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# Lactation Clinic: Improving Patient Lactation Support

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Lactation Clinic: Improving Patient Lactation Support

Iana Johnson

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### **Abstract**

Despite the numerous health benefits and recommendations that breastfeeding is the optimal method for nourishing infants, many still choose other ways to feed their babies during the first year of life. This project considers the initiation and future implementation of a Lactation Clinic as an additional patient support service provided in the inpatient and outpatient settings. A Failure Modes and Effects Analysis (FMEA) was conducted in an effort to evaluate and eliminate “what could go wrong” before such an establishment becomes operational. The Risk Priority Numbers (RPNs) from the analysis reveal the lack of use (RPN 50) and streamlining (RPN 20) as the top two risks associated with the implementation of the Lactation Clinic. In response to these findings, the Clinical Nurse Leader (CNL) has made suggestions and taken a lead role in assisting and creating new patient handouts and surveys. While the clinic is preparing to open its doors, it is the goal of the CNL and the facility that the additional lactation support will increase patient satisfaction to 90% and breastfeeding rates to 80%. The new patient survey will be utilized to measure these rates.

## Lactation Clinic: Improving Patient Lactation Support

### **Clinical Leadership Theme**

The Clinical Leadership Theme and Curriculum Element that relate most to this project is *Nursing Leadership*. The Clinical Nurse Leader (CNL) will take a lead role in establishing a Lactation Clinic on a Postpartum unit in an acute care setting. She will work with the interdisciplinary team in an effort to improve patient outcomes and satisfaction and to adopt the best practice recommendations.

The CNL Role Function involved with this project is *Advocate* and the End of Program Competency is: *Communicates effectively to achieve quality client outcomes and lateral integration of care for a cohort of clients*. The CNL will take a lead role and work with the interdisciplinary team to evaluate the progress of the project as well as perform a risk analysis to anticipate “what could go wrong”. In addition, she will focus on reviewing the literature and consider the experiences of other Lactation Clinics in the nation.

### **Statement of the Problem**

According to the American Academy of Pediatrics (AAP, 2012), breastfeeding provides newborns with the best start in life, is beneficial for both the mother and infant, and “is a proud tradition of many cultures”. The Centers for Disease Control and Prevention (CDC, 2016) states that “while 74.6% of infants born in 2008 began breastfeeding, only 23.4% met the recommended breastfeeding duration of 12 months”. This statistic supports the idea that mothers are in need of additional support and resources to continue breastfeeding. The Postpartum unit considered for this project recognized statistics such as these and being aware of the recent state rates of 25.4% of

exclusive breastfeeding at 6 months of age, decided that it needed to expand its lactation services provided (CDC, 2016). At the end of 2015 a multidisciplinary team was established to begin working on the implementation of a Lactation Clinic, as a way to address these needs. The purpose of this project is to support patients and the current breastfeeding recommendations, as well as to consider some of the risks associated with establishing such a clinic by performing a Failure Modes and Effects Analysis (FMEA).

### **Project Overview**

Since 2015, physicians, lactation consultants, nurses, and representatives from the billing and Information Technology (IT) departments have worked together to create the Lactation Clinic. The goal of this clinic is to provide additional breastfeeding support to both mothers who have delivered their infants at the facility and those who have not. It is the anticipation of the interdisciplinary team that the Lactation Clinic would connect with all breastfeeding mothers prior to discharge from the facility. Following discharge, the clinic hopes to reach out to mothers in the community with the help of physicians. The Pediatricians or the mothers' doctors can place referrals to the clinic depending on their patients' needs. Following that, the patient couplets (a couplet consists of a mother and her infant) can schedule appointments with the clinic. The lactation consultant can see patients on Tuesday or Thursday afternoons after they have been discharged from the hospital for thirty-minute long appointments or longer.

The goal of this project is to support the current recommendations for breastfeeding as the main source of nutrition to newborns and infants and to consider "what could go wrong" with the establishment of such a Lactation Clinic. The CNL has worked closely with the interdisciplinary team to update the current pamphlets that are

given to patients. The hope is to provide them with current information on the benefits of breastfeeding and to help “spread the word” about resources available to them after discharge. These pamphlets have also been distributed to doctors’ offices in the community. In addition, the CNL has worked with the interdisciplinary team to create a new pamphlet for the Lactation Clinic. This pamphlet explains the services provided there and it includes a map of the facility on the back. A special area where patients could write their appointment date and time on the back of the pamphlet has also been included. The CNL has also reviewed the literature to establish a common theme of why some breastfeeding mothers do not choose breast milk as their infants’ primary source of nutrition.

