

Public Employers Health Purchasing Committee

Summary of Policy Action & Transmittal

1. Policy Proposal Received From:

Oregon Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)

2. Summary of Policy Proposal:

Relating to various patient safety requirements included in purchaser-carrier/TPA contract or in carrier/TPA contracts with providers:

- *CMS Hospital Acquired Conditions (HACs)*
- *Oregon Patient Safety Commission hospital reporting*
- *Oregon Patient Safety Commission hospital surgical checklist*
- *Oregon Association of Hospitals & Health Systems non-payment of serious adverse events*
- *Oregon Patient Safety Commission adverse events reporting for non-hospital facilities*
- *List of “never events” that define “serious adverse events”*
- *Bariatric surgery guidelines (applicable when bariatric surgery is a covered benefit)*

[See attached table, “Patient Safety Contract Language, PEBB/OEBB 2010 – 2011”]

3. Committee Action(s):

- *Presentation (by Joan Kapowich, PEBB/OEBB) and discussion at May 24, 2010 meeting.*
- *Committee Action at October 25, 2010 meeting as follows:*

The Public Employers Health Purchasing Committee endorses contract provisions relating to patient safety similar to those used by PEBB/OEBB (see attached), and recommends that public and private employers in Oregon discuss with their carrier or third-party administrator including patient safety standards in their contracts.

4. Distribution:

- *Association of Oregon Counties, League of Oregon Cities, Special Districts Association of Oregon, Oregon Coalition of Health Care Purchasers, Oregon Business Council, Associated Oregon Industries, Oregon Business Association*
- *Mailing list of large Oregon employers and labor-management trusts*
- *cc's: Oregon Health Policy Committee, PEBB (chair) and OEBB (chair)*

**Patient Safety Contract Language
PEBB / OEBB 2010-11**

| Patient Safety Requirements | Medical | | | |
|---|------------------|-------------------|------------------|--|
| | PEBB | | OEBB | |
| | 2010 | 2011 ¹ | 2009-10 | 2010-11 |
| CMS Hospital Acquired Infections (HAIs) | <i>Required</i> | <i>Required</i> | <i>n/a</i> | <i>Potential Addition²</i> |
| Or. Patient Safety Comm.'s hospital reporting program | <i>Encourage</i> | <i>Required</i> | <i>Encourage</i> | <i>May move to Require²</i> |
| Or. Patient Safety Comm.'s hospital surgical checklist | <i>Encourage</i> | <i>Required</i> | <i>Encourage</i> | <i>May move to Require²</i> |
| Or. Assoc. Hospitals and Health Systems' serious adverse events | <i>n/a</i> | <i>Required</i> | <i>Required</i> | <i>Required</i> |
| Or. Patient Safety Comm.'s adverse events reporting for non-hospital facilities | <i>n/a</i> | <i>Required</i> | <i>Required</i> | <i>Required</i> |
| Bariatric surgery following PEBB guidelines | <i>n/a</i> | <i>Required</i> | <i>n/a</i> | <i>n/a</i> |

¹ This reflects PEBB's first round of contract renewal language. PEBB expects that this language will be further negotiated with the carriers. Furthermore, it is likely that the carriers will not agree to "require" all of these elements for 2011. At the very least, PEBB will "require" some and "encourage" others.
² These possible changes reflect issues that will be discussed with the carriers and the SEOW Committee prior to the 2010-11 contract amendments being completed

| Patient Safety Requirements | Dental | | | |
|--|--------|---|------|---------------------------------|
| | PEBB | | OEBB | |
| | 2010 | 2011 | 2010 | 2011 |
| List of "never events" of "serious adverse events" | n/a | Required | n/a | Potential Addition ² |
| | | * Includes not paying for work on wrong patient or tooth or causing loss of healthy tooth | | |

PEBB's proposed patient safety language for 2011 medical renewals

Patient Safety. PHP agrees to:

(a) Not pay for "hospital acquired conditions (HACs)" identified by Medicare guidelines as identified at http://www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp which PEBB and PHP intend will automatically update during the Term of this Agreement to reflect changes to Medicare guidelines.

