

IMPLEMENTING A DONOR MILK PROGRAM: HOW TO GET STARTED



Presented by:

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OBJECTIVES

Using pasteurized donor human milk for very low birth weight infants is known to improve outcomes, but many hospitals still struggle to implement a donor milk program

- ✓ Understand barriers and gaps in PDHM usage
- ✓ Building a team, a message, and an action plan
- ✓ Drafting a toolkit

Donor Human Milk Use in Advanced Neonatal Care Units — United States, 2020

Ellen O. Boundy, ScD¹; Erica H. Anstey, PhD¹; Jennifer M. Nelson, MD¹

Approximately 50,000 infants are born in the United States each year with very low birthweight (VLBW) (<1,500 g).^{*} Benefits of human milk to infants with VLBW include decreased risk for necrotizing enterocolitis, a serious illness resulting from inflammation and death of intestinal tissue that occurs most often in premature infants, especially those who are fed formula rather than human milk; late-onset sepsis; chronic lung disease; retinopathy of prematurity; and neurodevelopmental impairment (1). When mother's own milk is unavailable or insufficient, pasteurized donor human milk (donor milk) plus a multivitamin fortifier is the first recommended alternative for infants with VLBW (2). CDC's 2020 Maternity Practices in Infant Nutrition and Care (mPINC) survey was used to assess practices for donor milk use in U.S. advanced neonatal care units of hospitals that provide maternity care (3). Among 616 hospitals with neonatal intensive care units (level III or IV units),[†] 13.0% reported that donor milk was not available for infants with VLBW; however, approximately one half (54.7%) reported that most (≥80%) infants with VLBW do receive donor milk. Donor milk availability for infants with VLBW was more commonly reported among hospitals with a level IV unit, higher annual birth volume, location in the Midwest and Southwest regions, nonprofit and teaching status, and those designated Baby-Friendly.[§] Addressing hospitals' barriers to providing donor milk could help ensure that infants with VLBW receive donor milk when needed and help reduce morbidity and mortality in infants with VLBW (1,4).

^{*} <https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-tables-508.pdf>

[†] Level II = special care nursery; level III = neonatal intensive care unit; level IV = regional neonatal intensive care unit. <https://doi.org/10.1542/peds.2012-1999>

[§] Baby-Friendly USA is the accrediting body and national authority for the Baby-Friendly Hospital Initiative (BFHI) in the United States. BFHI is a global program to encourage the broad-scale implementation of steps to provide mothers with information, confidence, and skills necessary to successfully initiate and continue breastfeeding. <https://www.babyfriendlyusa.org>

The mPINC survey is a biennial census of all maternity care hospitals in the United States and territories to monitor practices and policies related to infant feeding. The survey is completed electronically by the persons most knowledgeable about the hospital's practices related to infant nutrition. In 2020, hospitals with advanced neonatal care units (level II, III, or IV) were asked how many infants (<1,500 g and ≥1,500 g) receive donor milk at any time while in the unit: few (0%–19%), some (20%–49%), many (50%–79%), most (≥80%), or donor milk not available.

The prevalence of donor milk use was examined by unit level and infant weight[‡] (<1,500 g and ≥1,500 g). For infants weighing ≥1,500 g, analyses included hospitals with level II,

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Continuing Education examination available at https://www.cdc.gov/mmwr/mmwr_continuingEducation.html