Part of the goal of this project is to also consider the risks associated with establishing a Lactation Clinic. The CNL has reviewed the literature focusing on other facilities’ experiences with creating such clinics. Attempts to connect with representatives from some of these Lactation Clinics have been unsuccessful, so this part of the project was influenced primarily by the literature. The CNL also focused on an interview with the facility’s lactation consultant with the intent to learn more about the establishment of the clinic (Appendix A). The CNL then used the information gathered to perform an FMEA and establish the main risks associated with having a Lactation Clinic.

The global aim statement related to this project was: To improve patient lactation support for all new mothers on the Postpartum unit and in the community. The process begins with the patient’s expressed desire to breastfeed upon admission. The process ends with a follow up/evaluation phone call after discharge from the unit. These services will also be extended to breastfeeding mothers in the community. By working on this process,

the expectation is to (1) improve patient satisfaction and outcomes as a result of the numerous health benefits of breastfeeding both for the mother and baby, (2) increase staff satisfaction in patient care provided, and (3) utilize hospital resources by providing support to the inpatient and outpatient population. It is important to work on this project because a need has been identified to improve (1) patient satisfaction and breastfeeding rates, (2) staff satisfaction, and (3) allocation of resources.

The specific aim statement for this project was: Starting in November 2016 with the opening of the Lactation Clinic, the aim is to improve patient lactation support to all new breastfeeding mothers both in the inpatient and outpatient settings. There will be 90% patient participation, ensuring their satisfaction. This participation will be established with chart audits and measured with follow up phone call questionnaires to the patients (Appendix B). As a result, breastfeeding rates will increase to 80% during the first 6-12 months, which would be measured by utilizing a patient survey provided at the clinic. The specific aim statement is a more concrete extension of the initial global statement listed above. It provides a method for tracking the effects of the Lactation Clinic and this project.

### **Rationale and Cost Analysis**

In an effort to consider the risks associated with the establishment of the Lactation Clinic, an FMEA was performed (Appendix E). This type of analysis “is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assist the relative impact of different failures, in order to identify the parts of the process that are most in need of change” (IHI, 2004). As a result, after meeting with the multidisciplinary team and interviewing the facility’s lactation consultant, two main

failure modes emerged. The first mode and the one that received the highest Risk Profile Number (RPN) was the possibility that the Lactation Clinic might not be used as much as anticipated. Three separate causes emerged under this failure mode: The possibility that health insurance might not provide coverage for the clinic's services, the inconvenience that going to the clinic might cause to patients who in the past may have had lactation consultants visit them at home, and the potential psychosocial issues that might arise from seeking additional breastfeeding help. The main effect of this mode would relate to the facility's financial inability to sustain the Lactation Clinic. This failure mode received an RPN of 50, suggesting some room for improvement. The CNL has recommended the need to increase advertisement for the clinic within the community and doctors' offices. Ensuring that these offices receive the updated pamphlets would increase the likelihood of patients and doctors to use and seek the clinic and its services. In addition, ensuring that patients receive adequate education on breastfeeding and its importance would be imperative.

The second failure mode is related to streamlining or making certain that referrals are entered in an effective and consistent manner. The cause for this failure mode involves the doctors' and healthcare staff's remembering to recommend and use the clinic. The effects of the mode would be inconsistent patient documentation and tracking. The RPN in this case is 20, which is much less than the first failure mode considered. The action to reduce the occurrence of this mode, however, is somewhat similar to the initial mode. It would be important to continue to advertise the clinic to physicians' offices and the community as a way to ensure that the correct streamlining is followed and remembered. Delivering the new pamphlets and brochures has been imperative.



To further strengthen this portion of the project, the health implications of breastfed and formula fed infants were considered. According to the American Pregnancy Association (APA, 2016) and numerous other reputable agencies, breastfeeding is the recommended newborn method of feeding. It is easy to digest, it provides the perfect balance of nutrients, it's contents change as the infant's needs change, and it is free. The nutrients of breast milk as the La Leche League (LLL, 2016) states consist of passing the mother's immunities to the infant. This does not guarantee that breastfed babies will not get sick, however, it does imply that they tend to have less severe cases of illnesses than formula fed infants. Formula, on the other hand, is not as "efficiently utilized as breast milk". Its nutritional content depends on its preparation, its dosage is determined by the people responsible for the newborn, and its "cost ranges from \$54 to \$198 per month" depending on the brand (APA, 2016).