(b) Require the following language to be included in its contracts with hospitals:

1. Language that specifically prohibits the hospital from charging PHP or a PEBB Member for HACs;
2. Language that requires hospitals to adopt the "Guidelines for Non-Payment of Serious Adverse Events" developed by the Oregon Association of Hospitals and Health Systems;
3. Language that requires hospitals to participate in the Oregon Patient Safety Commission's Adverse Events Reporting Program for Hospitals; and,
4. Language that requires hospitals to use a surgical checklist consistent with the Oregon Surgical Safety Checklist as endorsed by a coalition of Oregon quality groups and that shall include critical elements appropriate to the patient population. Furthermore, the surgical checklist used shall encourage full communication among the surgical staff regarding patient needs in the following three phases of care: prior to administration of anesthesia, prior to the first surgical incision, and prior to the patient leaving the operating room.
- (c) Include language in all its contracts with ambulatory surgery centers, nursing facilities, and retail pharmacies that requires participation in applicable Oregon Patient Safety Commission's Adverse Events Reporting Programs.
- (d) Include language in all its contracts with facilities approved to provide bariatric surgery that specifically requires the facility follow the guidelines adopted by PEBB regarding determination of whether the patient is an appropriate candidate for the surgery.

PEBB's proposed patient safety language for 2011 dental renewals

Patient Safety: Contractor agrees to not pay providers and to require providers to not charge PEBB members for the following events:

- (a) The removal of non-diseased tooth structure (cutting, drilling, or extraction) unless treatment planned for continuing care (i.e.

orthodontic extractions of health teeth);

- (b) The removal of non-diseased tooth structure (cutting, drilling, or extraction) without the patient's consent unless such consent cannot be obtained due to sedation and the removal is the professionally correct thing to do;
- (c) Performing an invasive procedure on the wrong patient or tooth;
- (d) Treatment that causes the loss of a healthy tooth;
- (e) The unrecognized retention of a foreign object in the patient's body that necessitates future care to address the issue; and,
- (f) Death or serious injury or disability resulting from the following:
 - A. a medication error;
 - B. a dental infection;
 - C. a fall in a dental facility;
 - D. a device in dental care; and,
 - E. a burn in a dental facility.

OEBB's proposed patient safety language for 2010 Medical renewals

f. Contractor agrees to:

- (i). **Participate** in the Oregon Patient Safety Commission's reporting program;
- (ii). **Require their contracted hospitals and ambulatory surgical centers** to use of the Oregon Patient Safety Commission's surgical checklist (originally created by the Institute for Health Care Improvement) and demonstrate participation in the reporting program; and
- (iii). Not pay for preventable "Serious Adverse Events" at Oregon and Washington hospitals based on the National Quality Forum's (NQF) list of 28 "Serious Adverse Events" in accordance with the following:
 - a) as defined by the Oregon Association of Hospitals and Health Systems in its "Guidelines for Non-Payment for Serious Adverse Events" and adopted by Oregon member hospitals or as defined by the Washington State Hospital Association and adopted by Washington member hospitals; and;
 - b) to the extent such Serious Adverse Events are readily identifiable through electronic claims data received by Contractor.
- (iv) Not pay for "hospital acquired conditions (HACs)" identified by Medicare guidelines in accordance with the following:
 - (a) as identified at http://www.cms.hhs.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp which OEBB intends will automatically update during the Term of this Agreement to reflect changes to Medicare guidelines.
 - (b) require the language to be included in its contracts with hospitals that specifically prohibits the hospital from charging a OEBB Member for HACs

OEBB's proposed patient safety language for 2011 Dental renewals

We are in the process of developing dental patient safety language for upcoming contract amendments

Public Employers Health Purchasing Committee

Summary of Policy Action & Transmittal

1. Policy Proposal Received From:

Oregon Health Policy Board (developed by Administrative Simplification Work Group & Oregon Health Authority staff.

