Welcome to the Continuity of Care Connections Initial Status Report Toolkit (note that we have changed the name of this sub-contract deliverable from “Initial Assessment Report” to “Initial Status Report” so as to ensure there is no confusion with Baby-Friendly USA assessment processes). Before you proceed with the initial status report process, please keep in mind the following reminders.

These activities may be conducted in several different ways, depending on your coalition’s preferences. Most states will have their Key Contacts conduct the initial outreach to each hospital and each community. The Project Director’s level of involvement may vary depending on your coalition’s project management plan.

The Project Director is ultimately responsible for ensuring that the following sub-contract activities occur (under Deliverable # 4: Initial Status Report), for each hospital and community, based on initial outreach by the Key Contacts:

- Identify/map existing community groups/resources providing direct support services to breastfeeding mothers within the hospitals’ catchment area(s).
- Become familiar with the hospitals’ existing procedures and practices on Steps 3 and 10.

The Project Director is also responsible for ensuring that Initial Status Reports (one for each hospital and community) and the Proposed Implementation Work Plan (one for each coalition sub-contractor) are completed and submitted.

Although this toolkit outlines separate phases of hospital liaison, mother, and community outreach, the outreach tasks may be conducted simultaneously and should not be considered a linear step-by-step process. As described above outreach tasks may be conducted by Key Contacts, Project Directors, coalition staff and/or volunteers, to best suit your individual coalition’s needs and resources.

Please contact Emily Lindsey at elindsey@usbreastfeeding.org with any questions about this toolkit or the Initial Status Report Forms.

**Quick Links**

**Initial Status Report Form: Hospital**
https://www.surveymonkey.com/s/Initial-Status-Hosp

**Initial Status Report Form: Community**
https://www.surveymonkey.com/s/Initial-Status-Comm

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Hospital Outreach

Phase A – Meeting hospital liaison(s)

Each hospital has identified 1-2 team members to be your liaison(s) for this project. Their contact information is listed at: http://gme.groupmindexpress.com/usbc/?da=5852. The Key Contacts (or other individuals handling initial hospital outreach) should schedule a meeting with each hospital’s liaison(s) to review and discuss their existing procedures and practices for prenatal education and post-discharge care. Remember that each hospital is currently working very hard towards Baby-Friendly designation, and may have started their work in another area than Steps 3 and/or 10. Coalitions should be sensitive to the overall context of what’s going on with the hospital, e.g., mergers/consolidation, layoffs, staff transitions. Coalitions should also be understanding and non-judgmental about where the hospital currently is in the process, and remain flexible to assist with prenatal education and post-discharge care when the hospital is ready.

Important Note: When speaking with hospital liaison(s), please remember that your coalition is not engaged to evaluate, assess, or make recommendations about Baby-Friendly designation. Do not offer recommendations or make evaluative statements pertaining to their designation or progress on any of the Ten Steps. Keep your work and conversations focused on supporting community connections for prenatal education and post-discharge care. If questions or concerns arise that are beyond this scope, please refer them to Baby-Friendly USA or NICHQ.

When meeting with hospital liaison(s), use the following discussion questions as well as the Achievable Markers and Status Descriptors for Prenatal Education and Post-Discharge Care (Appendices A & B) to guide your conversations:

- Does the hospital feel it has up-to-date information on community-based programs or providers that work with pregnant and postpartum women? If not, where is their information lacking?
- What’s working well with regard to establishing and maintaining connections with community-based programs or providers for prenatal education and post-discharge care?
- What’s important to consider about this hospital and/or the community/populations it serves, in relation to establishing and maintaining community connections?
- What questions does the hospital have about community-based programs or providers for prenatal education and post-discharge care?
- What does the hospital need to know to move forward with enhancing continuity of breastfeeding care?
- Does the hospital have a Continuity of Care Committee or Community Advisory Committee? Is this generally focused, or specific to breastfeeding and/or maternity support? If yes, who is on this committee?
- What does the hospital view as the highest priorities for the coalition’s activities around supporting community connections for prenatal education and post-discharge care?
- What’s important for the coalition to consider in prioritizing its subcontract work plan to best support this hospital?
- Given the context of the hospital implementing all Ten Steps, where do Steps 3 & 10 fall in their priority/timeline right now?
- If hospital is not actively working on Steps 3 & 10 right now, how can coalition help at the time they’re ready? Is there any preparatory support coalition could provide now?