In addition, the overall healthcare cost of formula-fed infants during the first year of life is higher than that of breastfed babies. A study conducted by Ball and Wright (1999) considered how often health services were sought for three common infant illnesses (lower respiratory tract diseases, ear infections, and gastrointestinal conditions) during the first year of life. The authors focused on infants from two facilities who were never breastfed, partially breastfed, or were exclusively breastfed during the initial months after birth. The findings of the study suggested that compared to 1,000 exclusively breastfed infants, babies who received formula had "2033 excess office visits, 212 excess days of hospitalization, and 609 excess prescriptions for these three illnesses per 1,000 never-breastfed infants" (Ball and Wright, 1999). Considering that 74.5% of the infants born in 2011 on the unit considered for this project were exclusively breastfed,

over 25% of the newborns there received other types of nutrition (California WIC Association, 2012). This suggests that close to one quarter of the babies in this facility may have had a substantial increase in healthcare cost as a result of their source of nutrition.

This study further strengthens the AAP and CDC's recommendations that breast milk is the optimal nutrition for newborns. In response to such findings and recommendations, the new Lactation Clinic will be implemented in November 2016. This clinic will not only strive to improve the breastfeeding experience of mothers and their infants, but it will also work on increasing patient satisfaction. In addition, the clinic will be open to the community as it attempts to improve overall breastfeeding rates at the local level.

By improving the rates of breastfeeding, the clinic hopes to also improve patient satisfaction rates. Such improvement would ensure financial assistance to the facility as 30% of Medicare reimbursements rely on patient satisfaction (Sherman, 2012). The facility's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, for example, provide an insight into the organization's performance from the patient's perspective. It is the hope that following the implementation of the Lactation Clinic, these scores would reflect the benefits that the additional services provide to breastfeeding mothers.

### **Methodology**

As a new service, the goal of implementing the Lactation Clinic is to provide breastfeeding mothers with additional lactation support after they leave the facility or in the community. The clinic is not operational yet, so the current analysis is on identifying

the risks that are associated with opening such a Lactation Clinic. To illustrate that two postpartum healthcare facilities were considered. One of them has a similar operational Lactation Clinic while the other does not. The focus of this part of the project is to assess how the two facilities measure, what types of issues they have come across, and what their patient satisfaction ratings show. Following this comparison, a list of actions has been presented, which will go into effect when the clinic is implemented. The results have assisted in suggesting the effectiveness of the Lactation Clinic. During the study a change theory was also identified as a way to enhance this CNL project.

The first healthcare facility is an acute care setting in Pittsburg, CA, that has recently implemented a Lactation Clinic (Thiebaud, 2014). The clinic was initiated to achieve best practice and to improve patient satisfaction. The initial steps in this clinic were to establish a multidisciplinary task force. Members of the task force consisted of all individuals involved in direct and indirect patient care, including representatives from departments such as billing, IT, quality control, public health, and organizations such as Women, Infants, and Children (WIC). They met routinely and worked on issues ranging from staff training, ensuring that all involved had received the same training, referral systems, billing and redoing all aspects of the clinic such as modifying its appearance, to updating its policies. The clinic's challenges consisted of finding space for a lactation room and allowing staff to attend trainings due to shortages. The space issue was resolved by converting one of the employee lounge areas to a breastfeeding room. This resolution met some initial resistance from the staff as they felt like they had to give up some of their space. The facility updated its breastfeeding pamphlets and piloted the proposed Lactation Clinic, which received favorable reviews. Consequently, the clinic

was opened on the premises of the facility. As the clinic's benefit to patients was recognized and the demand for its services increased, it became apparent that additional locations needed to be funded. The steps following that consisted of expanding the Lactation Clinic's services to six out of the facility's eight county clinics.

The second healthcare facility is located in Central California and has 119 beds. It received a three out of five HCAHPS patient experience rating stars (CMS, 2016). It is a smaller facility and staff nurses are most often the initiators and supporters of mothers' choices to breastfeed. According to the California Department of Public Health (CDPH, 2015), in 2015 only 59% of mothers who delivered in this facility exclusively breastfed their infants. This facility is the only acute healthcare institution in this county, which does not provide additional lactation support to its breastfeeding population. It has among the lowest ratings for exclusive breastfeeding (CDPH, 2016).