2. Summary of Policy Proposal:

- *A public-private technical work group will develop companion guides for the electronic exchange of: a) eligibility verifications (by December, 2010); b) claims (by July, 2011; and c) remittance advices (by January, 2012).*
- *The Department of Consumer & Business Services (DCBS) will adopt administrative rules directing all carriers to implement the companion guides by April, 2011 (eligibility verifications); October, 2011 (claims), and July, 2012 (remittance advices), respectively.*
- *DCBS will seek statutory authority from the 2011 Oregon Legislative Assembly to extend the required use of such companion guides to third-party administrators and clearinghouses not currently under DCBS jurisdiction.*

[See attached memo, "Administrative Simplification, Executive Staff Recommendations"]

3. Committee Action(s):

- *Presentation and discussion at September 27, 2010 meeting.*
- *Committee Action at October 25, 2010 meeting as follows:*

The Public Employers Health Purchasing Committee supports the broad adoption of uniform standards for the electronic exchange of information between providers and carriers. The Committee recommends that public and private employers in Oregon encourage their carriers or third-party administrators to: a) Participate in and support the work of the technical work group; and b) Adopt the companion guides within the timeframes prescribed by DCBS.

4. Distribution:

- *Association of Oregon Counties, League of Oregon Cities, Special Districts Association of Oregon, Oregon Coalition of Health Care Purchasers, Oregon Business Council, Associated Oregon Industries, Oregon Business Association*
- *Mailing list of large Oregon employers and labor-management trusts*
- *cc's: Oregon Health Policy Committee, PEBB (chair) and OEBB (chair)*

Oregon Health Policy Board
ADMINISTRATIVE SIMPLIFICATION
Executive Staff Recommendation
(Adopted by OHPB on August 10, 2010)

Date: August 10, 2010

Action item: Administrative Simplification Work Group Final Report – **Request for endorsement of recommendations**

Executive staff recommendation:

- Endorse the work group recommendations (*See below*).
- Emphasize the importance of broad participation in future work groups.
- Recommend prior authorization, referrals, and plain language billing for consumers be the next stage for further administrative simplification activity,
- Develop metrics to measure cost savings from administrative simplification activities,
- Explore/develop mechanisms to capture savings for consumers,
- Recommend that the State Office for HIT develop an implementation plan that addresses issues particular to small medical practices,
- Require quarterly Board updates on progress on implementation.

Benefit: The work group estimates annual savings of approximately \$93 million by 2014 if there is reasonably rapid compliance with the requirements and rapid adoption by providers of internal processes that take full advantage of electronic transactions.

The benefit accrues to physician practices and health plans primarily through savings in labor: it has been estimated that administrative simplification could save four hours of professional time per physician and five hours of practice support staff time each week, potentially creating opportunities for increased access and improved patient care. (*Health Affairs, June 2010*).

Lower practice support staff costs and back office support costs may translate into lower premiums and lower Medicaid costs. Lower costs in health plans can translate into either lower premiums or increased retained earnings.

Why the project was undertaken: To reduce the administrative cost of health care. Estimates of inefficient claims processing, payment and claims reconciliation are between \$21 and \$210 billion in the U.S. It has also been estimated that these administrative costs account for 10% to 14% of revenue in physician practices. (*American Medical Association Administration Simplification White Paper, 2008*).

The work group was created at the direction of the 2009 Legislative Assembly, which required the Office for Oregon Health Policy and Research (OHPR) to

convene a stakeholder work group to develop uniform standards for insurers, including standards for eligibility verification, claims, and remittance advice transactions and authorized the Department of Consumer and Business Services (DCBS) to adopt the recommended standards through administrative rules.

Previous Board Discussion:

Administrative Simplification recommendations were initially brought before the Board on May 11th, 2010. The workgroup recommended that Oregon adopt the Minnesota Plan, which is to standardize electronic processes by replacing companion guides with a single uniform companion guide for three key transactions and then require all plans, providers and clearinghouses to conduct those three transactions electronically.

The Board requested further information about the Minnesota plan; staff prepared a memo and further information about the Minnesota plan (*attached here*).

The Board also expressed concern that issues related to small medical practices were not adequately addressed in the workgroup recommendations. Staff, working with the Oregon Medical Association, identified and interviewed several practice representatives between June and July to address issues that may be particular to small practices (*See below*).