For each hospital, ideally the following materials will be collected:

- List of obstetric providers/practices delivering at the facility
- List of pediatric providers/practices with privileges at the facility
- Mother team member contact information
- Prenatal education promotional materials and educational handouts
✓ Post-discharge care promotional materials and educational handouts
✓ Written policies that address prenatal education or post-discharge care (if hospital offers and/or is willing to share)

Phase B – Meeting mother(s)

Contact the mother involved with the hospital’s Best Fed Beginnings team. It may be most helpful to either go directly to her home or find a good time to meet at a local place of her choosing. Remember, she is a mother and may have constraints such as young children, work/school schedules, and activities related to this project. If there is no mother on the hospital’s team, or if you would like feedback from more than one mother, reach out to a community organization that serves mothers such as Early Head Start, WIC, MOMs Club, MOPS, or mother-to-mother support groups.

Ask the mother(s) about her/their breastfeeding experience(s), regardless of delivery hospital. Discuss the following:
1) Delivery hospital (note if same or different than BFB hospital) and delivery date (aim for within the last year).
2) When did she join the BFB hospital team? What has been her role so far on the team? How does she feel she has contributed?
3) Did she receive prenatal breastfeeding education? If yes, where, when, and how did she feel it prepared her?
4) What kind of post-discharge breastfeeding care did she receive?
5) What does she feel would best help mothers in her area to help other mothers to breastfeed?
6) What community groups/resources does she or other mothers she knows use for:
   a. prenatal education or post-discharge care, especially, but not limited to breastfeeding?
   b. other family needs?
   (These may provide leads to find groups/resources the hospital and/or coalition are not aware of.)

Phase C – Identifying status descriptors, continuity assets and continuity gaps

Review the Achievable Markers and Status Descriptors for Prenatal Education and Post-Discharge Care (Appendices A & B). Based upon your interviews and conversations with the hospital liaison(s) and mother(s), choose the status descriptors that best describe each hospital’s current procedures and practices for each area:

Prenatal Education
✓ Affiliated prenatal clinic or services (if applicable)
✓ In-house breastfeeding education
✓ Coordination with community-based programs and providers

Post-Discharge Care
✓ Discharge discussion
✓ Follow-up care
✓ Discharge materials

Report your status descriptors on the Initial Status Report Form: Hospital (complete the online form once for each hospital). For each area that you rate a 3 or a 4, provide a brief explanation and/or vignette describing why this is a continuity asset. For each area that you rate a 1 or a 2, list at least two action steps that could be taken to address this continuity gap.
Community Outreach

These community outreach activities may be conducted by an individual or a group (e.g., Phase A could be a part of a coalition meeting).

Phase A – Identifying community groups/resources and touchpoints

First, make a list of groups/resources within each Best Fed Beginnings (BFB) community that provide direct support services to breastfeeding mothers in the areas of prenatal education or post-discharge care.

Then make a list of any additional community “touchpoints.” A touchpoint is defined as an entity that either currently refers families to breastfeeding groups/resources, or that could refer families to breastfeeding groups/resources if they were educated and/or connected. Some examples of community touchpoints might be: pharmacies, churches, or child care providers. Refer to the Community Dashboard for additional examples.

There are several ways to go about building the lists of community groups/resources and touchpoints, including:

- Gather and review existing resource guides from sources such as local breastfeeding coalitions, 2-1-1 information and referral systems, city/county public health departments, La Leche League groups, WIC offices, and local mother’s groups.
- Search the Internet for physicians associated with the Academy of Breastfeeding Medicine or American Academy of Pediatrics chapters, and for doulas, midwives, lactation consultants/specialists, peer counselors, maternity/baby stores, Early Head Start offices, community health clinics, hospitals, and other service organizations.
- Send a survey link to coalition members or supporters within the community to ask about their knowledge of and connections with community groups/resources.

