas sustain mentorship programs to increase providers?
R: They said they plan to work with WIC to include one IBCLC in a rural area to oversee WIC counselors.

Q: Sections two and six conflict. Can you explain the discrepancy?
R: It was not their intent to inhibit anyone who already practices lactation consulting. They want to fix the language to show that, so that midwives and others continue to do what is in their scopes of practice.

Q: What can the other providers who are not licensed IBCLC's call themselves?
R: Lactation counselors, lactation educators, WIC peer counselors.

Q: Is that not enough of a title difference to call oneself a lactation consultant versus being a certified lactation consultant?
R: The public doesn't understand the difference. It's clarity for them.

Q: Asked if the applicant you provide any examples of harm from non-IBCLCs?
R: Unfortunately there is not an avenue for that. They stated they have reached out to the IBCLE to see if there were any, but have not received a response.

Q: There was mention of harm to babies from child abuse. Asked if the applicant has heard of any of these cases.
R: Responded that she has not. A lot of the research is involved in early weaning. A lot of that research is referring to mothers who are breastfeeding and those who are not.

Q: What type of training do IBCLs receive for incidents like these?
R: The risk factors in relation to the early weaning stage. And the IBCLC helps devise a plan to help with complex feeding to decrease the risk factors.

Q: Asked whether the applicants were aware of the language conflicts in sections two and six before coming to the hearing today.

R: They were not aware of it before, but have reached out to the community to let them know they are aware of it and will be handling this issue soon.

Q: Asked what the applicants think the advisory committee will be doing, rules, discipline? Asked about their intent for what the disciplining authority is meant to do in addition to the secretary of health. Provided an example of the midwifery program where expensive experts are required in standard of care cases. Also discussed UDA grounds for discipline and conflicts between the UDA and IBCLC discipline/revocation of certification. Also asked whether they had considered voluntary certification rather than required licensure for Medicaid reimbursement, title protection.

Q: Asked when a lactation consultant would escalate to another provider, such as a physician.
R: Once the physician is concerned as to why the baby is not gaining weight.

Q: Asked whether the applicants can you name any other professions that require only a board certification in order to be licensed?
R: Nursing.

Q: Asked how licensure would increase access to lactation consultants.
R: Reimbursement would create a steady income to sustain being a lactation consultant on its own and allow opportunities to provide mentorships. Texas has a pilot program through the WIC program. Also the Surgeon General's Call to Action recommended states license IBCLCs to help with reimbursement and access.

Q: For reimbursement, why not try to get added to Medicare or CMS so that you can be billed?
R: Did not have an answer to that.

Q: What about the issue of limiting consumer choice, restraint of trade?
R: The legislation needs to be clear that it is not limiting choices, but titles. It is not intending to limit a scope but a title and standard of care.

Q: If a majority of the lactation consultants are RN's, couldn't somebody make a complaint to the nursing commission?
R: They could.

Public Testimony

Lorri Car, President of Washington Alliance for Responsible Midwifery

She asked whether there any data or research that can show the difference in the outcome of IBCLCs compared to other lactation consultants. She said she is not seeing evidence of bad advice from non-certified providers. How would 300 IBCLCs take care of the demand? A majority of mothers need simple lactation help, and there are not enough IBCLCs in eastern Washington. A doula would be the one helping with latch at three in the morning and could not advertise lactation consulting under the bill. It appears to prohibit anyone else form advertising

their lactation services. She gave an example of the midwifery scope of practice sunrise review done recently that resulting in the law limiting newborn care to two weeks. She said this type of challenge is going to happen here resulting in midwives being challenged by third party payers for lactation care. She also stated that Medicaid reimbursement is much lower than private paid care, estimating about 10 percent. She said the bill won't force carriers to pay, only allow them.

She also asked about mentorship programs. How can there be enough mentors? If every IBCLC currently certified would mentor someone, it would take five years. Also, they are all in the Puget Sound, not in rural areas. She said her student midwives would love to get IBCLC certified but it's not possible for them.

Q: If the bill were changed to title protection only, why couldn't other lactation care providers say they provide lactation consultation services without calling themselves lactation consultants? He suggested she could call herself a midwife who offers lactation consultation.

Audrey Levine, MAWS

She pointed to Wendy Gordon's comments (in the list of written public comments) which state this would exacerbate health equity and costs. She said she hasn't seen evidence of harm and that this is a solution in search of a problem. She referenced the discrepancies between sections two and six and reiterated Ms. Carr's example about third party challenges to the midwifery scope. She stated that midwives do a lot of lactation and breastfeeding support and most of it doesn't rise to the level of needing IBCLCs.

Q: Would adding specific language in the bill about lactation consultation being authorized in the midwifery and RN statutes help?
R: That's only part of the issue. It would not address the other lactation consultant categories.

Ms. Levine asked the applicants about getting IBCLCs into their bill and getting them written into federal payment system.

Applicant Wrap Up

The applicants reiterated that the conflicts between sections two and six were unintended and offered to collaborate with the midwives to fix the issue. They stated that IBCLCs look to midwives because they do such a great job with lactation, citing Ms. Carr's very high breastfeeding rates. The hole is after hospital births, when they are sent home and have breastfeeding issues, or when the doctor or nurse tells the mother to just go on formula.

Hearing Participants

Name	Representing	Position
Kim Rechner	Applicant	Support
Christina Kressin	Applicant	Support
Audrey Levine	Midwives' Association of Washington (MAWS)	Neutral
Sarah Cassidy	Self	Support
Tracy Corey	Self	Support
Melissa Slovek Bonghi	Self	Support
Lorri Carr	Washington Alliance for Responsible Midwifery (WARM)	Opposed
Eudine Stevens	WARM	Opposed
Kariann Rizzier	Self	Support

Appendix D

Written Comments

I read with interest the proposal for licensure of lactation consultants. I would like to make the point that creation of this new licensure would allow an important opportunity to improve the health and safety of nursing mothers and their families if the educational requirements for this profession included training in intimate partner violence (including intimate partner sexual violence) and reproductive coercion. New parents are vulnerable to abuse and coercion, and lactation consultants can help provide circumstances conducive to successful breastfeeding through their understanding of these issues and their ability to link new mothers to appropriate advocacy services.

Thank you for considering this option.

Best regards,
Jennifer Y. Levy-Peck, PhD
Psychologist, Author, Editor

This has got to be one of the worst ideas in the world! As a Mother of 5 children, I have had many different experiences with births and every one of my babies have brought on different experiences with breastfeeding/latching. Had I not had access for midwives or dulas to help my breastfeeding I would have given up. Midwives already receive training on lactation but the idea of making this a whole new certification, making it illegal for someone to give advise or care to a new mother is ridiculous and not necessary. Making this a billable service will stop many mothers from being able to afford help and care during this stressful time. There is no way insurance will cover this! I have been on government insurance for 8 years now, ever since my husband joined the military. With government insurance all things they deem to be 'big' they will help cover but lactation isn't going to be one of those. Not to mention how most people in the state do not live 30 minutes from a hospital, but are in a rural area.
How is endangering babies by stopping providers like midwives from helping them, and limiting their lactation assistance to only LC's going to increase public safety, especially in rural areas that are already underserved? How is having midwives or duals give direction or help with lacyional a public safety? Step out! You are trying to control too much, no one asked for this. If you took a poll from the states women population they sure wouldn't want this. Laws aren't made because our governors rule us, you work for us, and we say this is not what we want!
Leslie Stanfield

Please do not put restrictions on lactation help! This is a natural function mothers have helped each other with for generations! The access to midwives, doulas, and lactation consultants willing to offer free and discounted services is greater than ever now!!! Not to mention all the mothers willing to simply lend a helping hand to ANY WOMAN who needs help: teach, inform, encourage, and also share local resources!
Amanda Hale

I am a nurse who works with only Medicaid eligible pregnant women in Spokane, WA. I am not a lactation consultant. I provide maternity support. My clients. only have access to Lactation consultants through Hosp, which cannot bill for this service. The women cannot afford to pay a private Lactation consultant. Instead, these women give up breastfeeding when they begin having complications because there is no access to lactation consultants who can bill their Medicaid. Making lactation consultants licensed would allow this, which should increase our sustaining exclusive breastfeeding in this at risk

population.

Kathleen Bernier, RN
CHS Site Supervisor, Public Health Nurse
Unify Community Health Services

I am writing on behalf of breastfeeding mothers in Kittitas County, WA. Living in a rural community often limits access to specialized healthcare professionals. Currently in Kittitas County there are no licensed lactation consultants. Mothers in our community receive lactation support from the WIC office, a local breastfeeding group called "Nurturing Naturally" that is run by an elderly community volunteer with a passion for breastfeeding, nursing staff in the Family Birthing Center at Kittitas Valley Hospital (KVH), and midwives serving home birth families.

I am an experienced breastfeeding mother currently tandem nursing my two sons (3 years & 18 months), I have been a practicing doula since 2007 and have completed DONA certification, and I work in the Family Birthing Center at KVH. I strongly believe that breastfeeding is the right choice for my family and that women deserve access to competent, evidence based lactation care. However, I am concerned that in our rural community this proposal will in fact decrease access to lactation services for mothers and babies in the early postpartum period when they are the most vulnerable. In 2015, 86% of mothers were discharged from KVH exclusively breastfeeding and mothers can return at anytime if they need lactation support. This proposal will eliminate KVH as a resource to new mothers because although the nurses have extra education in breastfeeding and substantial clinical experience, none of them possess a lactation specific certification or license. The same is true of midwives who serve home birth families in our community.

I agree that in an ideal world market forces may potentially draw lactation consultants to Ellensburg, WA, but in the meantime I am concerned that this proposal will significantly limit access to lactation services for women in our community. If women are unable to receive lactation support from the currently available resources in our rural community their only option is to leave Kittitas County. This is an unacceptable burden to impose on women recovering from childbirth.

I ask that you please include mother/baby nurses and midwives in Section 6. of this proposal. Both of these professions routinely provide lactation support and are often a new mother's first advocate in her breastfeeding journey. They should be recognized as a valuable resources to women who have limited access in rural communities and elsewhere. In Kittitas County we have take great strides in recent years to support breastfeeding mothers and as a community we would like to continue this forward momentum.

I would like to receive updates during the review of this proposal this proposal.

Rozsika Steele

On behalf of the Washington State Academy of Nutrition and Dietetics, I am writing in support of the sunrise review application for licensure of International Board Certified Lactation Consultants (IBCLC) in Washington State.

As Registered Dietitians Nutritionists, we support IBCLC licensure for the following reasons:

- There is currently confusion by consumers and the medical community about the meaning of titles and the training requirements for various lactation care providers. For example, anyone can call themselves a “lactation consultant” regardless of their levels of training and

qualifications. There is often an erroneous assumption that everyone using the title lactation consultant possesses equivalent and adequate education, training and credentials. This presents a significant risk to women and their babies. Licensure is the only way to assure public safety and improve access to the level of lactation care and services that mothers need.

- Licensure will increase the public's access to appropriately trained, credentialed and licensed lactation consultants in order to protect consumers and improve breastfeeding success rates in Washington State. This, in turn, will lead to improved health outcomes.

We hope you will rule favorably.

Thank you.

Joan Milton, MS, RDN, CCRD
Washington State Academy President

Thank you for providing notice of the Sunrise Review to assess the need to create a licensing process for lactation consultants.

The Washington Legislature requested the Department of Health (DOH) to consider a sunrise application for a proposal that would create a new licensed profession, Licensed Lactation Consultants. If passed, the training and testing of licensed lactation consultants would be regulated by DOH and their scope of practice would be defined. There would be continuing education requirements and a mechanism for insurance reimbursement for licensed lactation consultants.

It should be noted that the licensure requirements do not specifically include a course on the Health Insurance Portability and Accountability Act (HIPAA) and health information and privacy laws for health care professionals.

Currently a variety of providers are allowed to provide consultation and education about breastfeeding under numerous titles and certifications. However, having licensed lactation consultants to provide lactation counseling and support for Medicaid and Public Employee Benefits (PEB) clients as a preventive service with no copay would be consistent with the commitment to value-based health care. Paying for lactation consultation is a patient-centered service.

There is clear evidence in the medical literature of the health benefits of breastfeeding for both mothers and infants. Babies who breastfeed have fewer ear infections, gastroenteritis, allergies, asthma and childhood obesity. Benefits for nursing women include more postpartum weight loss, reduced risk of breast and ovarian cancer, and lower rates of obesity and type 2 diabetes. These benefits increase with longer duration of breastfeeding. Additionally there is emerging evidence that adults who were breastfed as babies are less likely to be overweight or obese. Healthier people have lower health care costs.

<u>Public Employee Benefits</u>
Currently, most lactation services are covered by the PEB health plans as preventive services. Since lactation consultation is currently paid for by PEB health plans, there would be no policy impact and costs would be negligible if this legislation is enacted.

<u>Medicaid</u>
If the legislation is enacted, Medicaid would need to determine what services would be allowed and in what quantities. HCA reimburses for services that are now provided for free, such as with the Women Infants and Children's program (WIC). However, they are not separately reimbursed by Medicaid/Apple Health, but are included under pregnancy-related services. We would need to assure that the benefit would not be duplicative.

The operational impact would include enrolling the new professionals as Medicaid providers, updating rules, fee schedules and provider guides, and configuring Provider One. The managed care plans would need to be made aware of the new providers and services. Each plan would need to contract with providers and make arrangements to pay for the services.

While we cannot be absolutely certain about the fiscal impacts to Medicaid/Apple Health, we do not expect the number of visits or costs for the Medicaid population to vary significantly from the introduction of a new provider type. The services are already being provided by RNs, midwives, and other healthcare professionals as part of their normal scope of practice. By adding lactation consultants as a billable provider under Medicaid, we only anticipate a shift in the distribution of services between provider types.

Dennis Martin, Administrator, Office of Legislative Affairs and Analysis
Washington State Health Care Authority

Response to the IBCLC proposal to the DOH concerning the need for licensure of lactation consultants in Washington

They mentioned in section (4)

> "The primary benefit of regulation would be assurance of an identifiable, interdisciplinary health professional workforce that provides access to qualified lactation services to all segments of the population. Regulating lactation professionals will also provide an avenue for third party reimbursement for lactation support provided by IBCLCs. Currently there is a critical shortage of outpatient lactation services provided by qualified lactation professionals. This shortage of qualified lactation providers leads to a shorter duration of breastfeeding and increased healthcare costs for mothers, infants and increased societal cost."

As they have indicated there is a shortage of qualified lactation providers licensing them will not correct that problem as the wording implies:

It will actually reduce the number of breastfeeding consulting providers. Educational/clinical opportunities to complete the training to become an IBCLC are limited and nearly impossible to complete. Facilities employing IBCLC and individuals already certified as IBCLC are not open to someone shadowing for 6-8 months so they can get the clinical hours needed to complete the course. Relocation to a medical training center is about the only place one can accomplish the hours required and it is prohibitive for persons seeking the certification in medically underserved portions of the state.

They also alluded to the fact of insurance reimbursement will make it more available to the public.

This is not necessarily so. Hoping for reimbursement and actually getting it are 2 different issues. Nothing in the proposal actually mandates insurances to pay a specific rate. Insurance companies say insurance reimbursement is granted to licensed professionals but doesn't disclose the rate of reimbursement.

Insufficient Lactation Consultants/counselors now to cope with issues

They boast of 500 consultants around the state, however where are they located and who are they serving. With the majority of them living in and around Seattle the rest of the state is lacking services. A handful of IBCLC serve Spokane and the Tri Cities. Currently the medically underserved populations of Washington would receive less care and have fewer opportunities for on going support. I serve Klickitat and Yakima counties in which 1-2 IBCLC trained professional serve the region. However there are other trained lactation consultants and providers offering breastfeeding support to this populous. 1-2 people serving in a hospital cannot serve this entire population. To ask postpartum mothers to travel to larger metropolitan areas to find available services is unreasonable and a travesty. Yakima has an excellent

breastfeeding support community that is independent of IBCLC trained professionals. Women helping women, mothers mothering mothers, for the good of their children and for generations to come.

Destroying the ability of established breastfeeding support groups to continue support women.

Le Leche League has been providing ground level support for families since 1956. It was the original breastfeeding support organization. La Leche League of Washington's health care professional seminars are among the top lactation continuing education opportunities in the Pacific Northwest. Each year, LLL brings some of the most-sought-after experts in the field of lactation to Washington State to further understanding of best practices for breastfeeding. Taken from lll.org website 6/13/2016

For those professions and individuals that support and encourage breastfeeding exclusively for the first 6 months, I encourage the sunrise review committee to reconsider this proposal by making it a volunteer licensure open to a multitude of lactation training programs thus not limiting this support to only IBCLC's educated and licensed individuals but let them serve the community with their education and skills.

Fragmentation within our society through isolation

Society and the separation of extended family for support have fragmented our support and social structures, which negatively affects the success of a woman to breastfeed long term. Women need supportive women to ease the transition from pregnancy to postpartum/breastfeeding. First time moms need the support more consistently and need the ease of access to this support. Without it they feel disconnected and alone, sabotaging their chances of success.

This proposal conveys the idea that breastfeeding is another medical event and needs a licensed professional to manage and oversee rather than it being a natural biological process like birth, that has many faces of normal.

I believe lactation consultants offer a great service and to exclude care providers who have established relationships with these women would be a detriment to the health and well-being of these families and society.

Creating greater disparities of care for all women who want to breastfeed.

There is a lot of talk these days concerning correcting the disparities faced by women and children. The effects of this proposal will destroy and demolish the hope of accomplishing this goal within the state of Washington. This proposes that providers will have to deny services and these services won't be available. The low-income families will receive fewer services as Medicaid pay minimally and an IBCLC's will not be able to survive on the payments dispersed. Women have the right to choose their support team in perfecting the art of breastfeeding.

Licensure of one profession must not be to the exclusion of other professionals with similar or greater training for given topic to establish a monopoly of industry.

Proposals to regulate a health profession shall have the exclusive purpose of protecting the public interest. Applicants must demonstrate (RCW 18.120.010(2)):

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;

- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and

- The public cannot be effectively protected by other means in a more cost-beneficial manner.