Work group recommendations:

Recommendation #1: DCBS should adopt the uniform guides for three common administrative and financial transactions between providers and payers (eligibility verification, claims and remittance advice transactions)

Recommendation #2: All health plans should be required to conduct administrative transactions electronically on a phased timetable

Recommendation #3: In 2011 the legislature should authorize DCBS to apply the requirements to health plans, including third party administrators and clearinghouses that are not licensed by DCBS.

Action steps to implementing the recommendations:

1. A public-private technical workgroup will begin the industry analysis of the Minnesota companion guides and any other additional work completed in Oregon for an eligibility verification companion guide to be completed by December 2010. It will then complete work on a claims companion guide by July 2011 and a remittance advice companion guide by January 2012.
2. The Department of Consumer and Business Services (DCBS), in collaboration with OHA, will adopt administrative rules based upon the Policy Board workgroup recommendations and use the "Oregon" companion guides for eligibility verification by April 2011, claims by October 2011, and remittance advice by July 2012.

3. The Oregon Health Authority as a payer should follow the DCBS rules and require Medicaid managed care organizations, Medicaid providers, and others with which it deals to do so as well.
4. The OHA and DCBS will pursue legislation in 2011 giving DCBS authority to establish uniform standards for healthcare administrative transactions to all payers (including third party administrators and self-insured plans) and clearinghouses and to collect data from them to monitor progress and identify future opportunities.
5. DCBS and OHA should establish a leadership team to coordinate current and future work on administrative simplification. The leadership team would:
 - a. Continue close collaboration with health care stakeholders to monitor progress of current work and develop goals for future work.
 - b. Include the State HIT Coordinator and the Medicaid Director in order to ensure coordination with adoption of health information technology especially in small practices.

New information developed at the request of the Board's previous discussion:

Following the work group's presentation to the Board on June 8, staff has done additional analysis of the impact of the electronic transaction requirement on small providers.

- **Provider Cost:** Average initial implementation costs for an electronic practice management system will be about \$21,000 per provider—including the cost of lost productivity during the transition. The practice management systems required for electronic administrative transactions are a foundational component of a certified electronic health records (EHR) system; implementation of a full EHR system averages an additional \$25,000 per provider—for a total of \$46,000. The initial investment is potentially recoverable through the federal Medicaid and Medicare incentive programs. After the initial investment is recouped, annual savings of about \$11,000 per provider can be realized with those savings exceeding the ongoing costs of an EHR system.
- **Small Practice Feedback:** Staff, with assistance from the Oregon Medical Association, had targeted conversations with small physician practices so they could react to and provide feedback on the draft recommendations. Comments overall support the recommendations. Physician practices emphasized the importance of applying the requirements to third party administrators and clearinghouses to ensure standard electronic processes from all payers and vendors to providers. The primary barrier to physician compliance with proposed requirements that was mentioned was the physical absence in some rural communities of high speed internet access necessary to effectively transmit electronically. The physician practices interviewed would like the administrative simplification work to address credentialing,

more standardized drug formularies, and more standardized prior authorization systems and requirements.

Risks: (1) The federal government could change standards or fail to adopt standards by the dates specified in the federal health reform law, which would require Oregon to re-examine and perhaps modify its approach. (2) The recommendation is for DCBS to require health plans to do business electronically; the requirement for providers to do so is indirect, through the plans. Additional steps may be required to achieve near universal compliance by providers. (3) Most of the savings from administrative simplification take the form of reduced labor time; therefore, jobs could be eliminated if affected workers are not redeployed to other activities within a health plan or health care facility.

Conclusion: The opportunity for reducing administrative workload and cost savings from adoption of the recommendations is substantial. The risks outlined are outweighed by the significant return on investment for both providers and payers.