Phase B – Prioritizing and mapping Key Groups/Resources and Key Touchpoints

Now sort your lists to prioritize specific **Key Groups/Resources and Key Touchpoints** that you will populate onto the Community Dashboard (Appendix C). Enter these onto the top row, building one Dashboard for each BFB community.

When prioritizing which will be your Key Groups/Resources and Key Touchpoints, pay special attention to the following:

- Ensure that every community WIC agency is listed. Note that a community may have multiple WIC agencies and/or clinics and each should be listed separately.
- Do your best to list all obstetric and pediatric providers identified by the hospital; ensure that all the major clinics are listed.
- Review the information gathered from hospital liaison and mother interviews to make sure you’ve included the groups/resources and touchpoints that they identified as priorities.
- Note that the next phase will involve a deeper examination of the services provided by these Key Groups/Resources and Key Touchpoints, and their connections with the BFB hospitals, to identify existing continuity assets and continuity gaps, and action steps that could address the gaps.
Phase C – Identifying status descriptors, continuity assets and continuity gaps

Background

Many communities have breastfeeding resource guides that are distributed by obstetric offices, birth classes, and hospitals. These are helpful to a point. What’s different about this project is a focus on facilitating and fostering reliable and actionable connections between hospitals and these resources, to ultimately develop systems that ensure continuity of care.

The Community Dashboard (Appendix C) is designed to guide a process of gathering as much information as is reasonable about a community’s existing resources, including how aware they are of needs for breastfeeding support and how ready they are to partner to improve continuity of care. Ultimately this process will help identify:

- **Coordination Gaps** (to achieve improvement, needs increased communication, connections, or collaboration between existing resources, e.g., referral system or practices, material/information sharing), and
- **Resource Gaps** (to achieve improvement, needs funding to purchase/support a good or service or to create an entirely new resource, e.g., training, materials).

When considering which action steps to pursue for your work plan, it is recommended that coalitions focus on addressing Coordination Gaps over Resource Gaps, unless there are additional resources in the coalition, community, or hospital that can be brought to bear.

Using the Community Dashboard

- For each Key Group/Resource/Touchpoint listing in the top row, investigate and record the following in the column below its name. Obtaining this information can be done in multiple ways, including: web searches, individual phone calls, coalition/community conversations, discussions with hospital liaisons and mothers, etc. If working as a large group, it may be helpful to break into smaller groups or assign individuals to investigate each.
- First, mark an X in the appropriate box to record when service(s) is/are provided.
- Then mark an X in all appropriate boxes to record all type(s) of care given before, during, and after birth, and the type of touchpoint the listing is, if applicable. Note that a single listing may be both a provider of “type(s) of care given” and also a touchpoint.
- As you learn more about each listing, attempt to gauge where it is along the spectrum of awareness of needs for breastfeeding support, and readiness to partner to improve continuity of care. Choose a status descriptor from the chart on next page that best describes each listing, and enter the numbers on the bottom row of each column.
### Key Group/Resource/Touchpoint Status Descriptors

<table>
<thead>
<tr>
<th></th>
<th>Status Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Pre-Contemplation of Breastfeeding Support:</strong> Not aware of breastfeeding support needs or thinking about/intending to change to address needs; not considering partnerships to improve continuity of care (This could look like: staff not knowledgeable about breastfeeding, no coordination of referral efforts, not interested in participating in state/local breastfeeding coalitions).</td>
</tr>
<tr>
<td>2</td>
<td><strong>Contemplation of Breastfeeding Support:</strong> Aware of breastfeeding support needs and seriously considering action, but not yet committed to change to address needs; contemplating partnerships to improve continuity of care (This could look like: staff somewhat knowledgeable about breastfeeding, sporadic coordination of referral efforts, expressing interest in participating in state/local breastfeeding coalitions).</td>
</tr>
<tr>
<td>3</td>
<td><strong>Preparation for Breastfeeding Support:</strong> Aware of breastfeeding support needs and committed to taking action soon, may report initial steps towards change; preparing to partner to improve continuity of care (This could look like: staff knowledgeable about breastfeeding or actively seeking training, some coordination of referral efforts, beginning to participate in state/local breastfeeding coalitions).</td>
</tr>
<tr>
<td>4</td>
<td><strong>Action on Breastfeeding Support:</strong> Aware of breastfeeding support needs and clearly committed to taking action, making substantial effort towards change; actively partnering to improve continuity of care (This could look like: staff are planning for and/or regularly providing quality breastfeeding care, regular coordination of referral efforts, actively participating in the state/local breastfeeding coalitions).</td>
</tr>
<tr>
<td>5</td>
<td><strong>Maintenance of Breastfeeding Support:</strong> Breastfeeding support needs already being met as an established priority; robust partnerships ongoing to ensure continuity of care (This could look like: staff are consistently providing quality breastfeeding care and ensuring mechanisms for its sustainability, consistent coordination of referral efforts, actively contributing to work of state/local breastfeeding coalitions).</td>
</tr>
</tbody>
</table>