Considering these two healthcare facilities and reviewing the AAP and CDC's breastfeeding recommendations, it is clear that additional lactation support is beneficial for many mothers and their infants. The Lactation Clinic that is the focus of this project would provide both the breastfeeding patients of the facility and mothers in the community with such additional lactation support. The change theory appropriate for this project is Rogers Diffusion of Innovation Theory. According to Everett Rogers, "diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system" (Cain and Mittman, 2002). There are ten dynamics related to diffusion: relative advantage, trialability, observability, communications channels, homophilous groups, pace of innovation, norms and social networks, opinion leaders, compatibility, and infrastructure. This theory focuses on

moving people towards change and is appropriate for this project as it provides guidance for how to influence others. The lactation aspect of patient care on the Postpartum unit has always been present, however, with the establishment of the clinic, this service will become available to breastfeeding mothers even after hospital discharge and in the community. Considering the numerous health benefits of breastfeeding and following the recommendations, most all of the individuals involved with this project were easily convinced to accept it as a new change.

Following the project's implementation and together with the lactation consultant, the CNL will be focusing on maintaining the "drive" for this new change. This will consist of reminding physicians and healthcare staff of the clinic's existence and the great ways in which it can benefit all breastfeeding mothers and their infants. In addition, ensuring that all patients receive adequate breastfeeding education would be important. In an effort to continue the risk analysis, the CNL will schedule interdisciplinary team meetings at one month, three months, and six months after the opening of the Lactation Clinic. The focus of the meetings would be educational and to examine topics, such as "what we've learned this far". Currently, there is no statistical data pertaining to the facility's lactation services. The hospital and Postpartum unit have numerous patient surveys, but none of them address patients' breastfeeding experiences and desires. The CNL will work with the facility to incorporate a few lactation questions into the general surveys of patients when applicable. These questions would be similar to the questions listed in Appendix B. Such a practice would provide current data and moving forward, the CNL would be able to quantify the progress of the clinic. The statistical information gathered would be of great value to evaluate the effectiveness of the clinic.

### **Data Source/Literature Review**

Considering how new mothers and their infants would benefit from additional breastfeeding support provided by the Lactation Clinic and mothers who do not receive any additional help, the literature supports the predominant recommendations for breastfeeding. The CDC's Breastfeeding Report Card, 2016, indicates that 81.9% of newborn infants were breastfed in 2013 (CDC, 2016). This suggests that close to 20% of newborns received other types of nutrition, indicating that further work needs to be done to ensure that more babies follow the recommendations. In addition, the AAP (2012) clearly lists the initial period after the birth of an infant as a period when the baby would most benefit from human breast milk as the sole type of nutrition. The AAP also considers the numerous short- and long-term health benefits for babies who are exclusively breastfed as newborns.

Considering these recommendations, Bonuk et al. (2014) focused on the effects of primary care on breastfeeding duration and intensity. They conducted two patient trials in two obstetrics and gynecology offices in New York between 2008 and 2011. The focus was on patients without any additional lactation support and other patients who received variations of extra breastfeeding help. The authors' studies included the Provider Approaches to Improved Rates of Infant Nutrition & Growth Study (PAIRINGS) and the Best Infant Nutrition for Good Outcomes (BINGO) Study. The results indicated that mothers who met with a Lactation Consultant coupled with receiving additional guidance from prenatal care providers, showed higher instances of breastfeeding at three months postpartum. Such additional lactation support, as Glassman (2015) describes in her summary of the experience of one newborn clinic in New York, NY, was not only felt by

the breastfeeding patients, but also by the institution, and the community. In the case of the Lactation Clinic considered for this project, it is the hope that it also provides support to the entire community.

Additional research further considered mothers who received standard care vs. mothers who visited Lactation Clinics in an effort to receive additional support (Laliberte et al., 2016). The findings indicated that the rates of exclusive breastfeeding did not increase significantly with the implementation of the clinics, however, patient satisfaction showed an increase. Similar results were also noted by Witt, Smith, Mason, and Flocke (2012), who considered the routine integration of lactation services during post-delivery appointments. These authors' conclusion suggested that the implementation of outpatient lactation services paired with routine well-baby checks improved breastfeeding outcomes.