Response:

I agree that short-term breastfeeding can cause physical or emotional issues for mothers and babies. The physical effects of a poor latch, tongue/lip tie issues, insufficient milk, clogged ducts or mastitis influence a woman's view of her success. Also the emotional toll on the mother who thinks she is broken or inadequate because breastfeeding is not easy for her and the fear, shame, anger she feels can negatively affect all her relationships. In our midwifery practice we have seen these problem, identified them and given the mother the resources, support, or instruction to correct the problem. As I have spoken to several women concerning this topic, I was astonished at their responses: "The IBCLC consultant was hard to get in to see", "the advice was not helpful to their situation", "their concerns were ignored" and "they felt rushed to finish the session". Occasionally they would comment; "The lactation consultant gave me some tips to improve my latch" or "I was referred to Dr. so/so for a tongue or lip tie extensive evaluation." Their most beneficial help came from midwives, local support groups, other women, and LLL leaders. This proposal has failed to prove that an urgent public health remedy needs to be established. To the contrary, prohibiting the first responders of breastfeeding support to discontinue the service that has been provided and limit it to a few "experts" will create a public health crisis. The support being received currently is cost effective and beneficial to the women being served.

Statement made in proposal: There is no affiliated state organization.

Name(s) of other state or national organizations representing the profession:

Response:

- Le Leche League
- International lactation consultant association
- US lactation consultant association

"The applicant report references inaccurate and conflicting information about lactation care being provided to mothers and families by healthcare professionals."

"The applicant report references a critical shortage of outpatient lactation services provided by qualified lactation professionals. Are there health care professionals in addition to IBCLCs currently providing outpatient lactation services?"

"Also listed in that appendix are the education requirements for each profession. It is clear that the levels of training are vastly different among those listed professions, creating the possibility that providers will not possess the skills needed to address basic breastfeeding issues. Even advanced medical professionals such as MDs, PAs, CNMs, ARNPs, LPMs, may not receive the focused training to be able to address breastfeeding issues."

Response: The concerns of the DOH are the same as midwives and other providers that currently offer support without the same training as a IBCLC. I did not find their answer to be satisfactory. "They say that other professionals are not trained or qualified so they should be the only ones authorized to give care but elsewhere they say nothing will change in the care currently being given." It can't be both ways.

"The "no person may provide lactation care or services" part is what is directly offensive. It means that the other certifications which exist and currently are important in the role of women's healthcare and breastfeeding will be specifically barred from practicing until and unless they become IBCLCs, restricting access for women from a variety of sources and reducing it to only one preferred provider based on an exclusionary bias. This is designed BY and FOR IBCLCs to create a separate class for themselves to monopolize breastfeeding care. There is no evidentiary basis for this. Pediatricians, nurses, midwives and obstetricians don't even have the supposed qualifications for what is placed in this bill." Shannon Mitchell, Doula, CLC, CBE and Secretary of Washington Alliance for Responsible Midwifery (W.A.R.M.)

I am writing in opposition of the proposed licensure of lactation consultants. Access to breastfeeding support is already limited in many communities. In my community there are no Internationally Board Certified Lactation Consultants available after 5pm on weekdays and not at all on weekends. If a woman wants to access lactation services she must hope to get one of only a few appointments available with the hospital based IBCLC or the two in private practice. While federal Healthcare Reform requires that insurance companies provide coverage for breastfeeding support and counseling, existing providers are few. The federal law does not limit this care to only lactation consultants. Adding an additional burden of state licensure will not increase access to care for breastfeeding women but may actually decrease it.

As the proposal is written, my ability to provide lactation services as a Licensed Midwife will be stopped. I will not be able to provide educations, make assessment or plans to support my pregnant and newly postpartum mothers. This is not realistic. Under this legislation I would not be able to assist a new mom to get her baby latched properly to the breast, something that is incredibly important in the work I do to support a normal postpartum transition for the mom and neonatal transition to the newborn. I would not be able to manage feeding problems that come up commonly in the first 2 weeks of the newborn's life. In our state, we already have a high rate of women quitting breastfeeding before time recommended by the American Academy of Pediatrics. Many women site lack of support as a reason for early weaning. Removing my ability to be a support is not the answer.

As a Licensed Midwife, the majority of on-going postpartum care I provide is focused on lactation. I am licensed to care for the mother during her transition and the newborn for the first 2 weeks of life. I would be missing major health indicators if I am not allowed to assess lactation and make plans for care. Please do not limit my scope by creating a new lactation consultant credential.

Carolee Hall, LM, CPM
Around the Circle Midwifery
At The Birth House

On behalf of Association of Washington Healthcare Plan (AWHP) member healthcare plans, thank you for the opportunity to offer comments and share concerns as part of the Department of Health's (DOH) sunrise review of a proposal to create a new licensed profession: Licensed Lactation Consultants. AWHP is an alliance of our state's thirteen largest Health Maintenance Organizations (HMO), Health Care Service Contractors (HCSC), and Disability Insurers. Its diverse membership is comprised of local, regional, and national healthcare plans serving the needs of consumers, employers and public purchasers. Together, AWHP member healthcare plans provide health care coverage to over 5 million residents of Washington State.

Our members are committed to providing safe, quality affordable healthcare coverage options to the residents of WA State. As part of that commitment, healthcare plans support and encourage breastfeeding and recognize its importance to the health of women and infants. WA healthcare plans provide coverage of lactation assistance to mothers and infants in compliance with the Affordable Care Act (ACA),

including medically necessary breastfeeding support, counseling, and equipment for the duration of breastfeeding. Healthcare plans provide reimbursement for the services of lactation consultants. These services are generally provided in the hospital or clinics or through home health agencies and billed as part of the overall delivery reimbursement or other services.

We respect and appreciate the role that dedicated health professionals in our state play in providing assistance with breastfeeding. These include ob-gyn physicians and pediatric physicians, nurse practitioners, mid-wives, lactation consultants, and hospital, clinical, and visiting nurses, post-partum Doulas, and others. Additionally, we acknowledge the importance and value of our state's Women, Infants, and Children (WIC) program, as well as the peer support given through volunteer community-based groups and organizations such as La Leche League.

Specific to lactation consultants and their professional organization, we applaud the important progress they have made in training and certification. We also recognize their efforts to professionalize and elevate the career status of lactation consultants.

There are important issues, however, that need to be addressed if the applicant's proposal is to be given a full and balanced evaluation. We do not believe the applicant has sufficiently demonstrated that lactation consultants meet the criteria for establishment of a new category of professional licensure separate from the existing licensing structure for healthcare providers who are already practicing in this field.

By way of example, the application lacks empirical evidence that WA consumers are at risk of serious harm and that licensing of lactation consultants is required in order to prevent this serious harm. Additionally, there is a lack of evidence to substantiate that a significant access problem exists in our state. Certification and licensing for a number of professionals who provide these services already exist (e.g., advanced registered nurse practitioners, licensed midwives). Rather than creating a specific licensure for a narrow scope of practice, we would urge professionals to obtain an existing licensure and practice lactation consulting as a primary specialty.

We also note that the applicant anticipates that licensure will allow lactation consultants to unbundle and carve out their services so that they can bill for them separately-- apart from the existing integrated model of care and inclusive global reimbursement for deliveries. This is of concern because it moves in the opposite direction of integrated value-based care. Instead it will create a new category of fee-for-service billings that will result in additional cost to WA's healthcare system. Additionally, there will be increased costs for the administrative resources required to potentially contract with and credential lactation consultants on an ongoing basis.

Again, we greatly value and appreciate the important role that health professionals, including lactation consultants, play in providing assistance with breastfeeding and supporting the health and well-being of women and infants in our state. Please do not hesitate to contact me with any questions or to discuss.

Sydney Smith Zvara
Executive Director
The Association of Washington Healthcare Plans (AWHP)

The Midwives Association of Washington State (MAWS) appreciates the opportunity to provide input on the proposed Lactation Consultant legislation. As strong supporters and advocates of breastfeeding, MAWS leadership would like to acknowledge the proponents and the department for initiating a discussion about how to ensure quality in the provision of lactation services.

Upon review of the proposed language, we do have several concerns:

First, in Section 2, line 17 states, “No person may provide lactation care and services . . . unless he or she is licensed under this chapter.” Although in Section 6, line 19, “nothing in this chapter prohibits: (a) a person licensed under this title performing services within his or her scope of practice”, we feel that the language is not specific enough to protect access to high quality lactation services currently provided by numerous other provider types, including family ARNPs, family physicians, pediatricians, RNs, and licensed midwives.

While we have heard informally from department staff that the legislation is not intended to restrict the ability of these other providers to be compensated for lactation care and services, MAWS requests careful scrutiny and thought before this proposal moves forward. Having brought a sunrise review (with Rep. Eileen Cody) to the department, MAWS is familiar with the stated interest of the legislature to limit statutory language regarding health profession licensure and scope of practice to what is needed to protect public health and safety. At the same time, the lack of specificity in law has been used by third-party payors to challenge appropriately provided services that are not listed in statute.

Second, we have concerns that the legislation could create an access issue in rural areas lacking IBCLCs. There may be competent and trusted lactation consultants currently providing compensated care that would later be categorized as practicing without a license. One way to remedy this could be to provide credit for experience and a testing-out option for existing providers.

Lastly, we fear that the educational requirements for ILCBC certification may not be equitably available to diverse populations. In order to support the legislation under review, MAWS would want to be assured that the certification materials and examination are culturally sensitive as well as accessible to those that are low- income or with limited-English proficiency.

It is critical that we are not inadvertently creating barriers for communities of color. Breastfeeding rates among black and Native American families already lag far behind those for white families. We should be careful to not take actions that will limit providers already working or prevent their entry, or remove flexibility to utilize emerging health care support methods such as community health workers. MAWS encourages proponents and the department to consult with those currently providing care to these communities, and we are happy to provide contact information.

Thank you very much for taking the time to consider our comments.

Sincerely,
Valerie Sasson, LM CPM
President, MAWS Board of Directors

Audrey Levine, LM CPM
Chair, MAWS Legislative & Policy Committee

Amber Ulvenes
MAWS Lobbyist

The Sunrise Review for licensing Lactation Consultants currently seems to take a colorblind approach to an issue that contains vast racial disparities. Rates of breastfeeding are much lower in African American and Native American communities, partly due to complex histories of slavery, the practice of wet nursing, colonialism and separation of families through school boarding programs, the legacies of which are still being endured today. Among African American families, just under 60% initiate breastfeeding, as compared to 75% and 80% among white and Hispanic families, respectively. Only 30% of African American babies are still breastfed at 6 months of age, and a scant 12% by 12 months, half the rate of white and Hispanic infants (Centers for Disease Control and Prevention, 2013). Breastfeeding rates among Native American communities are similarly low. It is well documented that low rates of

breastfeeding contribute greatly to infant mortality, SIDS, maternal breast cancer, type 2 diabetes, and other enduring health issues throughout the lifespan (Victora et al., 2016).

Similarly, there are very few IBCLCs of color in the U.S. The professional breastfeeding organizations have documented multiple barriers to entry to the IBCLC profession for people of color, including the application process, educational and clinical requirements, lack of qualified mentors, and financial constraints in achieving and maintaining certification (2014 Lactation Summit Design Team). The professional organizations are only beginning to come to terms with the structural change that is necessary to equalize the playing field, and it is likely that equity in the professional ranks will not be achieved for years. Due to the complex histories in communities of color, consumers understandably desire breastfeeding support from someone who looks like they do and who carry an awareness of these complexities. This proposal does not address the issues that are faced by breastfeeding professionals of color in Washington State; this needs to be explicitly considered and addressed.

Furthermore, according to Sherry Payne, it is not the IBCLCs that have had the greatest impact on rates of breastfeeding in African American communities; it is the WIC Peer Counselors (International Lactation Consultant Association, 2014). Most breastfeeding parents need straightforward education and support, which can be provided by Peer Counselors and Certified Lactation Counselors, as well as midwives, doulas and professionals acting within the scope of their training. These professionals refer to IBCLCs when there is a complication that requires specialized education and training. This is similar to many other types of healthcare specialization. By setting the entry to licensure at the highest possible level of breastfeeding education and specialization, within a system that only reimburses those who are licensed, we ensure the continued devaluing and deskilling of community-based peer support, which is currently having the most positive impact on breastfeeding rates in communities of color, those who need it the most.

By licensing *only* IBCLCs (who are predominantly white individuals), and thus gaining insurance reimbursement *only* for IBCLCs, it effectively prevents other breastfeeding professionals (where people of color are almost entirely located in the breastfeeding support hierarchy) from participating in any sort of financially viable system. I worry that this is an inadvertent re-creation of racist structures that have been used by dominant medical associations throughout the last 150 years to raise standards to levels that only they could meet. This action appears to address only the interests of IBCLCs and the hospitals who employ the vast majority of them, not necessarily the interests of communities of color who arguably stand to benefit the most from increased rates of breastfeeding. I would like to see evidence of support or opposition to this sunrise review from communities and breastfeeding professionals of color in Washington and a racial equity impact analysis of how inequities at both the professional and the consumer level would be addressed by this proposed licensing law.

Respectfully submitted,
Wendy Gordon, LM, CPM, MPH
Seattle, WA

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WARM Position Statement on draft bill H-4795.1.1/16
re: Licensure for Lactation Consultants.

This bill has created a storm of debate and passionate opinions. While each person involved sincerely desires the best outcomes for breastfeeding mothers and babies, there is good reason to question how this bill will result in an improvement, rather than a detriment, toward that goal.

Midwives in particular expressed outrage at the wording used in supporting documents, which clearly indicates that those who drafted this proposal failed to do the simplest research beforehand which would have revealed that lactation education is a requirement for being licensed as a midwife in Washington, and that most of us have taken our courses through the IBCLC program, but are not certified as such since it is already part of the scope of our greater license.

However, as the recent disastrous effects of the challenge to our scope of practice regarding newborn care has proven, it appears that the law has been turned on its head and any traditional and grandfathered part of our scope which is not specifically spelled out within RCW 18.50 is subject to unethical attacks. The fact that not everything we do as part of our scope could possibly be listed, is a logical point which failed to be understood for newborn care, thereby setting a precedent for both logic and law to fail to be understood during a second attack on our lactation care. The wording of this bill will create a hostile challenge to our scope of practice which will result in legal proceedings, because midwives would be placed yet again in an untenable legal position. After the recent reduction of our scope of newborn care to only 2 weeks instead of the traditional 2 months, the only means we have of monitoring the wellbeing of our clients' babies is by evaluating the success of lactation, and now that scope would also be in immediate jeopardy. Since many of our clients never see another provider, they would be left without care entirely.

This is completely unacceptable and intolerable, and will have a detrimental effect upon our clients.

Lactation care providers who were certified under other programs, or trained in other ways, would literally be put out of work. Since there are only approximately 500 IBCLCs in the entire state, and many of those will not rush out to purchase a license, that means that the great majority of Lactation Consultants would be unable to perform those services, losing part or all of their professional income. Training is both expensive and very time-consuming, and in most areas of the state it is either impractical or impossible to obtain the number of clinical hours spent shadowing an IBCLC which are required under this proposal.

Further, to limit all professional lactation care providers who are currently serving mothers by making only one particular certification acceptable and legal, would cause great harm to the public by decreasing available services. The proponents of this bill admit that services are already too limited, so decreasing them further is certainly not a solution that has any potential for benefit to the public. This proposal would decrease lactation services radically, especially in all areas of the state which are not urban Puget Sound.

The goal of this bill is to allow a relatively small group of lactation consultants, and no others, to be able to obtain a license in order to bill Medicaid. But does this goal withstand scrutiny? In order to do so, each IBCLC will have to become licensed and obtain liability insurance. All of the other lactation consultants will have to become re-trained and re-certified, and do likewise, if they are to continue to legally work. This is a very expensive proposition in relation to the meager insurance remittance which they will receive from any Medicaid carrier, and there is no guarantee whatsoever that they will receive

any reimbursement at all. In fact, those who contract with Medicaid will be prohibited from being paid, even on a very reduced sliding fee scale, by all of those clients who are now insured under the ACA whether the insurance pays or not, so the providers may in fact end up being paid little or nothing at all. This will result in less providers being financially able to provide lactation services to low income clients, which will further reduce access to care for those families. Currently, low income families obtain lactation services mostly through community sources such as LLL, clinics and offices which already bill Medicaid for the visits but may effectively be prohibited from doing so under this bill, WIC workers, and midwives who usually do not even charge the client for this service. Proponents say that low income mothers will be better able to obtain care as a result of this bill, but an analysis of the facts does not support this claim.

Further, we must question why this proposal was written in such an exclusionary form. If the goal were really to improve access to lactation care, or to obtain the ability to bill Medicaid, why not request a license which is strictly voluntary, and in no way prohibits any other professionals from providing these services? Only licensed LC providers could legally claim to be licensed, so what potential harm could possibly be attributed to a license which is purely voluntary, for the purpose of billing insurance? Would prudence not dictate a voluntary and non-exclusive license as a test of theory, to see if in fact any benefit is seen as a result of licensure? There is no moral, ethical, legal, or practical reason to specifically limit professional lactation care to a monopoly by those few who would qualify for a license under this proposal. The wording of this proposal is unacceptable and unsupportable.

The only state which has any experience with this idea is Rhode Island, a state smaller than most counties in Washington. Yet even with its miniscule size, and therefore the potential for this proposal to increase access to services rather than decrease them, the proponents have offered no data to demonstrate how this idea has actually worked to improve outcomes in Rhode Island. Before leaping to embrace what could have been a terrible mistake, we should see hard data proving that breastfeeding outcomes actually improved as a result. Without evidence that such a bill significantly improved breastfeeding outcomes when it was enacted, this proposal has no merit.

To better gather the voices of the people, we posted a survey and invited both the public and professionals to take the survey, and to submit their personal comments as well. Demographic questions were asked about the lactation care given and/or received. A detailed breakdown of the responses and comments will be supplied for review at the hearing on July 12. An analysis of the application submitted in support of this bill will also be supplied at that time.

In summary, the proponents of this bill have failed to demonstrate that there is a public health crisis which would be solved by invoking this by-pass process, as opposed to using normal legislative means to achieve what should be a less disruptive and less harmful pathway for obtaining Medicaid reimbursement for lactation services. Therefore, WARM cannot in good conscience support this bill.