Report your status descriptors on the [Initial Status Report Form: Community](#) (complete the online form once for each community).

- For each that you rate a 4 or a 5, provide a brief explanation and/or vignette describing why this is a continuity asset. The form has up to five spaces to report continuity assets. If you have more than five from a single community’s Dashboard, prioritize for reporting on the form those that seem most likely to be relevant examples or best practices from which others could benefit.

- For each that you rate a 3 or below, list at least two action steps that could be taken to address this continuity gap. The form has up to ten spaces to report gaps. If you have more than ten from a single community’s Dashboard, prioritize for reporting on the form those that seem most likely to be an appropriate fit for the coalition to address (e.g., Coordination Gaps over Resource Gaps).

### Identification of Missing Resources and/or Potential Touchpoints

Go back to the larger list created in Community Outreach Phase A. Considering all the options for types of resources on the Dashboard, identify any areas where the community may be lacking in a certain type of resource altogether. Report these Missing Resources in the designated space on the Initial Status Report Form: Community.

Think about where families in the community live, work, and play; how they move through their lives; who they talk to, who they trust, and where they seek information. It might be helpful to refer to the first few rings of [The Surgeon General’s Call to Action Socio-Ecological Model](#), to help expand beyond the “usual suspects” to identify potential “non-traditional partners.” Identify one or two potential touchpoints that are currently not engaged, where it might be valuable to prioritize time on building connections. Report these Potential Touchpoints in the designated space on the Initial Status Report Form: Community.
## Prenatal Education – Achievable Markers & Status Descriptors

### Achievable Markers

<table>
<thead>
<tr>
<th>Affiliated Prenatal Clinic or Services</th>
<th>In-House Breastfeeding Education</th>
<th>Coordination with Community-Based Programs and Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting in the first trimester and continuing throughout pregnancy, whenever possible, education about breastfeeding, including individual counseling, is provided to pregnant women for whom the facility/associated clinics provide care, with content to cover topics stated below.</td>
<td>Group breastfeeding education classes are offered at various days and times, in needed languages to match local demographics, with content to cover topics stated below.</td>
<td>Community-based programs are fostered, and messages are coordinated with these programs and with providers in the community, to align with content topics stated below.</td>
</tr>
</tbody>
</table>

Prenatal education content in each area should include the following:
- importance of exclusive breastfeeding for first six months (and risks of supplementation)
- non-pharmacologic pain relief methods for labor
- importance of early skin-to-skin contact
- early initiation of breastfeeding
- rooming-in on a 24-hour basis
- feeding on demand/cue or baby-led feeding
- frequent feeding to help assure optimal milk production
- effective positioning and attachment
- that breastfeeding continues to be important after six months, once solid foods have started
- documented contraindications to breastfeeding and other special medical conditions, when individually indicated

The following may also be encouraged, in each area:
- participation in breastfeeding support groups during pregnancy
- attendance in classes, counseling, or support groups by family members/support persons

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### Status Descriptors

**CHOOSE THE STATUS DESCRIPTOR THAT BEST DESCRIBE THE HOSPITAL’S CURRENT PROCEDURES & PRACTICES ON PRENATAL EDUCATION FOR EACH AREA:**