Public Employers Health Purchasing Committee

Summary of Policy Action & Transmittal

1. Policy Proposal Received From:

Oregon Health Improvement Committee (July, 2010 draft)

2. Summary of Policy Proposal:

- *Model health care benefits provided by all employers include:*
 - *tobacco cessation*
 - *lactation services and equipment*
 - *preventive screenings*
 - *chronic disease self-management programs*
 - *mental health care*
 - *dental health care*

[See attaché HIP Recommendations and background on lactation services]

3. Committee Action(s):

- *Presentation and discussion at September 27, 2010 meeting.*
- *Committee Action at October 25, 2010 meeting as follows:*

The Public Employers Health Purchasing Committee pended the draft policy proposal from the HIC awaiting action by the Health Policy Board on the final report of the Health Improvement Committee.

[NOTE: The preventive screening recommendation has been addressed by P.L. 111-148, The Accountable Care Act.]

4. Distribution:

- *Retained by Committee staff for possible further consideration in 2011.*

From: Oregon Health Improvement Plan Committee

DRAFT July, 2010

HIP Recommendations to Public Employers Health Purchasing Committee

1. Organize OHA services such that full integration of mental health, addictions, oral and physical health care is achieved.
2. OHA purchased health care benefits reimburse:
 - evidence-based tobacco cessation that meets US Preventive Services Task Force recommendation
 - evidence-based chronic disease self-management programs such as Living Well
 - evidence-based weight management programs such as Weight Watchers
 - diabetes daily glucose testing supplies
 - lactation-related durable medical equipment and lactation specialists to provide lactation services
 - nutrition consultation with a registered dietitian and physical activity consultation with a certified exercise physiologist, and consider other medical and surgical treatment options following evidence-based reviews
3. Model health care benefits provided by all employers include tobacco cessation, lactation services and equipment, preventive screenings, chronic disease self-management, mental health and dental care.

Covering Lactation Services Lowers Health Risks and Costs

Covering lactation services is a primary prevention strategy that gives a high return on investment including improvements in lifelong health and significant reductions in health care costs.

Over 76% of Oregon's children miss out on benefits of exclusive breastfeeding.

Lower breastfeeding rates increase the incidence of many preventable chronic diseases and other health problems. That is why health experts recommend six months of exclusive breastfeeding as a way to improve the health of Mothers and children and reduce health care costs. Oregon Mothers have already gotten the message that breastfeeding is best-over 86% breastfeed their babies at birth. Unfortunately, recent Center for Disease Control (CDC) research shows only 23.7% exclusively breastfeeding for six months *and this rate has gone down 4% since 2005.*

Lack of access to lactation services contributes to lower breastfeeding rates.

Often mothers quit breastfeeding early or do not exclusively breastfeed because they are unable to access assistance when they encounter breastfeeding difficulties. Three Oregon surveys, the Pregnancy Risk Assessment Monitoring System Survey, the WIC Peer Counseling Research Project survey, and a Portland area hospitals survey showed that the majority of problems causing mothers to stop breastfeeding could be solved with early intervention from a lactation specialist.

Including lactation services, as part of all preventive services, including insurance and Medicaid coverage, will help mothers breastfeed longer. The Oregon Health Plan (OHP) – Lactation Analysis and Proposal recommended allowing “at least two” lactation visits. Reimbursement for community based visits with physicians and certified lactation consultants, breast pumps and pumping kits was another recommendation. In the long run, adding lactation benefits to insurance plans will save much more than it will cost.

Low exclusive breastfeeding rates increase health care costs.

An abundance of research document the increase in health risks and medical care costs associated with low breastfeeding rates. For example, there is an increased incidence of many costly chronic diseases.

Table 1: Maternal/Child Health Risks of Not Breastfeeding

| Disease | Increased risk |
|---|----------------|
| Diabetes | 40% |
| Recurrent ear infections | 60% |
| Obesity | 25% |
| Hospitalization for asthma or pneumonia | 250% |
| Maternal breast cancer | 39% |
| Maternal ovarian cancer | 26% |

There are many other risks and costs when children are not breastfed.

- In the first year of life alone, breastfeeding is associated with fewer cases of otitis media, respiratory infections and gastrointestinal illnesses.
- For every 1,000 babies not breastfed there are 2,033 more medical visits, 212 more days in the hospital and 609 more prescriptions.
- Formula-fed children in the US have a much higher rate of diabetes costing over one billion dollars per year in avoidable health care costs..