In an effort to examine breastfeeding and where the current trends are, a review of the barriers to breastfeeding was obtained. Srinivas, Benson, Worley, and Schutle (2015) considered improving breastfeeding rates by using a peer counseling technique and focusing on patients' attitudes and self-efficacy. Their conclusion suggested that breastfeeding attitude was a strong indicator for initiation and continuation of breastfeeding. The authors also discovered that peer support was of great benefit to mothers with low self-efficacy, suggesting that these mothers would benefit greatly from additional lactation support.

Other barriers to breastfeeding as Johnson et al. (2013) indicate are related to the abundant access to free formula in many communities. In addition, the authors discovered that the spouses of the breastfeeding mothers also greatly influenced their breastfeeding

decisions. The article's conclusion recommended that an increase of patient access to additional lactation support and an increase in spousal involvement would greatly improve breastfeeding rates.

### **Timeline**

The Lactation Clinic project was initiated at the end of 2015. Since then the multidisciplinary team has met routinely to discuss various important steps related to the implementation of the clinic. These steps have consisted of designing an order set and a method for documentation in the facility's Meditech electronic charting system, creating a way to bill for the services provided, ensuring that there is a comfortable area for breastfeeding mothers to feed their infants, providing education to the healthcare staff involved, and making certain that physicians were aware of the new clinic. The team has also met with a representative from the billing department to review the final coding methods for the Lactation Clinic. Following the implementation of these new codes, it is the facility's plan to have the clinic "open its doors" to breastfeeding patients during November 2016. The new and updated pamphlets have also been finalized. One month after the clinic has begun its operation, the CNL would conduct an interview with the lactation consultant, who is the clinic's lead contact person. This interview questions would focus on a "where are we now" and "what have we learned" type of an evaluation (Appendix C). To create a progress tracking method, the CNL has also created a patient satisfaction survey, which would be provided to new patients as they enter the clinic (Appendix D). The questions listed in Appendix B would provide the follow up evaluation of the patients' experiences.



### **Expected Results**

It is the expectation of the Lactation Clinic and the facility, that the additional breastfeeding support improves patient satisfaction while it follows breastfeeding recommendations. Similarly, patient satisfaction and improved breastfeeding rates are the expectations of the CNL as well, however, she has also focused on the process that helped achieve these outcomes. Furthermore, considering “what could go wrong” and ensuring that those risks have been considered before they create problems, have supported the outcome of this project. The FMEA would be of great importance as a risk analysis method after the clinic becomes operational. The patient survey questionnaires would demonstrate the effectiveness of the Lactation Clinic.

### **Nursing Relevance**

Breastfeeding is an important aspect of the postpartum care of a mother and her infant. The nursing focus for this population consists of supporting the patient and providing education as needed. Regardless of where the patient is (inpatient or outpatient settings), this new service would enhance the nursing focus. With the implementation of the Lactation Clinic, patients would have more opportunity for support and education, which would help improve their experience and ultimately their satisfaction.

### **Conclusion**

As the clinic awaits to open its doors during November 2016, the CNL and the multidisciplinary team continue to work together to ensure the successful implementation of the new service. The lactation consultant has delivered the updated pamphlets to all of the pertinent physicians’ offices. These pamphlets will help advertise the new service to local healthcare providers who will serve an integral part in ensuring the use of the

Lactation Clinic. The updated pamphlets will also help to enhance breastfeeding patient education as staff nurses provide care to their postpartum couples. It is the goal of the CNL that the increase in advertisement and patient education would support the clinic as it becomes operational.

At this time, the CNL has also met with the hospital's Chief Nursing Officer (CNO) to discuss the current status of the Lactation Clinic. In addition, to gain some understanding of how willing some patients might be to use the new service prior to its implementation, the CNL distributed ten copies of the patient survey listed in Appendix B to be handed out by the lactation consultant. Although a small amount of the patients were able to answer the questions, and considering that they had not been discharged from the unit at that time, their desire to continue to breastfeed and their interest in the new clinic were clearly stated. The patients' answers also indicated that they felt supported by the staff, which provides further support for the expected results of this project.