<table>
<thead>
<tr>
<th></th>
<th>Prenatal education needs not being met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prenatal education needs partially being met</td>
</tr>
<tr>
<td>2</td>
<td>Prenatal education needs mostly being met</td>
</tr>
<tr>
<td>3</td>
<td>Prenatal education needs fully being met</td>
</tr>
</tbody>
</table>

**Affiliated Prenatal Clinic or Services (if applicable)**

<table>
<thead>
<tr>
<th></th>
<th>No prenatal education provided at appointments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prenatal education provided at some appointments, content lacks consistency or doesn’t cover all topics, prenatal education not started in first trimester or delivered throughout the course of pregnancy.</td>
</tr>
<tr>
<td>2</td>
<td>Prenatal education provided starting in first trimester and continuing throughout pregnancy, content is consistent and comprehensive, but these procedures may not be universally applied.</td>
</tr>
<tr>
<td>3</td>
<td>Every mother receives prenatal education starting in first trimester and continuing throughout pregnancy, content is consistent and comprehensive, breastfeeding support group attendance is encouraged during pregnancy, as well as family member/support person attendance in classes, counseling, or support groups.</td>
</tr>
</tbody>
</table>

**In-House Breastfeeding Education**

<table>
<thead>
<tr>
<th></th>
<th>Childbirth education classes do not cover breastfeeding, no breastfeeding-specific classes offered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Childbirth education classes cover breastfeeding but no breastfeeding-specific classes offered, content lacks consistency or doesn’t cover all topics, classes offered only in one language and/or not offered with varied days/times.</td>
</tr>
<tr>
<td>2</td>
<td>Childbirth education classes cover breastfeeding and breastfeeding specific classes are offered, content is consistent and comprehensive, but classes are not offered in all needed languages or with varied days/times.</td>
</tr>
<tr>
<td>3</td>
<td>Childbirth education classes cover breastfeeding and breastfeeding specific classes are offered, content is consistent and comprehensive, breastfeeding support group attendance is encouraged during pregnancy, as well as family member/support person attendance in classes, counseling, or support groups.</td>
</tr>
</tbody>
</table>

**Coordination with Community-Based Programs and Providers**

<table>
<thead>
<tr>
<th></th>
<th>Hospital has no connections with community-based prenatal education programs or providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospital has some or weak connections with community-based prenatal education programs or providers, but little to no coordination of messaging to ensure alignment with listed topics.</td>
</tr>
<tr>
<td>2</td>
<td>Hospital has some or moderate connections with community-based prenatal education programs and providers, some coordination of messaging to ensure alignment with some listed topics.</td>
</tr>
<tr>
<td>3</td>
<td>Hospital has many strong connections with community-based prenatal education programs and providers, robust coordination of messaging to ensure alignment with all listed topics, breastfeeding support group attendance is encouraged during pregnancy, as well as family member/support person attendance in classes, counseling, or support groups.</td>
</tr>
</tbody>
</table>

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**POST-DISCHARGE CARE – ACHIEVABLE MARKERS & STATUS DESCRIPTORS**

### Achievable Markers

<table>
<thead>
<tr>
<th>DISCHARGE DISCUSSION</th>
<th>FOLLOW-UP CARE</th>
<th>DISCHARGE MATERIALS</th>
</tr>
</thead>
</table>
| Prior to discharge, a hospital staff member discusses with each mother **AND** a family member/support person (when available) plans for infant feeding after discharge. This should include information on:  
- importance of exclusive breastfeeding for first six months (and risks of supplementation)  
- available and culturally specific support services without ties to commercial interests (LLL or other community-based support groups, WIC, phone help lines, lactation clinics, home health services, individualized special resource persons)  
- feeding on demand/cue or baby-led feeding  
- frequent feeding to help assure optimal milk production  
- that breastfeeding continues to be important after six months, once solid foods have started  
- reasons to seek assistance  
- documented contraindications to breastfeeding and other special medical conditions, when indicated  