L. Carr, President
Washington Alliance for Responsible Midwifery

Addendum to
WARM Position Statement
on draft bill H-4795.1.1/16
re: Licensure for Lactation Consultants.

July 10, 2016

Part I. Analysis of inconsistencies, errors, omissions, and other concerns found in both the bill and the supporting documents.

A. BILL

P. 1 Sec. 1 (3)
To legally define “Lactation Consultant” as meaning only someone who is licensed under this chapter is wrong. It creates a monopoly on a common term used for anyone offering lactation services or advice, rather than setting apart those who are Licensed Lactation Consultants so that they can be identified by the public and bill Medicaid. It also prohibits all higher level providers from informing the public that they offer those services, which will reduce public access to care. It may also end up allowing insurance companies another excuse to deny claims from higher level professionals because they are not allowed to acknowledge that they also provide Lactation Consultation services. This exclusivity is not in the interest of the public. Allowing all other Lactation Consultants to be able to admit to the truth does not in any way allow them to claim to be “Licensed Lactation Consultants”, which is the only exclusive term that should be created by this Bill.

P. 1 Sec. 2
This section directly conflicts with Sec. 6 and with the proponents’ assertions that they are not preventing others from providing services. The only thing that this bill should prohibit is for anyone who is not licensed to represent themselves as being licensed. This section belies any honorable intentions by the proponents of the bill.

P. 3 Sec. 6
This section is contradictory to both Sec. 2 and to itself. The way these two sections are written creates a monopoly and removes lactation services from the scope of other professionals. There are no higher level healthcare professionals whose scope is written in the law as specifically including “lactation care and services” as defined in this bill. The recent disaster which resulted in the scope of newborn care for midwives being reduced from the traditional 2 months to only 2 weeks is an example of what will happen under this bill, only it will involve every type of higher level healthcare provider who formerly provided lactation care. Are the proponents of this bill claiming that they are asking for every single type of practitioner to have their laws open for revision, just to accommodate the proponents claims about how it will not affect those practitioners? There are serious consequences that would arise from this.

This section also prohibits student midwives from providing a service that is a vital part of their clinical experience. Contrary to what the proponents have stated in this application, student midwives are required to take courses in lactation care, and in their clinical training their preceptors expect them to obtain a great deal of experience in lactation. Many do in fact become lactation consultants during their midwifery training, and although the requirements of IBCLC are all contained within the training and education of a midwife, students rarely if ever are able to become certified (let alone licensed as LCs) because the overwhelming demands on their time as a midwifery student preclude obtaining time under

an IBCLC supervisor. What is being proposed here would stop the lactation training opportunities of the students who will be the healthcare providers with the best lactation outcome records of any in the whole state, and allow only students seeking IBCLC licensure instead. This is beyond unacceptable.

P. 4 Sec. 7 (1)
This section is inconsistent with the makeup of the Advisory Committees (AC) of other professions. For the proponents to claim that this bill is necessary to protect the public from harm done by lactation care, and then to request more autonomy than other professions enjoy, is hypocritical. If we were to follow the precedent of 18.50, then the AC for lactation consultants should also include at least one licensed midwife, one nurse, one physician, and a second physician who specializes in lactation disorders. If not, then perhaps midwives (who are primary care providers) will be forced to demand a greater level of autonomy on their own AC. The wording proposed here excludes from the AC the very upper-level professionals who are currently doing this work with great success. According to outcome statistics, with midwives achieving extended breastfeeding levels of >90%, lactation consultants should be subject to oversight by midwives. As this bill demonstrates, there appears to be a faction of IBCLCs who believe that only they can provide safe outcomes, which is far from true and indicates a need for oversight to improve professional perspective.

B. APPLICANT REPORT OUTLINE

P. 1 of 28
Proponents have not demonstrated any of the 3 requirements, all of which must be met. Theories and presumptions are not evidence.

While no one argues that the public health is improved by successful breastfeeding, there is no substantial quantitative data presented here which shows how this proposal could improve lactation outcomes.

There is also no quantitative data comparing the outcomes of IBCLCs to the outcomes of Lactation Consultants trained under any other programs. The only data demonstrates that outcomes are improved by having lactation care and services, as opposed to not having them. Since my own practice, in which I am personally the only one who took the IBCLC course, has a >98% breastfeeding rate at 2 months, and still >90% breastfeeding rate at one year, it is not reasonable to assume that IBCLCs are the only ones who can provide good care or improve breastfeeding outcomes. Comparative studies would be necessary prior to making such a sweeping assumption that only one type of training and certification is superior and is the only solution to a public health issue.

P. 2 of 28
Proponents fail to answer the question, and do not list the other national organizations, such as CAPPA. Please see https://galactablog.com/lactation-training/lactation-certification-programs/.

P. 3 of 28
States which regulate this profession: those who have introduced bills have absolutely no information to add to this discussion. Georgia passed a bill this year, so also has no information to offer. Only one state, Rhode Island, a state with only 1,600 square miles of area (smaller than most counties in Washington) passed a similar bill in 2014, and the date of enactment is not offered here.

So only a state where the public could drive to services within the boundaries of their own state in a half-hour or less from anywhere in the whole state, might have data showing the result of enactment of the

bill. Yet even the data, if any, from Rhode Island was not submitted with this application, so that we could consider whether this bill will have beneficial or detrimental effects on the public.

P. 3 of 28, Factors to Address, (1)
No one disputes any statements here; we wholeheartedly agree with all of them. However, these are all theoretical or potential harms, without any hard data to show how these are problems in Washington which are in any way caused by the lack of exclusive IBCLC licensure for LCs, or which can in any way be solved by exclusive IBCLC licensure of LCs.

If this application can be seriously considered, then based upon outcomes and the public health crisis created by the rates of C-sections, midwives should propose a bill prohibiting anyone but licensed midwives from providing maternity care to low-risk women. Sound crazy? Then so does this bill, because the premise is the same - only midwives would have actual hard data to support a claim that they are the singular answer to the problem. The proponents of this bill have no such hard data indicating that IBCLC outcomes are better than those of any other LCs.

P. 4 of 28 (1)(a)
This process assures nothing regarding the competence or quality of care provided, only that a particular program of education and training was completed. IBCLCs will not be trained under preceptors based upon the performance outcomes of those preceptors.

Note: Appendix 2&3 references are not exclusive to IBCLCs, they discuss the improvement in outcomes when LCs are used, as opposed to when they are not used. There are no comparisons of the outcomes of IBCLCs vs other Lactation Consultants.

Regarding the “critical shortage”; nothing in this bill can be reasonably argued to promote an increase in the availability of services, and in fact will result in an immediate and critical reduction of services when all other LCs are prohibited from working.

P. 6 of 28 (3) (a)
Few families ever pay out-of-pocket for LCs now (and no data is presented here), since most LCs who are currently billing Medicaid do so under other licenses or through their employers (mostly clinics or larger facilities). Others are given these services free of any additional charge, as part of their global maternity care, because insurance will not pay for these services even from licensed providers. So there is little theoretical basis, and no data has been offered, to support the claim of a disparity in care. Further, there is no part of this bill which will force insurance to suddenly play nice and reimburse for services that they are already routinely denying.

P. 6 of 28 (3) (c)
A search of the IBLCE registry on the ICLA site shows only seventy-one (71) in the whole state of Washington! Almost all of those are in the Seattle / urban Puget Sound area. Are the proponents of this bill suggesting that the public can be served by only 71 LCs who almost all live in a cluster in one corner of the state, many of whom are only accessible to patients of the facilities which employ them? Or are they promoting an agenda for the organization which would charge a fee for listing LCs on their online registry?

P. 6 of 28 (3) (d)
No harm has been demonstrated by the legal availability of other LCs. This bill would only reduce that availability.

P. 7 of 28 (3) (e)(f)
No wording exists in RCW 18.50 to specify “lactation care and services” under the scope of midwives. The proponents are being deliberately deceptive here, because it is not true that lactation is not a part of our required curriculum. Midwives have a well-documented and extremely high success rate for breastfeeding, but under this bill would be prohibited from continuing to provide these services.

P. 7 of 28 (3) (g)
No market forces are involved in Medicaid reimbursement. Only massive taxpayer grants (which by their very nature are discriminatory against small outpatient practices) create such an incentive, and at what cost to the state and to the public?

P. 7 of 28 (4)
Again, the only assurance to the public would be that licensed LCs have gone through a particular program, and that all other LCs will be removed from the number of providers who are available.

P. 7-8 of 28 (4)
Saying that insurance reimbursement would increase public access is a red herring statement, not supported by the changes in access to other providers under the ACA (as more and more are forced to switch to cash-only practices or face bankruptcy). First there would have to be adequate reimbursement (which is not the case), then the insurance carriers would have to be forced to actually pay (impossible if they are not regulated strictly under Washington state law), then all of the licensed LCs would have to contract with Medicaid and accept unlimited Medicaid clients, and then there would have to be literally tens of thousands of licensed LCs distributed adequately across the state, in order for public access to be increased as claimed here. That is a lot of impossible conditions to satisfy before these statements would have any validity.

P. 9 of 28 (4)(b)
This will put all other LCs, no matter how excellent their outcomes, out of work. Also, all other higher-level professionals would be severely hampered by challenges to their scope, and the inability to continue to identify to the public (advertise) the fact that they provide lactation services.

P. 12 of 28 (4)(e)(viii)
The theoretical increase in LCs is not supportable, as the Medicaid funds that they seek will not recoup the costs of training and licensure.

P. 14 of 28 (6)
This bill seeks to redefine a normal and natural human interaction as a “health profession” and regulate who can offer advice about a basic human non-emergency function - feeding a baby. This establishes a dangerously statist precedent whereby the state must license people before they can help someone learn to eat, regulating something which is a basic human right and natural biological function.

P. 15 of 28 (6)(b)
Statements herein are simply not true. For midwives, lactation training is part of our licensing requirements. The wording here is very deceptive, making it seem as if other professionals will not be affected, but under this bill they are. No true “exemptions” exist, as they are all conditioned upon circumstances which are not applicable.

P. 16 of 28 (7)(b)
Assuring a code of ethics does not equate to assuring quality. Adherence to IBCLC rules or changing guidelines also does not assure the public of competent outcomes, it only removes the public’s right to

choose a Lactation Consultant with known good outcomes who was trained under another program. So market forces (competition and a variety of choices) which normally reward good service reputations and encourage providers to seek a higher level of competence would actually be eliminated.

P. 17 of 28 (8)(a)
Great! So create a voluntary license for the purpose of Medicaid reimbursement, and leave everyone else out of it. Then Licensed LCs could bill; problem solved without harming others.

C. FOLLOW-UP QUESTIONS

1. Again, the proponents did not list midwives or tell the truth about their education. In some areas, midwives are the only available LCs.

The failure of medical curriculums should not justify a whole new license for LCs unless it is non-exclusive, otherwise this will only serve to further polarize doctors and excuse poor medical education, leaving only a group of specialists to provide lactation care.

2. This is not an adequate response, and there is not indication that this proposal meets the required criteria.

3. No language exists under 18.50 exists to allow midwives to continue to provide lactation care and services under this bill.

6. Here the proponents directly lie to the DOH, saying that; “There will be no change in the current scope of other lactation services available.” The bill very clearly makes it illegal for LCs who are not licensed under this bill to continue to work!

7. Here they admit that no one can offer LC services except through an IBCLC monopoly and license, which clearly contradicts what they claim in (6) above.

Common sense would tell us that only licensed LCs can claim to be licensed, which is protection enough.

This is not surgery we are talking about, it is feeding a baby. In most cases, these services do not require the level of training that is being proposed here. In other cases it is not enough training for the needed care to be within their scope of practice.

Families with serious problems are referred to serious professionals, like pediatric dentists for lip tie. Placing Licensed LCs in the middle only forces families to get additional referrals and suffer additional wait times (damaging to newborns) to go through another layer of care providers. History shows that patients could easily end up being required by insurance policies to go through a Licensed LC before being seen by a specialist in an effort to avoid follow-through of care, so that insurance will end up not having to pay claims.

If midwives can be required to screen newborns for various conditions, why could not other providers be required to adequately screen for lactation problems if they are going to provide maternity and newborn care? Would that not be a greater assurance to the public than what would result from this bill?

Part II. Survey conducted online, for 20 days, June 18 to July 8, 2016.

There were 9 questions in the survey identifying or describing experiences which relate to lactation care and services in Washington. A tenth question was simply an optional contact information request.

Q1. You are currently, or have past experience as a: (check all that apply)

- Answered: 75
- Skipped: 0

	N/A	Less than one year	1-5 years	5-10 years	10-20 years	More than 20 years	Total
Midwife	35.94% 23	14.06% 9	9.38% 6	9.38% 6	6.25% 4	25.00% 16	64
Physician	89.58% 43	2.08% 1	6.25% 3	0.00% 0	2.08% 1	0.00% 0	48
Nurse	80.77% 42	1.92% 1	3.85% 2	1.92% 1	1.92% 1	9.62% 5	52
Lactation Consultant, IBCLC	89.80% 44	2.04% 1	2.04% 1	4.08% 2	0.00% 0	2.04% 1	49
Lactation Consultant, other (includes LLL)	73.47% 36	0.00% 0	6.12% 3	10.20% 5	4.08% 2	6.12% 3	49
Nursing mother (skip any questions below that do not apply to you)	11.59% 8	10.14% 7	33.33% 23	23.19% 16	20.29% 14	1.45% 1	69
Other (please specify below*)	53.66% 22	4.88% 2	12.20% 5	14.63% 6	12.20% 5	2.44% 1	41

* Birth-Doula (DONA Int), LAc, LMP, CNP
Doula
Breastfeeding peer counselor
Midwife's Assistant, doula, MA, Certified Lactation Counselor
Doula
Grandmother
Doula and Student Midwife
Student lactation consultant, will sit the IBLCE exam this fall.
Doula, pediatric Occupational Therapist
Midwife birth assistant, and doula
Breastfeeding counselor
Doula
Doula
Doula and Childbirth educator, Student Midwife
Naturopath
Doula
La Lache League leader and Alice Doula
Student midwife (earning a bachelor of science in midwifery).
Childbirth educator ICCE
Doula

Most respondents were nursing mothers (61), many were midwives (41), 13 were Lactation Consultants with credentials other than IBCLC, 13 were doulas, and10 were nurses. Five (5) were IBCLCs.

Q2. Describe your service area (or where you live and receive care if you are/were a nursing mother). Check all that apply.

- Answered: 73
- Skipped: 2

	N/A or never	Rarely	Sometimes	Often	Mostly	Always	Total	Weighted Average
Home or freestanding birth center	5.80% 4	5.80% 4	14.49% 10	13.04% 9	27.54% 19	33.33% 23	69	4.51
Hospital or associated birth center	25.42% 15	18.64% 11	22.03% 13	15.25% 9	13.56% 8	5.08% 3	59	2.88
Clinic or office	16.39% 10	9.84% 6	26.23% 16	22.95% 14	14.75% 9	9.84% 6	61	3.39
Urban or suburbs	21.05% 12	8.77% 5	21.05% 12	14.04% 8	15.79% 9	19.30% 11	57	3.53
Rural or small town	14.06% 9	10.94% 7	17.19% 11	7.81% 5	21.88% 14	28.13% 18	64	3.97
Extensive medical services are available nearby	11.48% 7	9.84% 6	21.31% 13	24.59% 15	13.11% 8	19.67% 12	61	3.77
Medically underserved, or services are at a distance	15.00% 9	10.00% 6	25.00% 15	21.67% 13	20.00% 12	8.33% 5	60	3.47
Washington, west of the Cascades	40.68% 24	3.39% 2	13.56% 8	1.69% 1	15.25% 9	25.42% 15	59	3.24
Washington, east of the Cascades	35.00% 21	3.33% 2	8.33% 5	5.00% 3	16.67% 10	31.67% 19	60	3.60
Oregon	70.37% 38	9.26% 5	7.41% 4	7.41% 4	5.56% 3	0.00% 0	54	1.69
Idaho	90.57% 48	7.55% 4	0.00% 0	0.00% 0	0.00% 0	1.89% 1	53	1.17
Other*	67.31% 35	5.77% 3	9.62% 5	3.85% 2	1.92% 1	11.54% 6	52	2.02

* This is for Texas
OLYMPIC PENINSULA sometimes KITSAP
Missouri
Montana, Texas, California, Utah, New Mexico, Florida, British Columbia, Alaska
We are a military family but are from Washington and plan to return there after retirement in a few years.
Vammala, Finland
California
Wic
Washington
Wisconsin
When visiting family out of town.
MN, AZ, CO, WI
Kansas, Kentucky, New Jersey, Virginia
California

Respondents tended to be more from eastern WA compared to western WA, more rural compared to urban, more from home birth practices rather than hospital, and near equally split between medically underserved or not.

Q3. Describe your practice (or the practice where you received your care): Check all that apply.

- Answered: 73
- Skipped: 2

Less than 5 maternity care providers	86.30% 63
5-10 maternity providers	2.74% 2
>10 maternity providers	4.11% 3
20 or less clients/patients per year	10.96% 8
>20 clients, but less than 100 per year	35.62% 26
>100 clients/patients per year	12.33% 9
Women's health (gyn)	39.73% 29
Prenatal care	79.45% 58
Births (ob)	56.16% 41
Labor support (doula)	53.42% 39
Postpartum care	75.34% 55
Newborn care	71.23% 52
Pediatrics (infant/child)	19.18% 14
Full family practice	12.33% 9
Lactation consult	43.84% 32
Nutritional consult	36.99% 27
Childbirth, parenting, or breastfeeding education	56.16% 41
Maternity case management (health/medical)	15.07% 11
Social services (includes WIC)	10.96% 8
N/A	1.37% 1

The great majority of responses involved smaller practices that focus on maternity care, almost half of which provide lactation consult services.

Q4. How many of your clients/patients are: Check all that apply. (Mothers, describe what applied to your care.)