Summary of OHP cost/benefit analysis for coverage of lactation services.

OHP analyzed the possible financial impact of adding lactation benefits by looking at how often Medicaid women had breastfeeding problems and how often mothers used these services when they were available. They found that:

- If 15% of mothers used the service and the “lowest” cost savings were realized the benefit would be budget neutral; with the “most likely” cost savings the benefit would save \$600,000 per year.
- If 30% of mothers used the service and the “most likely” cost savings were realized the benefit would be budget neutral; with the “best” cost savings the benefit would save over \$2.8 million per year.

Table 2: Annual Costs for Covering Two Lactation Visits

| | Cost Estimates |
|--|-----------------------|
| Cost if 15% of women use the lactation benefit | \$703,463 |
| Cost if 30% of women use the lactation benefit | \$1,406,925 |

Table 3: Estimates of Annual Cost Savings with Added Lactation Benefit

| | Yearly Cost Savings |
|--------------------------|----------------------------|
| Lowest cost savings | \$664,710 |
| Most likely cost savings | \$1,329,421 |
| Best cost savings | \$4,220,384 |

Because Oregon women living on a limited income have breastfeeding rates similar to the general population, these cost savings can be applied to both groups. The OHP analysis does not include future saving in health care costs from reductions in long-term chronic diseases and other health problems. For a copy of the complete OHP analysis, contact Sue Woodbury, Director of the Oregon WIC Program.

Conclusion

The importance of providing lactation care to mothers is recognized by many health organizations including the United States (US) Department of Health and Human Services, the Surgeon General and the US Breastfeeding Committee. Provider reimbursement for lactation services is essential to the success of our efforts to improve the health of Oregonians by increasing breastfeeding rates.



UNITED STATES BREASTFEEDING COMMITTEE

STATEMENT ON BREASTFEEDING AS A CRITICAL STRATEGY FOR OBESITY PREVENTION

The United States Breastfeeding Committee recommends breastfeeding as a primary prevention strategy to reduce overweight and obesity and promote the maintenance of a healthy weight throughout the life span.

Obesity is recognized as a major and growing health concern in the United States. Due to its increasing prevalence and the chronic health risks associated with its diagnosis, obesity is a particularly challenging and complex issue to address. Multiple factors contribute to obesity and confound understanding of its progression, including nutritional, genetic, biological, hormonal, and environmental exposures. Exclusive breastfeeding is not a panacea for the obesity epidemic, but it is one of the most easily modifiable and cost-effective strategies available.

Research has identified breastfeeding as a potentially critical strategy in reducing the risk of obesity in adolescence and adult life. The exclusivity, as well as the duration, of breastfeeding must be considered when investigating the relationship between breastfeeding and obesity. All major medical organizations recommend exclusive breastfeeding for the first six months, followed by continued breastfeeding for the first year and beyond, with the gradual introduction of appropriate complementary foods to the infant's diet beginning around six months of age.¹

A recent systematic review of breastfeeding research conducted by the Agency for Healthcare Research and Quality (AHRQ)² reports an association between being breastfed and a reduced risk of being overweight or obese in adolescence and adult life. Exclusive breastfeeding appears to have an even stronger effect than combining breastfeeding with formula feeding. The incidence of childhood overweight and obesity was lower among infants who were exclusively



breastfed for the first six months of life.³ Studies that controlled for exclusivity and duration of breastfeeding showed a more significant protective effect against childhood obesity.

Possible explanations for the protective effect of breastfeeding against obesity include behavioral mechanisms such as metabolic programming, differences in macronutrient intake, and family environment.⁴ It is well documented that formula fed infants consume larger volumes and gain weight more rapidly than breastfed infants, with the increased weight being predominantly adipose tissue in formula fed infants, while breastfed infants gain proportionately more lean body mass. Research shows rapid weight gain during infancy is associated with childhood obesity.⁵

A multinational study of the growth of exclusively breastfed infants conducted by the World Health Organization (WHO) indicates that the 50th percentile BMI for exclusively breastfed infants is lower at and after 6-7 months of age.⁶ These data indicate that both formula feeding and non-exclusive breastfeeding may be contributing to the obesity epidemic among American children. The estimated population-attributable risk of childhood obesity due to formula feeding is 15-20%.⁷