This could also include information on:  
- normal newborn behavior  
- effective positioning and attachment  

| An early follow-up appointment with pediatric care provider is scheduled (preferably 2-4 days after birth and again the second week).  
Recommendation is made for the appropriate level of follow-up care based on needs identified in hospital, e.g., support group, peer counselor, lactation consultant, etc.  

| Printed information is distributed to mothers on how and where they can find help after returning home and types of help available.  
Mothers whose infants are not feeding well at the breast exclusively (medically fragile) or are separated are discharged with or have plans for immediate access to a single user breast pump and double pumping kit as well as information on proper methods for pumping and feeding, breast milk storage, and a follow up appointment with a lactation consultant. |

### Types of post-discharge care provided by the hospital may be categorized into the following:  
- Physical Contact: postpartum follow-up visit at hospital or home follow-up visit  
- Active Reaching Out: postpartum telephone call by hospital staff  
- Referrals: phone number to call, referral to hospital-based breastfeeding support group, referral to other breastfeeding support groups, referral to lactation consultant/specialist, referral to WIC, referral to an outpatient lactation clinic, list of resources for breastfeeding help, breastfeeding assessment sheet |
**Status Descriptors**

**CHOOSE THE STATUS DESCRIPTOR THAT BEST DESCRIBES THE HOSPITAL’S CURRENT PROCEDURES & PRACTICES ON POST-DISCHARGE CARE FOR EACH AREA:**

<table>
<thead>
<tr>
<th></th>
<th>Post-discharge care needs not being met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Post-discharge care needs partially being met</td>
</tr>
<tr>
<td>3</td>
<td>Post-discharge care needs mostly being met</td>
</tr>
<tr>
<td>4</td>
<td>Post-discharge care needs fully being met</td>
</tr>
</tbody>
</table>

### Discharge Discussion

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Discharge discussion is not held with mother regarding infant feeding, family member/support person is made a priority for inclusion (when available).</td>
</tr>
<tr>
<td>2</td>
<td>Discharge discussion is held with some of the listed topics covered, family member/support person is sometimes made a priority for inclusion (when available).</td>
</tr>
<tr>
<td>3</td>
<td>Discharge discussions are held covering all listed topics, family member/support person is involved (when available), but these procedures may not be universally applied.</td>
</tr>
<tr>
<td>4</td>
<td>Every mother is discharged with a discussion covering all listed topics, including an infant feeding plan, family member/support person is always involved (when available).</td>
</tr>
</tbody>
</table>

### Follow-Up Care

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Appointment is not made, no hospital follow up to ensure appointment/referral is made.</td>
</tr>
<tr>
<td>2</td>
<td>Mother is reminded to make appointment at discharge, hospital follow up is limited to phone call about patient satisfaction only.</td>
</tr>
<tr>
<td>3</td>
<td>Appointment is made prior to discharge, recommendation for level of follow-up care is made, hospital follows up with referrals and a phone call to ensure appointment is attended, but these procedures may not be universally applied.</td>
</tr>
<tr>
<td>4</td>
<td>Every mother is discharged with appointment made and day/time noted in chart, recommendation for level of follow-up care is always made based on needs identified currently and ongoing, hospital always follows up with referrals and a phone call to ensure appointment is attended and active contact is made with appropriate level of follow-up care.</td>
</tr>
</tbody>
</table>

### Discharge Materials

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Printed referral materials are not provided at all, at-risk couplets are not sent home with a breast pump or plans for immediate access.</td>
</tr>
<tr>
<td>2</td>
<td>Printed referral materials are provided but only contain hospital or affiliated clinic information (no referrals to community-based resources), at-risk couplets are told where to get a breast pump, if needed.</td>
</tr>
<tr>
<td>3</td>
<td>Printed referral materials are provided covering at least 3 of the options identified under “Referrals” above, at-risk couplets are sent home with a breast pump or plans for immediate access, but these procedures may not be universally applied.</td>
</tr>
<tr>
<td>4</td>
<td>Every mother is provided printed referral materials in her needed language, materials cover at least 5 of the options identified under “Referrals” above, at-risk couplets are always sent home with a breast pump or plans for immediate access.</td>
</tr>
</tbody>
</table>