- Answered: 72
- Skipped: 3

	N/A or unknown	**<1%**	**1-5%**	**5-25%**	**25-50%**	**50-75%**	**75-90%**	**>90%**	**Total**
In your care for less than 2 weeks postpartum	25.81% 16	32.26% 20	19.35% 12	8.06% 5	4.84% 3	1.61% 1	1.61% 1	6.45% 4	62
In your care for 2-4 weeks postpartum	24.14% 14	10.34% 6	15.52% 9	17.24% 10	6.90% 4	5.17% 3	3.45% 2	17.24% 10	58
In your care for 4-8 weeks postpartum	15.38% 10	1.54% 1	4.62% 3	7.69% 5	3.08% 2	13.85% 9	9.23% 6	44.62% 29	65
In your care beyond 8 weeks postpartum	27.42% 17	12.90% 8	17.74% 11	6.45% 4	9.68% 6	3.23% 2	6.45% 4	16.13% 10	62
Still at least partially breast-feeding at discharge	17.19% 11	0.00% 0	0.00% 0	1.56% 1	3.13% 2	0.00% 0	7.81% 5	70.31% 45	64
Exclusively breastfed at discharge	12.86% 9	0.00% 0	0.00% 0	1.43% 1	0.00% 0	1.43% 1	17.14% 12	67.14% 47	70
Still breastfeeding at one year	21.74% 15	0.00% 0	1.45% 1	1.45% 1	4.35% 3	15.94% 11	20.29% 14	34.78% 24	69
Provided lactation care entirely by you	19.70% 13	0.00% 0	4.55% 3	3.03% 2	13.64% 9	9.09% 6	19.70% 13	30.30% 20	66
Referred to or using other sources, not you, for routine lactation care	24.59% 15	13.11% 8	22.95% 14	18.03% 11	11.48% 7	6.56% 4	1.64% 1	1.64% 1	61
Referred to other sources or specialists for serious lactation issues	22.95% 14	13.11% 8	31.15% 19	14.75% 9	6.56% 4	1.64% 1	4.92% 3	4.92% 3	61
Using multiple sources, including you, for lactation care or advice	20.63% 13	4.76% 3	19.05% 12	15.87% 10	11.11% 7	12.70% 8	7.94% 5	7.94% 5	63

Most practices represented in this survey serve mothers for 4-8 weeks or longer, covering the early period during which breastfeeding is either firmly established or not. With that being the normal discharge time, the great majority were breastfeeding at discharge from care, most of those being the ideal situation of exclusively breastfeeding. The majority were also still breastfeeding at one year.

Most were given lactation care by their primary caregiver, with relatively few being referred to specialists or other sources for lactation care for serious problems, but many using multiple sources of lactation advice.

For primary care providers to achieve a level of breastfeeding success over 90% for an extended lactation period is phenomenal, and indicates that the population responding to this survey are not suffering from any deficiency in care.

Q5. Who most often provides lactation assistance for clients in your care, during these times (or who provided this care to you):

- Answered: 74
- Skipped: 1

	N/A	Midwife, out of hospital	Physician, nurse, or hospital midwife	Specialist (like ped. dentist)	Lactation consultant, IBCLC	Lactation consultant, other	Other pro (including doula)	Community help (LLL)	WIC or other social worker	Total
Initial newborn latch and first day	0.00% 0	77.03% 57	12.16% 9	0.00% 0	2.70% 2	1.35% 1	5.41% 4	1.35% 1	0.00% 0	74
First week of breastfeeding (after day 1)	1.37% 1	72.60% 53	5.48% 4	0.00% 0	4.11% 3	6.85% 5	5.48% 4	2.74% 2	1.37% 1	73
Ongoing routine lactation care or advice	2.74% 2	56.16% 41	1.37% 1	0.00% 0	5.48% 4	9.59% 7	8.22% 6	13.70% 10	2.74% 2	73
Lactation advice for minor issues	2.74% 2	64.38% 47	0.00% 0	0.00% 0	5.48% 4	1.37% 1	9.59% 7	12.33% 9	4.11% 3	73
Lactation advice for moderate issues	9.59% 7	42.47% 31	1.37% 1	1.37% 1	13.70% 10	13.70% 10	4.11% 3	12.33% 9	1.37% 1	73
Serious lactation issues	13.89% 10	12.50% 9	5.56% 4	13.89% 10	40.28% 29	9.72% 7	0.00% 0	4.17% 3	0.00% 0	72
Lactation support after discharge from care	6.94% 5	33.33% 24	0.00% 0	0.00% 0	8.33% 6	5.56% 4	9.72% 7	36.11% 26	0.00% 0	72

For most respondents, the person providing the critical lactation care (the initial latch and first week of breastfeeding) as well as ongoing care was an out-of-hospital midwife.

For moderate lactation problems, most were still managed by midwives but approx 13% each were referred to IBCLCs, other Lactation Consultants, and community lactation sources.

This trend changed only for serious lactation problems, when 40% were referred to IBCLCs and 14% to medical lactation specialists such as pediatric dentists.

Support after discharge from care shifted more toward community lactation help, such as LLL.

Q6. How easy is access for the average client (include considerations like price, wait times, and driving distance if the client has to travel to appointments) to each of these resources that are used for lactation care in your area/practice: (Mothers, describe your experiences.)

- Answered: 75
- Skipped: 0

	N/A or unknown	Impossible	Difficult	Moderate	Good	Easy	Total	Weighted Average
Lactation consultant, IBCLC	15.28% 11	13.89% 10	25.00% 18	25.00% 18	15.28% 11	5.56% 4	72	2.28
Lactation consultant, other	20.83% 15	0.00% 0	19.44% 14	29.17% 21	25.00% 18	5.56% 4	72	2.54
Hospital physician, midwife, or nurse	16.22% 12	4.05% 3	21.62% 16	20.27% 15	28.38% 21	9.46% 7	74	2.69
Physician or nurse in clinic or office	15.28% 11	2.78% 2	18.06% 13	36.11% 26	18.06% 13	9.72% 7	72	2.68
Midwives, non-hospital birth care	4.11% 3	0.00% 0	2.74% 2	4.11% 3	30.14% 22	58.90% 43	73	4.33
Community help (like LLL)	18.06% 13	0.00% 0	5.56% 4	19.44% 14	31.94% 23	25.00% 18	72	3.22
WIC or other social workers	21.92% 16	5.48% 4	12.33% 9	31.51% 23	24.66% 18	4.11% 3	73	2.44

As can be seen from the table above, for most respondents access to IBCLCs is difficult to moderate, while access to other non-IBCLC lactation consultants leaned more toward moderate to good.

Access to physicians, midwives, or nurses in all settings (hospital, clinic, or office) tends to be more moderate to good, as is access to WIC or other social workers.

Access to out-of-hospital midwives was reported as mostly easy, community help (like LLL) was mostly good to easy.

Of all of the choices offered, IBCLC consultants were the least accessible to the respondents.

Q7. Please rate the typical (most common overall) experiences that you have had or your clients have reported with:

- Answered: 74
- Skipped: 1

	N/A	Very poor, bad advice or care	Unsatisfactory, unable to solve problem	Satisfactory, made improvements	Good, problem solved or referred properly	Excellent, solved or prevented multiple or serious problems	Total	Weighted Average
Lactation consultant IBCLC	29.58% 21	2.82% 2	9.86% 7	26.76% 19	19.72% 14	11.27% 8	71	2.38
Lactation consultant, other	25.71% 18	2.86% 2	4.29% 3	30.00% 21	30.00% 21	7.14% 5	70	2.57
Hospital lactation consultants, unknown credentials	24.29% 17	18.57% 13	18.57% 13	27.14% 19	10.00% 7	1.43% 1	70	1.84
Midwives	2.70% 2	0.00% 0	1.35% 1	12.16% 9	41.89% 31	41.89% 31	74	4.16
Other professionals during routine care	30.00% 21	12.86% 9	17.14% 12	27.14% 19	10.00% 7	2.86% 2	70	1.83
Other professionals referred for lactation problems	42.03% 29	0.00% 0	2.90% 2	24.64% 17	18.84% 13	11.59% 8	69	2.13
Community help (LLL)	19.72% 14	0.00% 0	4.23% 3	29.58% 21	26.76% 19	19.72% 14	71	3.03
WIC	36.62% 26	14.08% 10	18.31% 13	22.54% 16	7.04% 5	1.41% 1	71	1.54

This question rated the satisfaction level with the success or failure of lactation care and services in the experience of each respondent (and/or as reported by their clients/patients).

The best care experiences by far were reportedly provided by midwives, which result persists even if all of the professional midwife respondents are removed from the data pool.

The second best care was reported as being provided by community sources such as LLL. Other, non-IBCLC Lactation Consultants also had favorable results, with somewhat less favorable overall reported for IBCLCs.

Professionals to whom referrals were made were seen as slightly less successful but still generally satisfactory or better.

Less satisfactory results were attributed to other professionals during routine care, and hospital lactation consultants with unknown credentials. WIC received the least satisfactory reports.

Q8. Please describe the affects it would have in your area if only state-licensed IBCLC's were allowed to provide lactation care and services, with no exemptions for midwives, physicians, nurses, or those trained under other programs. (With lactation care and services being defined as "…evaluation, problem identification, treatment, education, and consultation…")

- Answered: 74
- Skipped: 1

	Very negatively	Negatively	Moderately	Positively	Very positively	Total	Weighted Average
How would it affect your own clients/patients (or you)?	84.93% 62	12.33% 9	0.00% 0	2.74% 2	0.00% 0	73	1.21
How would it affect your professional practice?	75.38% 49	15.38% 10	3.08% 2	4.62% 3	1.54% 1	65	1.42
How would it affect other local health care providers?	69.57% 48	26.09% 18	2.90% 2	1.45% 1	0.00% 0	69	1.36
How would it affect the average nursing mother/baby in your area?	79.45% 58	16.44% 12	2.74% 2	1.37% 1	0.00% 0	73	1.26
How would it affect new mothers/babies?	84.93% 62	13.70% 10	0.00% 0	1.37% 1	0.00% 0	73	1.18
How would it affect mothers/babies with serious nursing issues?	78.08% 57	10.96% 8	8.22% 6	1.37% 1	1.37% 1	73	1.37

Responses show an overwhelming opinion that the bill, as written, will have a very negative effect on both the public and the professionals who provide lactation care, despite there being several IBCLCs who responded to the survey. If the IBCLCs are removed from the data pool, there are no positive responses.

Part III. Public comments.

A. From Survey, above:

Q9. Please submit your comments, requests, or observations.

- Answered: 37
- Skipped: 38

1. There are no IBCLCs in our area. My practice has >98% breastfeeding rate. This bill is shameful, for trying to create a monopoly on lactation care just so they can bill for a few pennies from medicaid! This will cause so many problems, and mothers and babies will be harmed by it.

2. Baby was born at home. Milk didn't come in until the 6th day. Only advice I really got was "nurse more", which didn't help because I have other children and nobody to help run the house. Partially nursed until 10 months. Never produced more than 50% of baby's needs. Doctor's only advice was to supplement. Didn't try to help with breastfeeding at all.

3. I don't know what IBCLC is so I'm not sure how it would affect me. After looking it up online to see what it means, I'm still not sure how to answer since I'm not sure who all is licensed. I think anyone in the OBGYN, Social Services and Midwife area's should have at least one person on their staff should be licensed if not more. All those area's that are involved with the birth of a child should be able to instruct the mother from the moment the child is born and not have to have another person come in and instruct the mom. My son was breastfed for only a few weeks then I went through postpartum. They put me on a med and I had to quit cold turkey with him. If I'd had my choice I would of pumped my self till I could breast feed him again. I wish I could of nursed him longer. We were going through a tough time when my daughter was an infant so I breast fed her till she was 2yrs old since it was cheaper to buy food for 3 mouths and nurse her. They are now 17 and 18 yrs old.

4. No one in our practice can understand why this is an issue, or why there should be an exclusive license. Most of us trained through the IBCLC program, but are not certified, and have no plans to do so. This would not benefit the public.

5. I work mostly in a small community clinic, and my services are in heavy demand. There is no one who is IBCLC-certified anywhere in my area. I received training under another program, and cannot pay the money or take the time needed to do another. If I were forced to obtain that training and pay for a license, I would be out of work and be forced to retire. Why are the proponents of this bill saying that there is an immediate health care risk to the public? And that they are the only ones who can safely provide lactation care? I find that quite offensive, almost slanderous, since we have such a highly successful breastfeeding rate. Many of the new moms that I serve cannot afford to pay for services and we make certain that they receive them anyway. Medicaid is a waste of time for my clients who are not seeing me through the clinic, because the liability policy we have to carry in order to contract with them is cost-prohibitive. It horrifies me to see a handful of people who claim to care about babies, being willing to put other professionals out of business, and leave those babies without lactation services! And for what?

6. I've nursed three children and dealt with shallow latch and severe over-production. My midwives have been phenomenal helping me correct latch and supply. This has been a free service provided naturally during appointments or in my home as needed. The hassle of finding a consultant, making an appointment, getting to an extra appointment, etc. with a cranky newborn would be a real impediment to enjoying the first couple months with my babies.

7. tHe government plan would have disastrous effects on breastfeeding success, which is linked to lifetime improvement in health for mothers and babies. fOr mothers, breastfeeding helps prevent or reduce obesity, and reduces incidence of breast cancer. fOr babies and children who breastfeed, there is improvement to IQ score, less infections of all kinds, less cancer, neurodevelopmental problems, blood pressure problems, cancers of all kinds, need for orthodontia, obesity, and heart disease.

8. Licensure will only decrease options for nursing mothers and babies! This is a bad idea, one that I do not support!

9. I live in an area where the closest IBCLC (1) is a 90 minute drive away. That's NOT practical for newly post-partum mothers. However, several birth professionals in my area have missed or dismissed moderate to severe tongue and lip ties and the accompanying symptoms. I am not satisfied with the level of professionalism, knowledge and attitudes of local providers.

10. Mothers already have an established relationship with their midwife, and are scheduling routine postpartum visits with them. They are the natural "go-to." The last thing a new mom wants is one more appointment. Obviously, if there is an issue greater than the ability of the midwife to handle, she refers.

11. IBCLCs are not available to everybody easily at any time. I have found that many doulas, LLL members, midwives and nurses are as good as or superior to IBCLCs, depending on their personal opinion and training background. IBCLC does not guarantee the best or most recent or inclusive information.

12. Some people have problems being believed about how serious their problem is. If you cut down the number of people who can legally help these women you are cutting down their chances of being believed and being helped. And if you cut down their chances of being listened to and helped you're cutting down the baby's chances of breastfeeding

13. I work in isolated, poor Amish communities who do not welcome outsiders. There is no money and the issues of modesty would prohibit an outsider from watching them breastfeed.

14. Pediatricians and specialists who resolve tongue-tie, those who do craniotomy-sacral therapy, and anyone with lactation education would have their hands "tied" and women and babies would be at a great disadvantage.

15. The charge alone puts assistance out of reach for low income women

16. Midwives are trained to support lactation and are familiar with how to refer appropriately when issues become too complicated.

17. IBCLC's are almost impossible to find in our area, most don't know much if anything when it comes to hard or special issue cases and repeat the same regurgitated information you hear in generic breastfeeding books.

18. My request would be that other care providers such as midwives, nurses, physicians, doulas, community services such as LLL would continue to be able to provide lactation care. It's unrealistic and detrimental to nursing families to make lactation care less accessible.

19. My midwife was the only one with all of the answers. La Leche League was helpful but the distance to meetings was too much for a mom with a new baby, and later with siblings it was not practical at all. I don't know much about certified lactation consultants, because there were no professional ones within hours of me, so I was fortunate to have a great midwife. She was the only midwife anywhere near me, too, even though I was near a lot of towns (small ones), and she was my midwife for all of my babies. I never really felt like I was "out" of her care, because anytime I had a problem or a question, I could call her and talk or see her right away, and she was so good with baby care. Getting an appointment with a doctor was hard, and took too long if a problem was serious. Friends who got breastfeeding advice from nurses and WIC workers were very unhappy, and many of them ended up going to my midwife for advice after no one else could help them.

20. As a mother who breastfed, I found that many times those "professionals" who offer lactation care are rushed, impatient and condescending. Many times, I have reached out to the knowledgeable, caring, attentive midwives, LLL, doulas, consultants, because they are first of all passionate about caring for mothers and babies, passionate about proper lactation care/assistance and will devote the time and energy to properly teach lactation techniques, because sometimes it doesn't happen in the first 5 minutes! To

legislate an area of care such as this is ridiculous in that it is limiting what we as humans do best, helping each other, by those who are invested and passionate in that area. To decrease the availability of lactation consultants or those who can provide care/assistance can only result in less mothers reaching out in ways they feel comfortable, to those they are comfortable seeking help from.

21. There is already a shortage of breastfeeding help, this will only make it worse. The best ones in our area are not certified, and they would not be able to work anymore.

22. I would highly recommend we support licensing for IBCLCs, but they cannot be the ONLY care providers providing this important information. They should be the go-to for problems, but education, evaluations and problem identification can belong to many categories of providers.

23. Midwives and many others involved in birth work have great interest in helping mothers and babies and their experiences and knowledge should never be undervalued.

24. Lactation consults take 5-7 days for appointment in Tacoma, pierce county. Due to the high rates of tongue/lip ties Seattle Breast Feeding is about 2 -4 weeks out for frenotomies

25. Mothers need to be able to contact their caregiver at all hours for breastfeeding help. This law would negate & criminalize work we don't even bother charging for; negate & criminalize work for which families routinely privately pay postpartum doulas. The lactation consultants behind this would better serve their communities by building a reputation that has families willing to pay privately for help, rather than building in more alienation and making it harder to get help. And criminalize the work of mother to mother groups like LLL? Absurd.

26. I am a doula and CNM who has practiced in homes, birth centers and hospitals in three states. Even my breastfeeding peer counsellors were better problem solvers than the local IBCLCs they followed and they were spot-on with referrals. All but a few hospital IBCLCs in hospitals I have practiced in are more interested in lecturing an exhausted new mom and promoting nipple shields and breast pumps than actually watching her breastfeed and helping her with her problems. Too many times the RN would come and get me after the LC had visited to actually help the mom, which usually took only 10-15 min. Done. I don't know if the IBCLC program is too academic rather than hands-on, but I do know it is essentially impossible for women of color and low-income women, many of whom provide the culturally sensitive care that is so desperately needed to improve breastfeeding rates, to become IBCLCS. I agree with the statement of the problem in this application. Bad advice doesn't get us where we need to go. But some of the bad advice is being given by IBCLCs and some of the best advice is being given by others. I'm not sure what the solution might be.