Newer research has investigated the relationship between breastfeeding and the co-morbidities related to obesity, such as hypertension, cardiovascular disease, and diabetes. AHRQ reports a minimal reduction in adult blood pressure for those adults who were breastfed as infants. Results from a meta-analysis of cohort and case-control studies reported a reduction in total and LDL cholesterol levels in adults who were breastfed.¹ AHRQ also reports evidence to suggest breastfeeding for more than three months is associated with a reduced risk of type 1 diabetes.¹ Another meta-analysis of seven studies reported that breastfeeding was associated with a reduced risk of type 2 diabetes in later life.¹

Optimal breastfeeding, as recommended by major medical organizations, contributes to normal growth and improved child and adult health outcomes. Policy and research aimed to improve



breastfeeding exclusivity and duration rates, especially among populations at risk for obesity, are essential components of a comprehensive national obesity prevention strategy.

USBC is an organization of organizations. Opinions expressed by USBC are not necessarily the position of all member organizations and opinions expressed by USBC representatives are not necessarily the position of USBC.

© 2010 by the United States Breastfeeding Committee. Cite as: United States Breastfeeding Committee. *Statement on Breastfeeding as a Critical Strategy for Obesity Prevention*. Washington, DC: United States Breastfeeding Committee, 2010.

¹ American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk (policy statement). *Pediatrics*. 2005;115(2):496-506.

American Academy of Family Physicians. Family physicians supporting breastfeeding (position paper). <http://www.aafp.org/online/en/home/policy/policies/b/breastfeedingpositionpaper.html>. Accessed May 7, 2007.

Academy of Breastfeeding Medicine Web site. <http://www.bfmed.org>. Accessed June 1, 2007.

James, DC, Dobson B, American Dietetic Association. Position of the American Dietetic Association: promoting and supporting breastfeeding. *J Am Diet Assoc*. 2005;105(5):810-818.

American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women and Committee on Obstetric Practice. Special report from ACOG: breastfeeding: maternal and infant aspects. *ACOG Clin Rev*. 2007;12(1)(suppl):1S-16S.

National Association of Pediatric Nurse Practitioners. NAPNAP position statement on breastfeeding. *J Pediatr Health Care*. 2007; 21(2): A39-A40.

U.S. Department of Health and Human Services. *HHS Blueprint for Action on Breastfeeding*. Washington, D.C.: U.S. Department of Health and Human Services, Office on Women's Health; 2000.

World Health Organization/UNICEF. *Global Strategy for Infant and Young Child Feeding*. Geneva, Switzerland: World Health Organization; 2003.

² Ip S, Chung M, Raman G, Chew P, Magula N, DeVine D, Trikalinos T, Lau J. *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries*. Rockville, MD: Agency for Healthcare Research and Quality; 2007. Evidence Report/Technology Assessment No. 153.

³ Gillman MW, Rifas-Shiman SL, Camargo CA, et al. Risk of overweight among adolescents who were breastfed as infants. *JAMA*. 2001;285:2461-2467.

⁴ Li R, Fein SB, Grummer-Strawn LM. Do infants fed from bottles lack self-regulation of milk intake compared with directly breastfed infants? *Pediatrics*. 2010;125(6):e1386-e1393.

⁵ Dewey KG. Is breastfeeding protective against child obesity? *J Hum Lact*. 2003;19(1):9-18.

2025 M Street, NW, Suite 800 • Washington DC 20036 • Phone: (202) 367-1132 • FAX: (202) 367-2132
E-mail: office@usbreastfeeding.org • Web site: www.usbreastfeeding.org



United States Breastfeeding
COMMITTEE
PROTECTING • PROMOTING • SUPPORTING

⁶ World Health Organization. *WHO Child Growth Standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: Methods and development*. Geneva, Switzerland: World Health Organization; 2006.

⁷ Dietz WH. Breastfeeding may help prevent childhood overweight. *JAMA*. 2001;285:2506-2507.