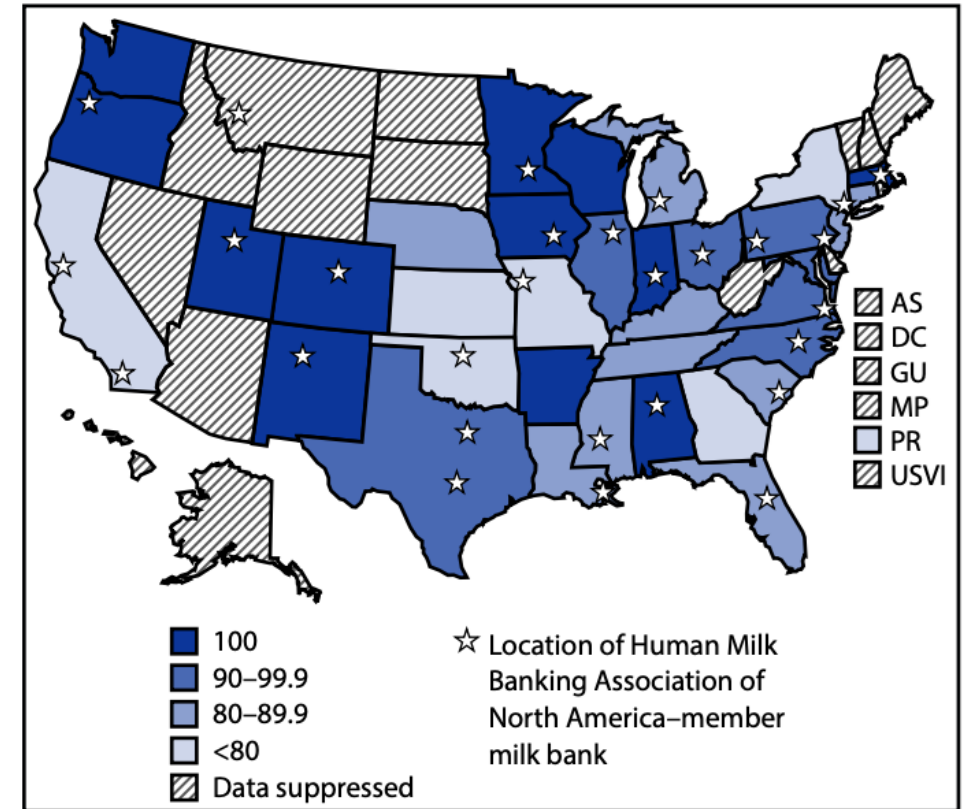
DONOR HUMAN MILK USE IN ADVANCED NEONATAL CARE UNITS — THE UNITED STATES, 2020

PDHM use varies greatly by region, hospital, and NICU size and type.

What are the challenges to implementing a donor milk program?

- Hospital leadership support
- Logistical challenges
- Lack of standardized policies
- Lack of staff training, knowledge, and perceptions about health benefits & safety
- Lack of parent knowledge and perceptions about health benefits and safety
- Milk bank proximity
- Milk availability, cost, and reimbursement

FIGURE. Percentage of hospitals with level III or IV neonatal intensive care units reporting donor milk was available for infants weighing <1,500 g, by state* — Maternity Practices in Infant Nutrition and Care, United States, 2020



Abbreviations: AS = American Samoa; DC = District of Columbia; GU = Guam; MP = Northern Mariana Islands; PR = Puerto Rico; USVI = U.S. Virgin Islands.

* Includes all U.S. states, territories, and DC; data were suppressed when the sample was <5. The locations of 28 Human Milk Banking Association of North America–member milk banks are also noted.

Quality of Care in US NICUs by Race and Ethnicity

Erika M. Edwards, PhD, MPH,^{a,b,c} Lucy T. Greenberg, MS,^a Jochen Profit, MD, MPH,^{d,e} David Draper, PhD,^f Daniel Helkey, MS,^d Jeffrey D. Horbar, MD,^{a,b}

abstract

BACKGROUND: Summary measures are used to quantify a hospital's quality of care by combining multiple metrics into a single score. We used Baby-MONITOR, a summary quality measure for NICUs, to evaluate quality by race and ethnicity across and within NICUs in the United States.

METHODS: Vermont Oxford Network members contributed data from 2015 to 2019 on infants from 25 to 29 weeks' gestation or of 401 to 1500 g birth weight who were inborn or transferred to the reporting hospital within 28 days of birth. Nine Baby-MONITOR measures were individually risk adjusted, standardized, equally weighted, and averaged to derive scores for African American, Hispanic, Asian American, and American Indian infants, compared with white infants.