27. All care providers who see end of pregnancy and immediate postpartum and lactating clients need to have basic to excellent lactation training. Lactation issues are a NOW thing. Lactation issues can be avoided with proper support from current care providers. Improved breastfeeding statistics can occur only with more care providers trained in lactation and giving proper information and support to their clients not LESS.

28. As a nursing mother in Central Washington I had difficut time finding resources and accessing support to help me with a very specific challenge. My OB was unreachable with my challenges as her nurse would not let me schedule a follow up for nursing issues--I needed a prescriptionI could not get. The hospital lactation consultants were my only source of support, and they were not familiar with my particular issues. I have not had experience with a la leche league consultant to anwer the survey questions regarding LLL.

29. There are no ICBLCs practicing in our county. There is one licensed midwife who is competent but can't bill all health insurance yet and has a very small practice. Some hospital and clinic nurses/doctors have expertise and others not so much. The distance and drive to see an ICBLC in another county would be hard on new moms, and the inability to bill for lactation services provided by hospital or clinic nursing staff who are well-trained but not certified might be a hardship on those practices. I believe we need more capacity for home visiting lactation services too, especially for the most vulnerable women and babies who don't have good access to transportation. We need to make sure that lactation consultation is competent, but obtaining the ICBLC is so onerous that I'm afraid we will never have good access in our small rural communities if lactation consulting is limited to ICBLCs.

30. In my experience there have been multiple issues (tongue and lip ties specifically) not picked up by hospital staff (pediatrician, nurse, lactation consultant) that have negatively impacted feeding relationships in our area. It was through LLL, outside provider care and self research that these items were identified and then eventually treated. Narrowing the number of people available and trained to assist with these matters will negatively impact breastfeeding rates in our area as success with breastfeeding early on typically increases rates of continued breastfeeding. If only a select few can assist with these matters there will be longer wait times, more time and money required and likely a reduction in successful breastfeeding relationships. Care providers trained in these areas that are already being sought out for other care/appointments (such as midwives) should be allowed to continue doing so as our goal is more successful breastfeeding not less.

31. There are many other healthcare professions, such as midwives, who are credentialed, and more than capable of serving breastfeeding women. To narrow it down to only allowing state-licensed IBCLCs seems absurd, and would surely cause an uproar. This should be looked into thoroughly before a final decision is made.

32. As a WA State Licensed Midwife, I provide exclusively in-home care to my clients throughout the childbearing year. The women and babies I serve often live rurally. I have extensive background knowledge and experience with Lactation, and provide excellent, in-home, evidence-based, compassionate care. It is ridiculous that I might not be compensated or allowed to do this important work of Lactation services with all of my clients. IBCLCs are specialists in their field that I very much appreciate and use on occasion, as needed, but they cannot possibly be the sole providers of Lactation care.

33. This may be one of the most dangerous ideas to come along in years.

34. My experience is varied and unique. I am a CNM, and started my practice in-hospital, moving to about 30% home, then 100-% homebirth. Self employed lactation consultants are fine. LLL is great. But WIC and hospital based nurses and lactation consultants tend to use many interventions that discourage and frighten the mother/family. They are much more likely to recommend scheduling, nipple shields, and formula (or pumping and feeding with a bottle). If I am unable to help in a relatively short time, my referrals tend to be to their pediatricians and their office nurses, since they seem to have the incentive to satisfy theit clients and seem less competitive towards the midwives. The client usually knows the pediatrician and plans on regular appointments in their office. It is easier to monitor HIPPAA compliance when the mother isnt expected to share health information with yet another party.

35. Limiting breastfeeding care to licensed IBCLCs would seriously impair access to quality, affordable, practical, professional, and experienced breastfeeding support. This would be a huge disservice to mothers and babies. We should be expanding access to breastfeeding support. We should not be taking away the rights of women to seek quality breastfeeding care from qualified professionals.

Sincerely, Brandy Stuart Student Midwife (MCU) Doula Mother of 5 89 months experience as a nursing mother (and counting!!)

36. It wouldn't affect my clients because I'll keep doing it, it will effect my ability to get paid for that 3 day postpartum visit which is nearly all breast feeding support.

37. The ability of a woman to access help through experience yet unlicensed care providers they know and trust is very important to young mothers. Midwives in my area offer help to those who can't afford it or whose insurance will no longer cover it. They do it for the benefit of the baby/mothers. Making it illegal for them to do so would negatively affect many women in my area.

B. The following comments were submitted on social media, below links to the survey, instead of being submitted as part of the survey:

38. It's true that an unintended consequence of this legislation could be a challenge from insurance companies--similar to what we went through with Premera and NB care--about reimbursing licensed midwives for lactation services since it is not specifically listed in statute as being within our scope. That is one of the issues MAWS is planning to speak to in our comments. And hopefully, you'll get lots of responses to your survey demonstrating the extent of breastfeeding support that licensed midwives provide.

39. “The "no person may provide lactation care or services" part is what is directly offensive. It means that the other certifications which exist and currently are important in the role of women's healthcare and breastfeeding will be specifically barred from practicing until and unless they become IBCLCs, restricting access for women from a variety of sources and reducing it to only one preferred provider based on an exclusionary bias. This is designed BY and FOR IBCLCs to create a separate class for themselves to monopolize breastfeeding care. There is no evidentiary basis for this. Pediatricians, nurses, midwives and obstetricians don't even have the supposed qualifications for what is placed in this bill.” Shannon Mitchell, Doula, CLC, CBE and Secretary of Washington Alliance for Responsible Midwifery (W.A.R.M.)

40. When continuity of care is disrupted, the chance of positive outcome is compromised. A midwife has had sufficient training to offer support to a breastfeeding mother. If she is forced to find other support, especially in remote areas, her healthcare is limited as well as her right to chose her provider.

41. Excerpts from online discussion about access to lactation care, with names redacted for privacy, showing that mothers even in urban Yakima need to travel as far as Tri-Cities to see an IBCLC, but can be seen by other types of Lactation Consultants:

> “My son is 8 weeks old and I am in need of a lactation consultant. He just had a lip and tongue tie corrected on Monday and I need some help to correct our poor latch that resulted from the ties. Anyone know of an LC who is familiar with lip and tongue ties?”
>
> “The LC who was recommended to me is K at -- Services. You can schedule with her there or she will come to you. There is also a drop in that she is usually at on Wed 12-1p. The only IBCLC I know of is in Kennewick and is who the DDS recommend after he did my son's revision.”

"Yes the only IBCLC that I know of that sees patients is the same one H. mentioned in Kennewick."

"If you are a WIC client there is an IBCLC there named S., but you may have to be pretty pushy to get an appointment with her. I work with an IBCLC as well, but unfortunately she doesn't see clients privately :(it is so hard. This is why I have considered becoming and IBCLC, the need is so great in this area."

"Unfortunately Healthy -- will not see your child past 28 days of age. I'm a pediatric nurse practitioner and certified lactation counselor at --Pediatrics and regularly see mom's for lactation issues."

42. To Whom it May Concern:

I am writing on behalf of breastfeeding mothers in Kittitas County, WA. Living in a rural community often limits access to specialized healthcare professionals. Currently in Kittitas County there are no licensed lactation consultants. Mothers in our community receive lactation support from the WIC office, a local breastfeeding group called "Nurturing Naturally" that is run by an elderly community volunteer with a passion for breastfeeding, nursing staff in the Family Birthing Center at Kittitas Valley Hospital (KVH), and midwives serving home birth families.

I am an experienced breastfeeding mother currently tandem nursing my two sons (3 years & 18 months), I have been a practicing doula since 2007 and have completed DONA certification, and I work in the Family Birthing Center at KVH. I strongly believe that breastfeeding is the right choice for my family and that women deserve access to competent, evidence based lactation care. However, I am concerned that in our rural community this proposal will in fact decrease access to lactation services for mothers and babies in the early postpartum period when they are the most vulnerable. In 2015, 86% of mothers were discharged from KVH exclusively breastfeeding and mothers can return at anytime if they need lactation support. This proposal will eliminate KVH as a resource to new mothers because although the nurses have extra education in breastfeeding and substantial clinical experience, none of them possess a lactation specific certification or license. The same is true of midwives who serve home birth families in our community.

I agree that in an ideal world market forces may potentially draw lactation consultants to Ellensburg, WA, but in the meantime I am concerned that this proposal will significantly limit access to lactation services for women in our community. If women are unable to receive lactation support from the currently available resources in our rural community their only option is to leave Kittitas County. This is an unacceptable burden to impose on women recovering from childbirth.

I ask that you please include mother/baby nurses and midwives in Section 6. of this proposal. Both of these professions routinely provide lactation support and are often a new mother's first advocate in her breastfeeding journey. They should be recognized as a valuable resources to women who have limited access in rural communities and elsewhere. In Kittitas County we have take great strides in recent years to support breastfeeding mothers and as a community we would like to continue this forward momentum.

43. Because I facilitated the survey, I entered the applicable data from my practice but did not submit any comments, so I will do so here.

Although it is personally reprehensible to me to see a normal human function such as breastfeeding being treated as a healthcare situation requiring a license from the state, I can understand the impulse for a professional care giver to want to obtain a license in order to bill for insurance reimbursement.

However, as a professional who bills Medicaid, I also know that just because a license would allow them to submit a claim to insurance, it in no way presumes that they will actually receive any payment or that if they do that the payment will be worth the effort and expense required to even send in a claim.

Meanwhile, the consequences of creating a monopoly on lactation consultants for a single professional certification group could be staggering under a bill written like this one. The proponents state that there will be no changes to scope for those who are currently providing these services, but the language of the bill clearly shows otherwise. At the very least, it will create a challenge to every higher level professional to “prove” that lactation care and services are part of their scope of practice, which will require language changes within the RCW of each and every one of those separate professions. Further, it will prohibit all of the current Lactation Consultants who will not be eligible for licensure to be out of work and unable to continue to serve the public. This will result in an immediate and critical shortage of any lactation care in most of the state of Washington. With only 500 IBCLCs eligible, of which an unknown number would seek licensure, most of the state would be without care entirely.

44. Don't give in! Licensing will destroy the entire intent. Licensing guts good intentions and gives them the power to destroy. Don't give in. You WILL be Sorry!

45. Really? I understand some of the thinking, but this will do serious harm to so many mama/baby pairs. A better course of action would be to educate everyone who provides direct care to pregnant and breastfeeding moms.

46. Think about who has been holding the ranks for years la Leche league and other mother-to-mother organizations... Not ok to dominate the field because you want insurance reimbersment.

47. Hmmm...I see the slight wording change in the bill that restricts their definition above to only a select few. Interesting. Deceptive. Not good.

48. By the time a new mom can get access to a lactation consultant there may be irreversible harm. Breastfeeding is a learned process. We learn from those who have breastfed before us and from trying it ourselves. If we create a "specialist" type view of breastfeeding we are going to continue to make it a mountain that is overwhelming for new moms. We already often make it too complicated.

Let's keep it simple and allow women who have breastfed, been educated in the basics, and those who do have higher training help those who truly have unique situations requiring unique care.

49. I agree, this is such a basic human-rights normal life process, which has been supported by experienced nursing mothers since humans have existed. Licensure will do nothing to improve care or access to care, it will only increase costs and make this wonderful service the sole territory of a handful of state-approved professionals, by shutting out all of the other professionals who are already providing it with great success. Do we really need the state to regulate breastfeeding now? Oh, my...

50. It just makes your boobs feel so foreign like you have to have a degree to use them. Good grief. They fill with milk, see what your babe does, if ya get stuck ask for help. We all could benefit from hearing breastfeeding being casually discussed in everyday life instead of being a success vs failure type

scenario. Too many moms fearful of the "inadequacies" of their bodies bc we have to be referred here, couldn't birth a certain way, couldn't nurse our babes. Please keep the government out of my bra.

51. If this is in anyway true, in anyway, this is where the line will be drawn.

52. …really want these folks to be accountable, because the next person to reduce my scope of practice is likely to be called "defendant"...I have had enough.

53. I hope to become a lactation consultant someday, the schooling process seems quite a bit over the top. Schooling does great for knowledge but nothing tops experience and time spent.

54. It sure is sad that a tiny group of 20 IBCLCs who created an "organization" think that they can corner the market on lactation work for the whole state. :-(Even if every one of the 500 certified IBCLCs in the state were to work on nothing but lactation consulting 120 hours per week, they could NEVER serve the whole state. How many thousands of us are out here doing that work now, and it still is not enough?

55. I looked into to become IBCLC certified in Yakima. It seemed almost impossible as I was either not allowed to shadow the consultants or they simply didn't have a large enough practice for me to reach the hours necessary. Even the people I reached out to were frustrated as they really wanted to help, but pretty much had their hands tied. So, if that's the case & traveling becomes the only option for someone to become certified where does that leave our area for seeking out help for breastfeeding.

56. I'd be fine with licensure was voluntary but I'll admit I have a hard time seeing what these things lead to in the future. Will it continue to slope towards everyone needing to be licensed in the future? I love the idea of access to information. Licensure does provide access to evidence based information (sometimes). I'd prefer though that volunteer organizations such as la leche league be allowed to remain as they are able to reach out to uninsured, young, first time moms, etc more easily. We are in a high media type culture and I get calls, Facebook messages, and textx for la leche league weekly bc it's convenient for moms and dads to reach out quickly this way. I always offer meeting support but many people now want access to quick info. If the only resource is a lactation consultant wait times on return calls will be slower, billing will be an obstacle, and a subset of mother's simply will not be served.

57. I have already had 2 call backs, the state rep and from a board member reviewing the proposal, she said she has been getting calls from midwives which is helping her decide, what she could not make clear was what this means for midwives and other practitioners explaining the request "was complicated"

58. I see serious issues here. (1) Our scope of practice does not specifically mention this service, any more than it specifically mentioned newborn care. That means that based on the recent newborn care decisions, the precedent which has been set now says that helping mothers get babies to latch and nurse is not within our scope of practice because it is not specifically stated in the law, so we would be performing a service in violation of this proposed law (not my opinion, this is our legal status after the last bill, which I personally find very unfortunate). (2) The application actually states that midwives do

NOT have training in lactation services, in spite of the fact that it is required for our license! Not what I would call a provider-friendly move. (3) It further lies by omission when asked about other state and national organizations (such as non-IBCLC programs) representing the profession, and simply replies instead that there are no other state organizations. It happens to be an IBCLC cert which hangs on my own wall, but that response on the application is a gross misrepresentation, because there are other national organizations and other certifying training programs for lactation professionals, some of them very good - and we should all be opposed to any total monopoly in routes to health care education and training. (4) To what urgent public safety issue are they referring when justifying the need for this bill? Midwives already have a success rate of well over 95% exclusive breastfeeding at final appointment, they admit to a shortage of lactation consultants already, and this will make an even greater shortage by taking away all of the other types of LC certification as well as taking away the lactation support that midwives are already providing. Like M. said, if we cannot act quickly because we have to call in some specialist, babies will suffer. Bottom Line: This amounts to a giant grab of a large portion of our scope of practice, especially now that the only scope of care we have which includes babies over 2 weeks of age is our ability to assess the effectiveness of breastfeeding. This must be fought, and hard. No more reductions in our scope can be tolerated.

Sherry Thomas, Policy Coordinator
Washington State Department of Health Sunrise Reviews
P.O. Box 47850 Olympia, WA 98504-7850

Dear Ms Thomas:

In support of licensure in WA state for IBCLCs.

I am an IBCLC and have held this credential since 1994. I have worked with many hundreds of mother and baby couplets, supporting successful lactation.

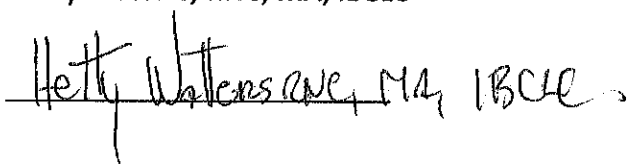
The Affordable Care Act (ACA) makes provision for breastfeeding support by ensuring that lactation support and education be covered by insurance. However, in WA state, IBCLCs are not licensed as care providers (unless under a second credential such as MD.) I believe it is essential that IBCLCs be licensed in order for these services to be covered by health insurance. For many families, because costs relating to pregnancy care and birth are expensive; the cost of unreimbursed lactation services may result in families not utilizing lactation services.

I will share a common scenario:
Mom has given birth 5 days ago. Her healthy baby is born at term and she is a healthy mother. Mom is concerned she "does not have enough of her own milk" to meet the needs of her infant. The health care provider she has chosen for her baby does not have information on the desirability of exclusive breastfeeding and suggests she give the baby human milk substitutes (HMS) to make sure the baby is "getting enough".
One of the most common concerns for new mothers relates to worry regarding milk supply. 1 [i]
Suggesting this Mom give formula, reinforces the Mom's concern that she is not making enough milk for her baby. Being told to give the baby formula can wreck Mom's confidence in her body's and the baby's ability to breastfeed without the help of artificial milk. Self confidence is the number one reason that breastfeeding succeeds. Suggesting HMS does not support Mom's self efficacy.
Introducing even one feeding of HMS will change the infant's gut flora from the flora of exclusively human milk fed infants, increasing the risk of autoimmune illness and sensitization to cow's milk allergies.
Feeding the baby formula, using a bottle creates mechanical challenges to breastfeeding. Milk fed to babies using this method pours readily into the infant's mouth and the infant may imprint on this method of feeding. Bottle nipples often lead to improper suckling. When using a bottle many babies learn to bite down on the nipple to stop the flow of fluid. [ii]Biting at the breast will injure Mom's nipples.
Digesting something that is not Mom's milk (HMS) takes time and baby is then not nursing as often as need be to stimulate abundant milk supply. Thus [iii]the use of HMS can eventually lead to low milk supply.

Providing Mom with information[iv] on milk supply and normal post-birth neonatal weight loss and return to birth weight will help allay Mom's concerns regarding her milk supply and will allow this family to continue with exclusive breastfeeding.
All IBCLCs have information to support this mother and to help her exclusively breastfeed and overcome the use of HMS in the above scenario thereby fostering long-term optimum health of this mother and baby.