Following the implementation of the clinic, the action plan put in place by the CNL would serve as an indicator of sustainability. The champion of the clinic, the lactation consultant, would "drive" this plan as she continues to meet with the multidisciplinary team to discuss the progress of the new service. In addition, the patient surveys would create an insight into the status of the clinic and the needs of the patients. As breastfeeding continues to be the optimal nutrition method for infants, the long-term goal of the CNL and this project is to provide additional lactation support to breastfeeding patients, which would not only increase satisfaction, but also improve overall breastfeeding rates in the inpatient and outpatient settings.

This project has been a great Clinical Nurse Leader opportunity and it has been made possible with the guidance and tremendous support of the faculty at the University of San Francisco. The mentorship received at the academic and clinical settings has been immense.

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Appendix A  
Interview with S.H. – Lactation Consultant  
September 20, 2016

1. What has been done until this point?
  - Many meetings with the multidisciplinary team have been conducted since 2015
  - An outpatient lactation form to go into Meditech has been created
  - Would be able to schedule appointments using SharePoint
  - Should be receiving the clinic's furniture during last week of September
  
2. Where does the Lactation Clinic stand currently?
  - Awaiting to hear back from A.D. from billing to confirm that we have an approved coding method for the services provided, billable source
  - Finalize the "fluidity" of the process, ensure that every aspect has been considered
  
3. What is the target of the clinic?
  - The target is to schedule at least 20 appointments each month in order to keep the clinic operational. Each appointment would be 30 minutes long and it would consist of providing lactation education and any additional breastfeeding support that is needed by the patient.
  
4. Have you encountered any challenges until this point?

- Besides finding the appropriate codes for billing, which we are still working on, we haven't encountered any additional substantial problems. Most everyone has been very accepting of the idea to provide more lactation support to patients and members of the community.
5. What problems might arise in the future in your opinion?
- Getting everyone to use the services and the system
6. If able to "redo" the entire project, what would you do differently?
- I would have started it much earlier.



Appendix B  
Follow Up Phone Questionnaires to Patients  
(Following discharge from the hospital)

1. How long were you on the Postpartum unit?
2. How would you describe your experience?
3. Prior to the delivery of your infant, what was your plan for feeding your baby?
4. Did it change after you delivered?
5. If so, what influenced the change?
6. Did you feel supported by the staff?
7. Did you receive breastfeeding education and support from the staff?
8. Did you request to see the Lactation Consultant?
9. Are you still breastfeeding?
10. Do you think you will benefit from a meeting with the Lactation Consultant at our new clinic?

Appendix C  
What have we learned after one month?

1. In your opinion, how is the clinic doing one month after its opening?
2. What has gone well?
3. What has not gone as well as planned?
4. About how many patients have utilized the clinic this far?
5. About what percentage of them have been discharged from this facility?
6. How is the process of referring, ordering, and utilizing the clinic by all involved working?
7. How fluid of a transition has this been for physicians and the staff?
8. What, if anything, would you change or revise for the clinic's second month of operation?
9. What might go wrong at this point?
10. What is your long-term goal for the Lactation Clinic?

Appendix D  
Lactation Clinic – Patient Questionnaire

1. How was your pregnancy and delivery? Any complications?
2. When did you deliver?
3. Have you breastfed your other children? If so, for how long?
4. How long would you like to breastfeed your baby?
5. Besides breastfeeding, do you use any other methods to feed your infant?
6. Do you have help at home?
7. What are your breastfeeding concerns today?
8. What are your breastfeeding goals?
9. Do you plan to go back to work? If so, what are your plans about breastfeeding at that time?
10. Do you use a breast pump at home?

Appendix E

| Steps in the Process | Failure Mode  | Failure Causes  | Failure Effects                                     | Likelihood of Occurrence (1-10) | Likelihood of Detection (1-10) | Severity (to the project) (1-10) | Risk Priority Number (RPN) | Actions to Reduce Occurrence Of Failure   |
|----------------------|---------------|---|---|---------------------------------|--------------------------------|----------------------------------|----------------------------|---|
| 1                    | Lack of use   | No coverage by insurance<br><br>Not convenient<br><br>Psychosocial issues – guilt, etc. | Inability to sustain clinic and “break even”        | 5                               | 1                              | 10                               | 50                         | Deliver pamphlets to doctors’ offices to help inform the community and all involved about the clinic<br><br>Ensure adequate breastfeeding education |
| 2                    | Stream-lining | Stakeholders do not remember to use the clinic  | Patient charting and tracking that are not complete | 2                               | 2                              | 5                                | 20                         | Continue to advertise clinic in the community, offer treats such as candy when doing so   |