Thank you for coordinating the sunrise review in support of credentialing IBCLCs as care providers in WA state. I am very much in support of this effort.

Yours truly
Hetty Watters, RNC, MA, IBCLC



1 The Surgeon General's Call to Action to Support Breastfeeding. Centers for Disease Control and Prevention (US); 2011.

2. Marsha Walker, Fast Facts: How to Deal with Common Breastfeeding Issues

[iii] American Academy of Pediatrics Breastfeeding and the Use of Human Milk 2005
[iv] Academy of Breastfeeding Medicine *Guidelines for the Use of Supplemental Feedings* ***2009***

March of Dimes Foundation
Seattle, WA
marchofdimes.org

July 7, 2016

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Reviews
P.O. Box 47850
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(360) 236-4612

Re: Letter of support for licensure of Lactation Consultants in Washington State

Dear Ms. Thomas:

On behalf of the March of Dimes, I am writing to share our support for the licensure of Lactation Consultants in Washington State. The March of Dimes is the leading non-profit in maternal and infant health, funding scientific research, providing community programming, and advocating for laws and regulations to improve the health of pregnant women, infants and children since 1938.

Breastfeeding is the best method for feeding virtually all newborns. Breastmilk fulfills an infant's total nutrient requirements during the first four to six months of life. Breastmilk also provides antibodies that protect infants from disease. Breastfeeding is not only the optimal way to feed most infants, it provides a time for maternal-infant interaction that promotes their relationship.

Lactation consultants play a significant role in promoting and educating women about breastfeeding. There is currently confusion by consumers and the medical community about the meaning of titles and the training requirements for various lactation care providers. For example, anyone can call themselves a "lactation consultant" regardless of their levels of training and qualifications. There is often a mistaken assumption that everyone using the title lactation consultant possesses equivalent, and adequate, training and credentials. This presents a disparity in the quality of care that new mothers may receive. Which also leads to challenges for adequately trained and credentialed lactation consultants to bill insurance plans for the service.

We support this effort to increase the public's access to appropriately trained, credentialed and licensed lactation consultants in order to protect consumers and improve breastfeeding success rates in Washington State. If you have any further questions, please feel free to contact me at rday@marchofdimes.org. Thank you for your consideration.

Sincerely,

Ryan DAy

Ryan Day
Director of Advocacy & Government Affairs
March of Dimes

I am writing in support of the licensure for Internationally Board Certified Lactation Consultants (IBCLCs). I am an RN IBCLC that has been working in a hospital setting for the last ten years and have a firsthand experience of the critical need for increased access to lactation care. I support this legislation because I feel it is an important component of creating greater access to lactation care for women and making women's health care more equitable.

This legislation would enable hospitals to expand care and hire more staff to meet the needs of breastfeeding women as well as increase access to lactation care by enabling IBCLCs to setup private practices independently and see clients in the community. In my current hospital position, my shift is divided by time spent working with inpatient couplets and seeing outpatients. There is only one working IBCLC on the floor at a time with specific lactation duties. I am not able to see every breastfeeding couplet on the floor due to time constraints and high census numbers and must triage care accordingly. The lactation team can only see 14 outpatients a week! Our hospital has about 150-200 deliveries a month. This means many mothers and babies can wait up to a week to be seen and others give up before receiving care.

The key to successful breastfeeding and a positive experience is early and continued support. Many people influence a women's breastfeeding experience and access to different sources of support is critical. The intention of this bill is not to limit the sources of support but to increase access to trained professionals that are practicing evidence based care when normal breastfeeding is not happening.

Certified Professional Midwives (CPMs) voiced concerns in previous comments that this bill would limit their scope of practice in helping mothers with breastfeeding. I agree the language presented in the legislation in Section 2 line 17 and Section 6 line 19 seems contradictory and vague. It is important that the language is clear and specific and does not impede on any other providers ability to provide lactation care. The lactation care that CPMs provide is excellent . They work with a low risk population and give one on one care that extends past the birth and initial latch. I rarely see clients of CPMs due to the attentive care and their specific education in lactation. It is imperative that this bill increase access to lactation care and not inadvertently limit care.

CPMs attend roughly 3% of births in the state. The majority of women in Washington state give birth in hospitals and do not have the same access to such holistic care as provided by CPMs. While birth and breastfeeding are normal life experiences both can be challenging and difficult. The health and well being of the mother during pregnancy and her labor/birth have a huge impact on her breastfeeding experience and success. Obesity, polycystic ovarian syndrome, diabetes, pregnancy induced hypertension, prematurity, illicit drug use during pregnancy, inductions, c-sections, drugs in labor, in-vitro fertilization, elderly first time moms, breast reductions, tongue ties and other high risk conditions all play into the success or difficulty of a breastfeeding couplet. The need for professionals who are trained with a more specific skill set to assist the couplets in these situations is paramount.

WIC peer counselors, LLL leaders, CPMs , MDs and other lactation specialists who are not IBCLCs are vital in assisting women with normal breastfeeding issues

and in recognizing issues that need a higher skill set. When a breastfeeding issue arises, the value of licensure for IBCLCs is ensuring that women and children are receiving lactation care from a professional that is practicing current evidence based care, held accountable by a code of ethics established by the IBCLE and governed by the IBCLE with disciplinary procedures for any violation of the code of ethics. IBCLCs are obligated to maintain continuing education every 5 years and to recertify by exam every 10 years.

Many of the CPMs also voiced concerns regarding inadvertently creating barriers for lactation care for women in rural areas or communities of color. The goal of this legislation is to increase access to care for women. WIC peer counselors, LLL leaders, MDs and other lactation specialists can still work with breastfeeding women within their scope of practice and current access to those providers will not change. No restrictions on current provider practices will result from this legislation—it will instead increase the access to high-quality lactation support.

CPMs were also concerned about barriers for women of color or low income to meet the education and contact hours required to sit for IBCLC examination. IBCLE provides three different pathways to become an IBCLC. The pathways include experience for women working with breastfeeding couplets in the role of LLL leaders and WIC peer counselors. The educational requirements can be obtained online and at community colleges. As an international certification, IBCLC provides culturally sensitive educational and examination materials. The examination is offered in many different languages worldwide and they have financial scholarships for applicants.

My personal experience has been that even women in urban areas are not currently receiving adequate access to lactation care. It is mandated by the Affordable Health Care Act but yet difficult to obtain. IBCLC licensure will enable more people to provide lactation care by making it financially feasible to do so. Currently, IBCLCs and lactation specialists are compensated by clients paying out of pocket for visits outside a hospital or clinic that has a mid-level provider. For families struggling financially, the ability to pay out of pocket is possibly a sacrifice they can not make. Reimbursing the IBCLC directly will enable families to use federally mandated health care and more women and babies will have access to lactation care.

According the last CDC breastfeeding report card in 2013, nationally 76.5% of women ever breastfed, 37.7% of women were exclusively breastfeeding at 3 months and only 16.4% of women were still breastfeeding exclusively at six months. A women's ability to continue to exclusively breastfeed is impacted by many different factors including the lack of paid maternity leave in the United States. Access to WIC peer counselors, LLL leaders, lactation specialists, CPMs and MDs that support breastfeeding is imperative for women to successfully continue breastfeeding. All of these roles are part of the solution to foster success and increase breastfeeding rates. However, by creating IBCLC licensure and the ability to directly bill insurance for services, Washington State will increase access to lactation care by IBCLCs when women are facing breastfeeding difficulties complicated by medical and or health issues, thus enabling more women to

establish a strong breastfeeding groundwork and continue to successfully breastfeed.

Respectfully,
Melissa Petit BA RN IBCLC

I am a Lactation Consultant (LC) currently practicing in a small rural hospital in Washington State. I have been an LC for many years, and have practiced in a variety of inpatient as well as outpatient settings, including pediatric offices & as a home health nurse. I know how important the services of a certified LC can be to mothers & babies.

I do not, however, think that requiring a license to practice will improve services or increase access to an LC. In addition, I am very concerned that this proposal will create barriers to the practice of LC's, and could prohibit staff RN's from providing breastfeeding support & education at the bedside.

The cumulative effect of this proposal may well do the opposite of what it seems to intend, resulting in fewer mothers & babies receiving the services of an LC.

Thank you for your time,

Katherine Mix, RN, MS, IBCLC

I'm writing to share my story of how a local IBCLC impacted my breastfeeding relationship with my son, now 9 months old. My midwives and pediatrician both did tongue tie assessments when my son was born and in the first few weeks of his life. They said he did not have one. It was clear my son wanted to breastfeed, but was unable to maintain suction while trying to latch. I finally called a recommended consultant after two weeks of bloody nipples and she did a two hour assessment, weighing him before and after. She was concerned he had not regained his birth weight and was concerned about his suck strength. My son couldn't get the middle of his tongue up to suck effectively. We adjusted our feeding plan and watched his progress. With her guidance we went from formula supplementing 1-2 bottles per day, painful nipple damage, and a low weight baby to healed nipples, and an exclusively breastfed, baby. She recommended an excellent doctor who identified a sneaky posterior tongue tie. After it was corrected, my son started gaining .75-1.5lbs/week. Our strong breastfeeding relationship continues through today. She was on call 24/7 for weeks as I had new questions about stool, gas, production, pumping after I returned to work, production concerns, etc. I do not know where I would have otherwise received this information and the confidence to get what I needed at work.

Thank you,
Kabri Lehrman-Schmid

Kathrina was an absolute lifesaver for our baby and this new mama.
It all started when we went in for postpartum check-up 3 days after labor, and our baby had lost a little over 10% body weight. This was concerning and when seeing my pediatrician the next day she was concerned and wanted to see weight gain overnight. This was discouraging for my breastfeeding journey for I really had set a goal to exclusively breastfeed my baby.
After this appointment our pediatrician, I felt as thought there had to some kind support out there, but who could help us over night? Every 2 hour feeding was crucial, every day was crucial to get our baby on the right track, I knew the hospital had lactation support, but with our short 24 hour stay we weren't able to receive adequate support and in addition, we were on day 4 after the birth which was landing on a Friday making it hard to see a specialist in the hospital. I was desperate and had previously received a

contact for Kathrina from a friend, this came to my memory and I promptly gave her a call. I was surprised by Kathrina's generous and passion for help, knowing how urgent I was she was able to help me there on the spot, she did a over the phone consultation that answered a lot of my concerns and questions. In addition, we were able to do a face-time immediately that evening. THIS WAS AN ABSOLUTE lifesaver, we went over my latch and she watched me feed, and did some positioning corrections and my latch was fixed! It was a night and day difference!

The next day we went in for a weigh in, this was only 14 hours since the our previous weigh in, and our baby has gained a whopping 2oz over night!
It was so relieving to see that we were headed in the right direction.

Having someone like Kathrina there to help you along your breastfeeding journey can be the thing that you need to succeed. It is not easy, and for many like me, who had their milk come in later due to recovery and needed the personable help, Kathrina was the person to go to. She was helping on me and baby's schedule which was crucial in those first days after birth. If you want someone who is so personable, goes above and beyond, and extremely passionate and skilled at what she does I highly recommend this service!

-Cindy Kim

I am a postpartum nurse at Swedish First Hill where we have over 600 births per month and thus I work very closely with IBCLCs. Without IBCLCs mothers would not be able to establish successful breastfeeding plans in the hospital that they can carry out at home. I am certain that without IBCLCs mothers and newborns would have negative health outcomes. I have witnessed patients stressed out, anxious, and about to give up on breastfeeding due to poor lactation advice from non IBCLCs. It is crucial that we have IBCLC staff in and out of the hospital.

Lindsey Trainer

After being IBCLC for 26 years I see daily how new families have better breastfeeding/health outcomes when assisted by an IBCLC in both the hospital and the community.

Denise Stuart, BSN, RN, IBCLC

La Leche League supports breastfeeding support for all families. The more available breastfeeding resources in the community, the higher chance of breastfeeding success. LLL Leaders focus on parent to parent support, and are not breastfeeding professionals. We empower parents to solve their own breastfeeding challenges and we celebrate their successes. When a breastfeeding problem is beyond our scope, we are happy to refer parents to local IBCLCs.
In contrast, IBCLCs are trained breastfeeding professionals with thousands of hours of hands on training, making them qualified to support breastfeeding parents with complex medical situations beyond the scope of a LLL Leader. They also support parents as a valuable member of a medical team and are able to work with a breastfeeding dyad's other medical providers in ways LLL Leaders cannot.
LLL Leaders tend to see families from the entire range of socioeconomic strata. We are aware that only upper income families are able to access IBCLC care, as it is out of the financial reach of many families. So, when we refer families to IBCLCs, we know that only a small subset will be able to afford that level of care. Many turn to support from their medical team, which while covered by insurance, often lacks the precise training in lactation support that IBCLCs possess. Licensure for IBCLCs would open up access to this incredibly valuable resource to all of the families we serve, reducing the risk of premature weaning. Licensure for IBCLCs in no way conflicts with the role of the LLL Leader in Washington State.

Thank you for the opportunity to comment.

Betsy Hoffmeister, IBCLC
Mom to Isaac and Rebecca
Co-Leader, LLL of West Seattle
President, Board of Directors, LLL of Washington

I am writing today in support of licensure for IBCLCs. I have been an accredited IBCLC for six years. I enjoy my work and am honored to have the opportunity to work with families throughout King County. I am one of a select few IBCLCs who do in-home lactation support. This is a valuable service because all of my clients are recovering from childbirth; many are recovering from major abdominal surgery or stitches in their perineum; and all are exhausted. It is vital to me to help families breastfeed in their homes, where mom can nurse in a more realistic, comfortable setting than in an unfamiliar office or hospital chair.

Unfortunately, my fee is beyond the scope of far too many mothers. I charge commensurate with my colleagues in King County, and significantly less than my peers in other parts of the country. Two consequences:

- First, at least three times per week, families with urgent need for breastfeeding support contact me. Often, parents are literally weeping in pain and frustration. The parent will tell me their concern, and make an appointment. Then, after they hear my fee and that insurance may or may not reimburse them – particularly Regence and Premera, the two biggest insurers in the area – parents say they will call me back. Then they don't. I lose multiple clients per week this way. I don't have any way of knowing what happens to these families.
- Second, 100% of my clients are upper middle class or upper class. 95% or more of my clients are white, with a very few Southeast Asians and Asians. I can count on one hand the number of African American and Hispanic women I have served in the past 6 years. This is a disastrous inequity. I feel confident that if I were covered by insurance, I would be able to reach a far more diverse audience, particularly those families most at risk of premature weaning and its attending health risks. I know that low income families are able to visit their WIC offices, but they do not have access to the type of in-home lactation support that more wealthy women can afford. This inequity has societal consequences. All infants have the right to their first food, human milk, and breastfeeding support from an IBCLC supports that right.
- Those clients who can afford me want me to answer all of their breastfeeding questions in two hours, even though breastfeeding changes from hour to hour, day to day, week to week, month to month.
- In contrast, I am in-network with Aetna. Aetna allows its clients up to six visits with an IBCLC. This is an unimagined luxury! I have never seen a client more than three times, but in those three visits, I have been able to bring many extremely difficult challenges to a healthy resolution. Mothers who would have been forced to give up on breastfeeding are able to solve their problems and go on to breastfeed much longer than they had anticipated. In one case, I visited a mother with a near term-premie baby at her home on a Sunday afternoon. The baby was tiny and not gaining weight well. I was able to help the family figure out how to get milk into the baby, deal with excruciating pain for the mother, and increase the mom's milk supply. In the next visit, we taught the baby how to breastfeed with no pain for the mom. In the last visit, we covered basic longterm breastfeeding problems. This was only possible due to the coverage by Aetna. Interestingly, this client was a woman of color.

I cannot urge the committee strongly enough to support licensure for IBCLCs. We provide an invaluable service to the community – but only to those who can afford us. Licensure would enable a much wider range of mothers to access our services. Thank you.

Sincerely,

Betsy Hoffmeister, IBCLC

Hello, my name is Crystal. I struggled with breastfeeding, mastitis thrush, low supply, and I didn't have any help until I scheduled with a lactation consultant. If it wasn't for them, I wouldn't have been able to get my baby to latch without a shield. I also had to pump for awhile and they helped me get my baby back to breast when my nipples were healed. If it wasn't for their knowledge and encouragement I wouldn't have made it past the first month! I nursed for 2 1/2 years with my first and had them reinforce my skills with my second and am still nursing now, 14months!

Thanks for reading!
Crystal

When my oldest son was born, he was in the NICU for several days. Breastfeeding required too much energy therefore he was strictly bottle fed. After he was released from the NICU, it was our goal to breastfeed for all the obvious benefits. As a first time mom that was already distressed from a stressful birth and my son being hospitalized, it was emotional and devastating to not be able to help my son do something I knew was so important for his well being. I felt so helpless and frustrated. The medical expenses were already huge adding more services was out of the question.

Bethany Coski

I am writing in support of postpartum mothers and babies and their vital need for access to skilled follow up support with IBCLCs for assist with breastfeeding.
I am an IBCLC in large hospital in Seattle. I help mother baby couplets with breastfeeding in the baby's first few days of life. I know that when moms get discharged from the hospital almost all of them NEED skilled, follow up support. I have seen many return ED visits and re-admissions for breastfeeding problems that could have been avoided with good follow up. Often with these moms, especially low income families with no access to support, give up breast feeding altogether. Our community, our society, cannot afford to fail mothers and infants. We need to wrap our arms around mothers and babies and protect their breastfeeding relationship. We need to help them be successful. We need to make sure they have good quality support.
Please support IBCLC licensure to ensure this support is widely available. Please help protect breastfeeding.

Thank you,
Elizabeth Murphy, RN,BSN, IBCLC

When my daughter was 2 weeks old (DOB 6/6/2013), her pediatrician (Dr. Molly Linhart, Bainbridge Island, Kitsap County, WA) became concerned that she was still losing weight and suggested immediate supplementation. In addition to the weight loss, I was dealing with excruciating pain, bleeding nipples, and sleep deprivation due to baby needing to constantly nurse. I was a wreck. Exclusively breastfeeding was a very personally important goal, so I was devastated that it wasn't working out.

When I shared that with my daughter's pediatrician, she directed me to the amazing Melissa Bonghi IBCLC, RN, for which I am ever grateful. Melissa came to my house less than 12 hours after I called her. She patiently weighed my daughter, watched me feed, made adjustments, weighed again, watched again and so on. She identified a disorganized sucking pattern, high palate and posterior tongue tie. She hugged me and told me I was doing great. She reminded me to eat food, to nourish myself so I could care for my daughter, she helped me find the resources I needed to have my daughter's tongue tie clipped which

helped her nurse more effectively and ended the relentless pain I had experienced while breastfeeding. She helped me track my daughter's weight, showed us how to latch properly, taught us how to use an SNS and checked in with us repeatedly to make sure we were doing ok. She saved our breastfeeding relationship, which was priceless.

Melissa charges $120/hour I believe, and is worth every penny and then some. My insurance, per the Affordable Care Act, says they cover lactation services but since I didn't give birth at Harrison, I couldn't go there and I couldn't afford to go to Seattle repeatedly back to the hospital in which I had given birth. I had been laid off at 6 months pregnant, money was tight and I was battling mounting Postpartum Anxiety. My family made great sacrifices to afford one visit with Melissa and when I told her I had to forgo any follow up, she very kindly and generously accepted trade for services for the much needed follow-up meetings.

I am very lucky to live in an area with quite a few IBCLC's who offer high quality, knowledgeable support, there is no reason families should not have access to their care, however it's not financially viable (especially in a county where Medicaid covers 50% of births) for everyone to pay hundreds of dollars out of pocket for qualified care. Nor should these trained professionals be put in a position where they have to give their services away to ensure families have access to lactation support.

At 2 weeks old my daughter was considered "failure to thrive," we started using an SNS with donor milk at 3 weeks, had her tongue tie clipped at 3 months, worked with Melissa Bonghi, Emily Healy IBCLC, the Seattle Children's Hospital Infant Feeding Clinic and Dr. MaryAnn O'Hara from 2 weeks to 4 months old. By 6 months old, my scrawny, plagiocephalic, tongue-tied baby with torticollis, reflux and colic had become a chubby, thriving, cheerful, delightful exclusively breastfed baby. Without Melissa's home visits, none of those doors would have been opened. And by healing my baby and her ability to breastfeed, my Postpartum Anxiety began to subside as my physical pain diminished, my sleep increased and my genuine, fact-based fears about my baby's health were addressed. My entire family benefitted in innumerable ways from the care we received. I dream that some day, all families will have access to the care they need and deserve.

Elizabeth Montez

1st Email: I had a patient that said she went to a local pediatric clinic that had a "lactation specialist" (NOT ibclc certified) that did an inaccurate test weight (allowed a diaper change) that showed 0 transfer. this then caused the patient to start supplementing baby with formula. an accurate test weight could have prevented this and allowed for more breastfeeding support.

2nd Email: I had a patient who had low milk supply with her last baby she stated she came to Yakima memorial hospital's breastfeeding clinic and was able to see a IBCLC who helped her everyday for a week. she said her baby had a significant weight loss and she had to initially start supplementing but through the help of the lactation consultant she was able to build her milk supply and she was exclusively breastfeeding by 8 weeks and continued to breastfeed until baby was 15 months old.

Kimber Roberts

I would like to submit that the “proof of harm” being requested that excludes early weaning and formula use IS proof of harm in and of itself. The simple fact that there is a profession dedicated to promoting and advancing the science and practice of biologically normal infant feeding and that profession certifies individuals at various levels of competency, yet the general population and most medical providers still find formula use and early weaning as not harmful demonstrates the vital need for Washington state to recognize IBCLCs as the professionals that they are. Feeding infant formula to any infant harms the infant, the mother, and their breastfeeding relationship. The research showing the superiority of at the

breast feeding and exclusive intake of human milk and the risks (harms) of formula feeding is clear, and I won't belabor that point. The simple fact that these stories are being requested shows the need for other medical professionals to be able to identify and recognize the expertise of IBCLCs and to learn how better support women in providing the biologically normal and appropriate feeding practices and resist the impressive marketing and lobbying tactics of manufacturers who produce commercial infant formula.

Patient story:
Mom was arrested at about 10 weeks postpartum and her exclusively breastfed baby was cared for by her family while she served a 72 hours in jail. When she spoke to the medical professional upon arrival at jail, she said she needed a breast pump or some way to express milk because her breasts were full and painful. She was told to quit complaining and go back to her cell. I saw her about 3 hours after she was released from jail, I loaned her a hospital-grade breast pump and referred her to the emergency room at the local hospital as she was complaining of a fever, 8/10 breast pain, red swollen painful breasts, and feeling like "I've been run over a dozen times." She was diagnosed with mastitis due to over 72 hours of no access to a pump or her baby in order to effectively remove milk from her breasts.

Erika Queen
WIC Nutrition Program
Karen I Fryberg Tulalip Health Clinic

The *CHI Franciscan Health System* is regional health care system in the Tacoma area. We have 5 hospitals that do obstetrics and we provide inpatient and outpatient Lactation Services to the communities of Tacoma, Federal Way, Burien, Enumclaw and Bremerton/Silverdale WA and we are dedicated to the well-being of women and their children in Washington State. We support the Surgeon General's Call to Action to Support Breastfeeding,and recommend the licensure of International Board Certified Lactation Consultants (IBCLC).

There is currently confusion by consumers and the medical community about the meaning of titles and the training requirements for various lactation care providers. For example, anyone can call themselves
a "lactation consultant" regardless of their levels of training and qualifications. There is often a mistaken assumption that everyone using the title lactation consultant possesses equivalent, and adequate, training and credentials. This presents a significant risk to women and their babies. Licensure is the only way to assure public safety and improve access to the level of lactation care and services that mothers need.

We strongly support this effort to increase the public's access to appropriately trained, credentialed and licensed lactation consultants in order to protect consumers and improve breastfeeding success rates in Washington State.

Debbie Raniero MBA, RNC
Regional Director, CHI Franciscan Health Family Birth Centers, Lactation, Family Education

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The ***American College of Nurse-Midwives (ACNM}*** is the national professional association for nurse-midwives. As president of the Washington Affiliate of ACNM, I wish to register our organizational support for licensure of International Board Certified Lactation Consultants (IBCLC). There are about 500 nurse-midwives practicing in Washington State, primarily in hospital settings. Midwives are dedicated
to the health and well-being of women and their children and this includes support for initiation and continuation of breastfeeding. We support the Surgeon General's Call to Action to Support Breastfeeding, and recommend the licensure of International Board Certified Lactation Consultants (IBCLC).

Our board certified lactation consultant colleagues provide an invaluable service by helping mothers to be successful with breastfeeding so that newborns can have the healthiest start in life. However, there is currently confusion by consumers and the medical community about the meaning of titles and the training requirements for various lactation care providers. For example, anyone can call themselves a "lactation consultant" regardless of their levels of training and qualifications. There is often a mistaken assumption that everyone using the title lactation consultant possesses equivalent, and adequate, training and credentials. This presents a significant risk to women and their babies. Licensure is the only way to assure public safety and improve access to the level of lactation care and servkes that mothers need.

We strongly support this effort to increase the public's access to appropriately trained, credentialed and licensed lactation consultants in order to protect consumers and improve breastfeeding success rates in Washington State.

Mary Lou Kopas, CNM, ARNP President
Washington State Affiliate of the American College of Nurse-Midwives (ACNM)

On behalf of the March of Dimes, I am writing to share our support for the licensure of International Board Certified Lactation Consultants (IBCLC) in Washington State. The March of Dimes is the leading non-profit in maternal and infant health, funding scientific research, providing community programming, and advocating for laws and regulations to improve the health of pregnant women, infants and children since 1938.

Breastfeeding is the best method for feeding virtually all newborns. Breastmilk fulfills an infant's total nutrient requirements during the first four to six months of life. Breastmilk also provides antibodies that protect infants from disease. Breastfeeding is not only the optimal way to feed most infants, it provides a time for maternal-infant interaction that promotes their relationship.

Lactation consultants play a significant role in promoting and educating women about breastfeeding. There is currently confusion by consumers and the medical community about the meaning of titles and the training requirements for various lactation care providers. For example, anyone can call themselves a "lactation consultant" regardless of their levels of training and qualifications. There is often a mistaken assumption that everyone using the title lactation consultant possesses equivalent, and adequate, training and credentials. This presents a significant risk to women and their babies.
Licensure is the only way to assure public safety and improve access to the level of lactation care and services that mothers need.

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Justin Garrett, Regional Director of Advocacy & Government Affairs
March of Dimes

The Washington State Perinatal Collaborative is a volunteer organization of Perinatal providers dedicated to the well being of women, pregnant women and their children. We support the Surgeon General's Call to Action to Support Breastfeeding, and recommend the licensure of International Board Certified Lactation Consultants (IBCLC).

There is currently confusion by consumers and the medical community about the meaning of titles and the training requirements for various lactation care providers. For example, anyone can call

themselves a "lactation consultant" regardless of their levels of training and qualifications. There is often a mistaken assumption that everyone using the title lactation consultant possesses equivalent, and adequate, training and credentials. This presents a significant risk to women and their babies. Licensure is the only way to assure public safety and improve access to the level of lactation care and services that mothers need.

We strongly support this effort to increase the public's access to appropriately trained, credentialed and licensed lactation consultants in order to protect consumers and improve breastfeeding success rates in Washington State.

Roger Rowles, MD, OBGYN
Chair, Washington State Perinatal Advisory Committee

The Perinatal Service Line at Yakima Valley Memorial Hospital is dedicated to the well being of women and their children in Washington State. We are a non-profit hospital and the Level Ill Perinatal Center for Central Washington. Memorial births around 3,000 babies each year. Our staff of lactation consultants are IBCLC certified and provide lactation support on the maternity unit, in our N.I.C.U. and Pediatric departments, as well as providing a postpartum,outpatient lactation support clinic. We support the Surgeon General's Call to Action to Support Breastfeeding,and recommend the licensure of International Board Certified Lactation Consultants (IBCLC).

There *is* currently confusion by consumers and the medical community about the meaning of titles and the training requirements for various lactation care providers. For example, anyone can call themselves a "lactation consultant" regardless of their levels of training and qualifications. There is often a mistaken assumption that everyone using the title lactation consultant possesses equivalent, and adequate, training and credentials. This presents a significant risk to women and their babies. Licensure is the only way to assure public safety and improve access to the level of lactation care and services that mothers need.

We strongly support this effort to increase the public's access to appropriately trained, credentialed and licensed lactation consultants in order to protect consumers and improve breastfeeding success rates in Washington State.

Mary Hart, RN, MSN
Senior Director, Perinatal-Pediatric Service
Line Yakima Valley Memorial Hospital

I am a registered nurse and an IBCLC working in a large hospital in Tri Cities, Washington. I have been an RN for nearly 30 years, and have practiced as an LC for over 10. Not a single day goes by at my job in which I don't encounter a patient that has been given misinformation on breastfeeding from another health care professional. Those early days and months after a mother gives birth can be difficult, exasperating and complicated for families, especially if a mother is having problems breastfeeding. Being given well meaning but incorrect advice at this time can, and often does undermine a mother's ability to breastfeed.

Understanding the process of Breastfeeding takes time, dedication, and a depth of knowledge. Being a Lactation Consultant is labor intensive. People in other health care disciplines may know a lot about many things, but when it comes to breastfeeding, they JUST DON'T GET IT.
Anne Collett

I am writing you today to share my personal breastfeeding experience and also my experience supporting those who want to breastfeed (as a Certified Lactation Educator and La Lache League Leader) in an effort to support making IBCLCs a licensed profession. Both my experiences have been/are within Snohomish County Washington.

My personal experience which highlights the need for licensure of IBCLCs started by a L&D nurse (no breastfeeding training) telling me I need to use a nipple shield for no apparent reason. This shook my near non-existent confidence as a brand new mother with no friends/family support and was also completely unnecessary. Most every new mother is being set up with a fear of not having "enough" milk to feed their child with incorrect information such as this, which greatly increases the risk of breastfeeding cessation shortly there after. My second experience was being told by a family doctor to "top off" my feedings with a bottle because my son was not near the 50% mark on the growth chart as an infant. He was growing fine, gaining weight, meeting milestones, and happy. Being told this not only crushes a new mother's confidence in herself and her body, it can also be detrimental to breastfeeding continuation (breaking the milk removal/milk production cycle). Had I not sought out (and was fortunate enough to have had insurance coverage) of an IBCLC to correct this misinformation and rebuild my confidence, we may not have made it to 14mo+ of breastfeeding. Nor would I have had the confidence and correct information for breastfeeding my second son for 2yrs.

In experience as a CLE and LLL Leader, I see many, many, many mothers with very similar experiences. Being directed to do things that 1) are detrimental to breastfeeding continuation 2) they have no training or authority to be giving such advise. Most of this "advise" is well intended, but because they lack the knowledge and training of how breastfeeding work (even the basics), does the complete opposite of their intentions. Mother's are being told things such as:
"you are starving your child by not giving him formula as you wait for your milk to come in" - a pediatrician "just top off each feeding with a bottle of formula" - family doctor
"breast milk isn't needed after 6month" a pediatrician
"he is just using you as a pacifier, don't nurse him so often" - a pediatrician
"don't let your baby nurse more than 15mins" - L&D nurse
"she should only nurse every 3/4hrs" - nurse
We are constantly cleaning up after all this incorrect information given to these families by people who have more authority and yet NONE of the training and/or knowledge as IBCLCs do.

When IBCLC becomes a licensed profession, doctor's office, pediatrician offices, hospitals, midwife offices, OBGYN offices, family practices, etc can hire on an IBCLC to evaluate, diagnose, educate and support these families (with correct information) and have the ability to bill their insurance (without hassle) with little to no cost to the family, therefore greatly enhancing the chances of prolonged breastfeeding. This is a win-win situation and a no brainer. IBCLC support (and the "benefits" of breastfeeding) should be available for every family, not just those who are fortunate enough to be able to afford it.

Thank you,
Amber Miracle

I am e-mailing you to support the licensing of Catherine Fenner, IBCLC and other lactation consultants. Catherine and I have shared many clients throughout the last 5 years for breast feeding support and this support has improved the ability of women to breast feed. Many new moms get frustrated in the first week of their infant’s life if breast feeding is not going well. As a pediatrician, I received no training in breast feeding or how to help women who have breast feeding difficulties. I was fortunate enough to spend 7 years with a ARNP who was also licensed as a lactation consultant and she taught me a great deal. I still have mom’s and infants who I cannot adequately help their breast feeding difficulties and instead of putting these children on formula and the mom giving up, most of my mom’s by getting lactation support can go on and breast feed as long as they want. The breast feeding data for why breast is

better than formula is exploding and yearly I am amazed at what breast milk offers over formula. Most recently it is clear even the flora of the babies gut is completely different from formula fed infants and this modulates the immune system of the infant and affects the risk of obesity, improved antibody response to vaccines and improved outcomes when exposed to disease. The human oligosaccharides are unique to human breast milk and they create a barrier to GI viruses and bacteria thereby reducing or preventing GI disease.

I hope you will consider the lactation consultants request for licensing so that they can bill and be paid by the medical insurance companies.

Carol Doroshow, MD, FAAP
The Kids Clinic

Having CLC in the hospital setting is very nice to assist staff with breastfeeding. They are able to take more time with the patients in order to assist and explain with breastfeeding and support the moms. It helps encourage and empower the mothers, especially first time mothers in order to feel successful with feeding.

Samantha Schnelbach

Hello and thank you for the invitation to give public comment.

My first of 4 children was almost 9 1/2 pounds and the nurses at the hospital told me that he was "such a big baby" that I would probably not make enough milk for him, and that he should be given formula. I already was feeling like my body had failed me, as I needed a c-section, and now my confidence in my ability to breastfeed was also low. I continued to supplement with formula at home when he seemed hungry more often than every 3-4 hours (which is quite normal for a newborn I now know). I was given erroneous information by well-meaning but misinformed people with little breastfeeding specific training, but as I had heard the term "lactation nurse" thrown around before I thought the nurse I was talking to were experts and did not know to ask for an IBCLC.

My son was at 2 months diagnosed by his pediatrician with dairy allergy, most likely caused by being sensitized to dairy protein in formula in those early days. His symptoms were fussiness and blood in his stool, which was quite scary for me as a first time mother. I had to take him to an internist at Seattle children's Hospital because he was still having symptoms for several weeks after I stopped eating dairy and stopped giving him regular formula. That was an extra expense to my family for the special doctors visits, traveling to Seattle, trying the very expensive elemental formula, and having to buy new foods to completely change my diet to keep dairy protein out of my breastmilk.

At one point, I considered calling an IBCLC for guidance, because my pediatrician did not have knowledge about how to improve my breastfeeding experience, other than telling me to go off dairy. However when I found out my insurance would not cover the cost, I did not make an IBCLC appointment.

I since overcame my breastfeeding difficulties and went on to successfully breastfeed 3 more children and was inspired to become a La Leche League leader and recently an IBCLC. My goal is to help increase access to breastfeeding support in my community and to improve breastfeeding rates in Washington.

Breastfeeding is one of the most simple and beneficial interventions that can improve public health and lives of infants and young children, as reported last January in the Lancet series. But it is a process that can get derailed quickly if problems in the early weeks are not corrected because a woman's milk supply may never recover. I know of women who have had to wait 6 weeks for an appointment with a specialist

and who have had to see multiple doulas/midwives/La Leche League leaders/ IBCLCs/physicians to finally get the referral and expertise that they need for their specific problem. That is a harmful waste of time for a breastfeeding dyad and many new mothers just finally give up in the midst of all the hassle and carting a new baby from appointment to appointment.

Licensure would make it more clear to a parent when they are trying to figure out who to ask for help. It would avoid real harm to our public health and breastfeeding rates that comes from asking the wrong people for help or self-diagnosing via the Internet because their insurance won't cover a private practice IBCLC visit. It would allow IBCLCs who are already out in their communities and those who are aspiring to get the message that the thousands of dollars and hours they have spent on their training is important and essential. It will give communities of color more access to breastfeeding support from IBCLCs out of the hospital setting and perhaps inspire more providers of color to pursue IBCLC certification. I can not even count how many times someone has posted on the aspiring IBCLC Facebook pages that they would love to become an IBCLC to help their own community of color, but without licensure there is not a sustainable career path that they can see.

Please consider these all in your decision. Other states have led the way and Washington is primed to be the next in IBCLC licensure.

Colleen Huck

I am writing this letter in strong support of better funding for lactation support within our state. As a family physician performing obstetrics, I have the opportunity to see many nursing infants and their mothers as patients. I have observed, over the last 5 years in practice, a significant barrier to access. This occurs particularly in the first 2 weeks when women are struggling with supply, confidence, and poor latch. During this critical time period, if they do not have access to adequately trained help, the result is often abandoning breast feeding and switching to formula. This has many socioeconomic issues for our State, it also has significant health implications for both mother and infant raising rates of post partum depression, increased rates of otitis media and URI's for infants, and of course, lack of protection from SIDS.

Since being in practice, I have had many unfortunate incidents of lack of access to certified lactation consults-for a long period, there were only 2 available to refer within my area. This has created issues with not being able to get appointments in a timely manner resulting in poor success with breastfeeding.

My own two children (both late preterm infants) were successfully breastfed to 15 months and 18 months, respectively. We faced many barriers with jaundice, poor latch and poor weight gain. Additionally, my second had Respiratory Distress Syndrome requiring an NG tube and CPAP with 8 day NICU stay. Without the strong support of the lactation team within the hospital, I would not have had the successes that I did in exclusively nursing them. I am proud to say that despite their early challenges, they did exceptionally well with very few upper respiratory issues and knock on wood, only one case of otitis media between the two of them (after weaning).

I firmly believe more success stories like mine would exist if we had the same support for our outpatients as we do our inpatients and strongly support insurance reimbursement for International Board Certified Lactation Consultants (IBCLCs).

Jessica Van Fleet-Green, MD
Yelm Family Medicine

I remember looking forward to accessible IBCLC care (with improved insurance coverage) through the ACA for families needing to return as an outpatient to hospital Lactation Services or to have IBCLC

Lactation support after discharge home outside the hospital/clinic setting. I was very much looking forward to promoting the expertise of my fellow IBCLC's in the community!

Since the ACA was implemented, I have been very disappointed how broad an interpretation of the ACA in family insurance policies. I was informed by fellow IBCLC's outside of the hospital/clinic setting that they continued to not be included in, or were minimally covered by, insurance policies to provide excellent Lactation care and follow-up support. Lactation care outside the hospital or clinic was still a family decision whether to pay out of pocket or cancel the Lactation Support needed.

I still find the need to inform families, before discharge home, to contact their insurance and learn what kind of coverage they have for Lactation support, and for Breast Pump supplies.

Colette Davenport

I had a patient whose baby had a significant weight loss (14%) on day 5 of life. The test weight showed only 4 gm transferred after what appeared to be a good feeding with a good latch. My first priority is to feed the baby, then work on establishing/maintaining mom's supply. I recommended feeding the baby 2 oz of breastmilk or formula every 2-3 hours, that mom start pumping, and to return for a weight check the next day so we could evaluate if milk supply was up and weight was up. Mother went home and instead decided to "google" her information and change the feeding plan. She did not show up for the weight check, and when the care provider called her at home, she stated that she read on the internet that all the weight loss was due to fluid retention from the mom's epidural. This baby was placed in a very dangerous situation because mom chose to follow up with Dr. Google instead of a professional lactation consultant. Websites and peer groups can often place doubt on the advice of an expert, partly because sometimes we tell the patient what they don't want to hear. Having state licensure would help to validate our credentials and our training.

Vivian Loudon

I work on a busy LDRP unit that does around 3000 births a year. A while ago I had a mother, who had just delivered an infant, tell me that she had inverted nipples. She had been told this by someone during her prenatal care. As a result, she had purchased a horn like pump to use to help pull out her nipples. Upon examination mother was noted to be sore and had some minor tissue damage from how much she had been using the horn pump. Mothers nipples everted quite easily and baby was able to latch very well after delivery. This mother had been torturing herself and worrying unneccessarily about being able to feed her baby because of what someone had told her.

We also see a fair number of women who have had augmentation or reduction of breast tissue. They come in unprepared for what to expect or watch for with breastfeeding. These women often are told by the surgeon that they should be able to breastfeed. The obstetricians do not address this issue and many times the fact that they have even had surgery is not known until I am consulting with them after the birth of their infant. This is often devestating news and info that should be addressed during pregnancy.

We serve a large Spanish popluation that are all convinced that they have no milk. These women have very limited access to care and even less to lactation care. These women get much of their info from family members.
We have a huge problem with out phycisians and how they counsel breastfeeding mothers. Much of the info is not up to date and is not reflected by current literature. There is a huge need for healthcare training accross the board and earlier access to breastfeeding counseling for pregnant and postpartum women.

Sherolyn Berdan

When my first daughter was born, Josephine, she was the most amazing thing I had ever seen. Right when she was born, after she was placed on my chest, the first thing she did was lift her head and look me in the face with her big beautiful green eyes.

A lactation nurse at the hospital mentioned that Josephine was tongue tied.

I worked hard at trying to breastfeed Josie, my nipples were bruised and bleeding every day right from the get go. I mentioned it to Josephine's Dr. during an early check up, and he basically told me to toughen up. I eventually gave her a bottle during the crucial first two weeks, and was never able to make enough milk for her the rest of her first year.

I eventually paid out of pocket to go and see a lactation nurse near my home. She said again that Josephine was tongue tied, and made it clear that if I wanted to give my baby the benefit of breast-milk then I needed to get it taken care of right away. I ended up having to see a natro-path, again not covered by my insurance, to have it cut for Josephine.

After two weeks of pain, bleeding, and frustration on her part and mine, we finally got off on the right foot. However because my supply wasn't established, I was never able to make enough for her, and eventually gave up around 10 months. No amount of pumping could make up for missing out on that first two weeks.

Margaret Mead Gill

I am a registered nurse and an International Board Certified Lactation Consultant. I work in a large hospital in Seattle, both inpatient and outpatient. As you are probably aware, the CDC found that without the support of lactation services provided in a hospital/clinic setting. About 1 in 3 moms will quit breastfeeding early. This means higher cost to the mom/family, the organization and the public in general. If there was a licensure created, hospital and clinics like the ones I work for, could bill for my services this more people could be helped, increasing health outcomes which decreases cost. Please consider the licensing of lactation consultants with utmost importance. Thank you.

Melissa Chasan

I work as an RN/IBCLC at Swedish Medical Center in Seattle. Our hospital patients have access to Lactation consultants while in hospital, but are very often unable to get qualified help with Lactation in the first few weeks of baby's life, the time when Lactation most commonly fails. In our state, approx 90% of new mothers start breastfeeding, which says that the desire to breastfeed is high, but only 20% of infants are still breastfeeding at 6 months of age, often due to lack of support from highly qualified Lactation consultants. I have been working in this field for over 20 years and see a great need for state licensure of Lactation Consultants. Phoebe Gosho, BSN,IBCLC

phoebe gosho

I breastfed both my children for a year and a half. Without my lactation consultants I would not have been able to acheive my goal. I am also a postpartum nurse and without our lactation consultants many of the

women and babies would not be provided the attention, encouragment, support and education they need to acheive their own personal breastfeeding goal. Breast is Best!

Krystal Willingham

Hi. I am an IBCLC. I live in a semi-rural part of WA State, Kitsap Co. My story starts with Google. If I wanted to work part-time as an IBCLC and be assured that I'd get paid, I'd just wait on Google. In their desperate need and desire to seek the best informed lactation help locally in Port Orchard, I have been called multiple times over the past year. I don't advertise. I must be on some list somewhere. (Actually, I'm an RD who happens to be an IBCLC as well working as a nutritionist at KCR-WIC.) When I ask how they got my number, the only answer has been Google. Nice. Anyhow, most recently, a woman called and I tried to refer her to a community resource like La Leche League but then it turned out she's eligible for WIC so now she is my client. Short story is that baby has an upper lip tie and mom is determined to make bf work. After multiple phone calls trying to find someone on the Kitsap Peninsula who would see a week old baby for a possible revision, I got her referred to someone in Gig Harbor. That this mom made it to me via Google and that I was able to assist her using my IBCLC skills via WIC warms my heart. But, what if she didn't quality for WIC and got lost in the melee of poorly constructed and seldom updated bf resource pamphlets?

Jeanne Panciera, RD, IBCLC

I am writing in support of IBCLC Licensure. I am an RN, IBCLC in private practice and see on a daily basis the lack of access to care that many moms experience. As an IBCLC I go through extensive training in order to obtain my IBCLC. Because of this extensive training and experience I am able to identify very complex breastfeeding issues and work with the moms primary care provider to come up with a plan of care that addresses these issues. This decreases the risk of early weaning which prevents ongoing long term harm to mother and baby.
Tracy Corey

I am an RN, IBCLC, working at Swedish Medical Center in Seattle WA as an inpatient lactation consultant. I have been an RN providing health care for 44 years. It has come to my attention that my patients are not following up on their outpatient lactation follow up recommendations due to inability to afford it. In many cases, insurance will not cover this much needed service due to lack of "License" of the Internationally Board Certified Lactation consultant. This seems ridiculous and short sighted to me that moms may stop breastfeeding their infant too early, due to lack of help with their lactation difficulties. It seems to me that a IBCLC should not only be a "certificate" but a "License" covered by insurance like other trained, licensed professionals and covered by insurance.

Judy Blank

Hi. I am an IBCLC. I live in a semi-rural part of WA State, Kitsap Co. My story starts with Google. If I wanted to work part-time as an IBCLC and be assured that I'd get paid, I'd just wait on Google. In their desperate need and desire to seek the best informed lactation help locally in Port Orchard, I have been called multiple times over the past year. I don't advertise. I must be on some list somewhere. (Actually, I'm an RD who happens to be an IBCLC as well working as a nutritionist at KCR-WIC.) When I ask how they got my number, the only answer has been Google. Nice. I'm flattered. Anyhow, most recently, a woman called and I tried to refer her to a community resource like La Leche League but then it turned out she's eligible for WIC so now she is my client. Short story is that baby has an upper lip tie and mom's nipples are getting torn up and she is determined to make bf work. After multiple phone calls

trying to find someone on the Kitsap Peninsula who would see a week old baby for a possible revision, I got her referred to someone in Gig Harbor (oh, and how I wish it were easier to get babies seen for a possible revision. That resource needs improving as well.) That this mom made it to me via Google and that I was able to assist her using my IBCLC skills via WIC warms my heart. But, what if she didn't quality for WIC and got lost in the melee of poorly constructed and seldom updated bf resource pamphlets? It happens all the time.

Jeanne Panciera, RD, IBCLC

I am a registered nurse, an International Board Certified Lactation Consultant, and a retired La Leche League Leader. I've been assisting families with breastfeeding for nearly 20 years. I have worked in the community, and now in a large birthing hospital, Swedish Medical Center. Licensure for lactation consultants will protect the public by ensuring high educational and clinical standards for lactation consultants. Families deserve to have this level of protection when seeking help for their breastfeeding problems. Breastfeeding confers life long benefits on both Mothers and Infants. Including IBCLCs as licensed providers will increase access to lactation care and prevent the harm done by early breastfeeding cessation, such as increasing the risk for diabetes, obesity, and SIDS.

Melissa Slovek Bonghi

Appendix E

Rebuttals to Draft Recommendations

Kim Rechner RN
9026 Little Bear Ct SE
Olympia, WA 98501
September 28, 2016

Ms. Thomas
Policy Coordinator
Washington State Department of Health
P.O. Box 47850
Olympia, WA 98504-7850

Re: Rebuttal to Findings in Lactation Consultant Sunrise Review

Dear Ms. Thomas:

The Washington Lactation Consultant Licensure Collaborative (WALCLC) was disappointed in the recent findings of the Washington State Department of Health (DOH) review of the Lactation Consultants Sunrise Review. We remain convinced that licensure of lactation consultants using the IBCLC standard is in the best interest of mothers and babies of the state. Please accept the attached rebuttal to the findings of DOH.

If you have any questions, please contact us at KimRechnerRN@gmail.com

Sincerely,

Kim Rechner RN

Sunrise Review Rebuttal

First Criterion: Unregulated practice can clearly harm or endanger health or safety.
DOH did not believe the proposal met this criterion and the proposal only provided anecdotal incidents or generalized examples of harm that would not rise to the level of requiring state regulation or would not be addressed through the proposal.

Recent work published in Maternal and Child Nutrition quantified the impacts and costs attributable to suboptimal breastfeeding rates in the United States. Key findings include:

- Suboptimal breastfeeding has a substantial impact on both maternal and pediatric health outcomes and costs.
- Nearly 80% of the excess deaths and medical costs attributable to suboptimal breastfeeding are maternal.
- Suboptimal breastfeeding is associated with considerable health impact, and cost in the United States has a larger impact on women's health than previously appreciated.
- Results suggest that women's health providers require training in lactation support and management as an integral part of preventive health for women.

http://onlinelibrary.wiley.com/doi/10.1111/mcn.12366/full

Second Criterion: The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.
DOH did not believe the proposal met this criterion and that the proposal would not reduce the incidence of most of the problems identified in the applicant report.

The Sunrise Review noted that a large majority of IBCLCs already hold an underlying RN or RD credential and that the public can already expect to receive initial and continuing professional ability from these health care professionals. However, IBCLCs are recommended and found effective to sustain breastfeeding intensity and duration. There is no other lactation provider group that has evidence that their level of training produces these results. https://uslca.org/wp-content/uploads/2016/07/Efficacy-of-the-IBCLC.pdf

The Sunrise Review continues by stating there is already a route to report inadequate care through each profession's disciplining authority and that health care providers should already refer mothers to lactation specialists when necessary. Unfortunately individuals who have only basic lactation training are unaware of how little they know and may not refer mothers for higher level care. The mothers they serve are also unaware that there are IBCLCs who are more competent to provide help to overcome breastfeeding problems. Therefore, they seek no further assistance and this results in the harm of premature weaning and at times acute threats to the health of mother or infant.

Third Criterion: The public cannot be effectively protected by other, more cost-beneficial means.
DOH did not believe the proposal met this criterion and in most cases, it creates a duplicative process for regulation of health care providers who are already licensed in Washington as an RN or RD. However, this fails to recognize the IBCLC as separate profession. Only 3% of all nurses have any lactation qualification, and not necessarily an IBCLC certification.

The Sunrise Review suggests a less-burdensome alternative to licensure, voluntary certification, may be an

option to address potential confusion about education and skill levels of lactation care professionals. DOH continues to explain, “With voluntary certification, the department grants recognition to lactation consultants meeting certain qualifications, who would be subject to the Uniform Disciplinary Act, chapter 18.130 RCW. Non-certified lactation care providers would still be authorized to perform the same tasks as long as they did not use the protected title of “certified.” The qualifications for certification should be evaluated to determine what additional programs may be sufficient, in addition to IBCLC, to meet the minimum qualifications. This alternative may help with insurance reimbursement for lactation care as well.”

The only difference between this alternative to licensure and the proposal is the qualifications required for certification. In the alternative, they are not defined, and in the proposal, the qualification is IBCLC or equivalent. It is not clear that the two options are different in any other ways.

Thank you for sharing the results of your committee's draft report. I am a retired La Leche League Leader, a RN and an IBCLC with 17 years of experience working in the community. I appreciate the opportunity to share my thoughts. The draft report states our request to create a new professional group of healthcare providers, lactation consultants, has not met the goals of the law as it is defined.

First Criterion: Unregulated practice can clearly harm or endanger the health or safety.

I sense the requirement to prove harm to the public will always fall short of your expectations. I know in the effort to promote licensure, I will not, nor do I plan to, denigrate and point fingers at other breastfeeding supporters: doulas, peer counselors, birth and breastfeeding educators, and La Leche League volunteers as causing harm. It seems as if the committee is requiring the licensing group to make enemies of our friends. The bill we drafted reads as conflicting, because it asks to license Lactation Consultants, but on the other hand say Licensed Healthcare Providers already provide lactation care within their own scope of practice: Medical Doctors, Physicians Assistants, Advanced Registered Nurse Practitioners, and Midwives. As seen at the hearing, Midwives are concerned that the new law would result in restriction of their practice. Again, is not the intent of our group to restrict the scope of practice of Midwives, nor to limit breastfeeding supporters. We all agree the harm of early wean is significant, and not all of the causes of early weaning will be resolved by licensing lactation professionals, but we can hope to ameliorate the problem by creating an additional type of healthcare provider to provide clinical lactation care. The possibility of a variation of clinical lactation providers as related to areas and type of practice, large birthing centers to rural community health centers to independent practitioners, is something to examine further, and could be somewhat similar to those of Mental and Behavioral Health Professional's variations in educational and clinical experience.

Second Criterion: The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

It has been demonstrated that many current Healthcare Providers have limited training and experience to address breastfeeding problems. Recommendations have been made to address the lack of training, however those recommendations have been in place for over a decade and very little has changed. The current

failure to meet breastfeeding initiation and duration goals exists within this environment. Also, consider healthcare costs, a typical visit with a Lactation Consultant is 1.5 hours in length. What is the costs for an MD, ARNP, PA, for 1.5 hours of their time for counseling breastfeeding dyads? Then, if you image the cost, can you imagine any MD, ARNP, PA that has the time available in their schedule to accommodate a lengthy 1.5 hours visit?

Licensure of Lactation Consultants does not resolve the issue of other Healthcare providers with little training for providing lactation care. What licensure can do is expand the choice of the type of provider, and assure the public a Lactation Consultant has the specific knowledge and training necessary to address breastfeeding problems.

Third Criterion: The public cannot be effectively protected by other, more cost-beneficial means.

The costs related to the establishment of a new board, and then the administration of a new license is something everyone is concerned about. I would like to know more about the true costs, however I have not been given any evidence, or breakdown from the Department of Health as to what the costs would be, only vague guesses. As all of the health professions are licensed by the state, some collaboration seems possible to reduce costs. Certification does not meet the goals of our group, however I appreciate the committee's thoughtfulness in seeking some solution. The costs of not breastfeeding are too high to do nothing, but the wrong remedy will not provide a cure.

Thank you,

Melissa Slovek Bonghi RN, IBCLC