RESULTS: This prospective cohort included 169 400 infants at 737 hospitals. Across NICUs, Hispanic and Asian American infants had higher Baby-MONITOR summary scores, compared with those of white infants. African American and American Indian infants scored lower on process measures, and all 4 minority groups scored higher on outcome measures. Within NICUs, the mean summary scores for African American, Hispanic, and Asian American NICU subsets were higher, compared with those of white infants in the same NICU. American Indian summary NICU scores were not different, on average.

CONCLUSIONS: With Baby-MONITOR, we identified differences in NICU quality by race and ethnicity. However, the summary score masked within-measure quality gaps that raise unanswered questions about the relationships between race and ethnicity and processes and outcomes of care.



BIAS IN SUPPORT TO FAMILIES

Research continues to show that families in the healthcare system are treated differently based on race, ethnicity, marital status, and other demographics. Health outcomes are directly impacted.

Erika M. Edwards, Lucy T. Greenberg, Jochen Profit, David Draper, Daniel Helkey, Jeffrey D. Horbar; Quality of Care in US NICUs by Race and Ethnicity. *Pediatrics* August 2021

Families feel unheard,
ignored, and devalued





WHO IS ON YOUR TEAM?



PDHM MULTIDISCIPLINARY TEAM

- Physicians and providers in Neonatology/OB/Pediatrics/Family Med
- Lactation staff
- Nursing staff
- NICU nurse educator
- NICU dietician
- Safety or compliance staff
- Patient and family education
- Family member advocate
- Ad hoc members:
 - Supply chain
 - Procurement
 - Hospital contracting
 - Finance





WHAT IS YOUR CALL TO
ACTION (WHAT DO YOU
WANT TO ACHIEVE?)

DEVELOP YOUR ELEVATOR SPEECH

Key factors:

- Interesting
- Memorable
- Succinct

Content:

- What problem are you solving
- What is your solution
- What key benefit will be realized



HUMAN MILK IS A COST-EFFECTIVE INTERVENTION

Cost of NICU stay for VLBW infants with a mean of 56.5 days is **\$219,669**

Phibbs CS, Schmitt SK, Cooper M, et al. Birth hospitalization costs and days of care for mothers and neonates in California, 2009–2011. *J Pediatr.* 2019;204:118-125.e14.

Cost of NOT feeding human milk

- Morbidities specific to not feeding human milk
- Life
- Reputation
- Burnout

In a study testing the *Cost of Not Breastfeeding tool* that was published in June in *Healthy Policy and Planning*, Dr. Dylan Walters (PhD) and fellow researchers found that each year around the world, not breastfeeding costs almost 700,000 lives and \$341 billion.

Dylan D Walters, Linh T H Phan, Roger Mathisen

Health Policy and Planning, Volume 34, Issue 6, July 2019, Pages 407–417, <https://doi.org/10.1093/heapol/czz050>

MEAN TOTAL NICU HOSPITALIZATION COST BY PRESENCE/ABSENCE OF EACH PREMATURE-RELATED COMPLICATION (*N* = 426)

Complication	Present [mean (SD)]	Absent [mean (SD)]	Difference (95% CI)
Late-onset sepsis	\$297,182 (185,378)	\$175,273 (96,927)	\$121,909 (70,648–173,169)
Necrotizing enterocolitis	\$283,026 (211,759)	\$179,727 (97,609)	\$103,299 (40,515–166,083)
Bronchopulmonary dysplasia	\$293,574 (138,760)	\$141,127 (63,377)	\$152,447 (128,158–176,736)

NICU neonatal intensive care unit, *SD* standard deviation, *CI* confidence interval

Johnson, T.J., Patel, A.L., Schoeny, M.E. *et al.* Cost Savings of Mother's Own Milk for Very Low Birth Weight Infants in the Neonatal Intensive Care Unit. *Pharmacoeconomics Open* **6**, 451–460 (2022). <https://doi.org/10.1007/s41669-022-00324-8>

COST OF A DONOR MILK PROGRAM

- Equipment

- Freezer - BioMed Department input, Joint Commission

- The Joint Commission standards require that organizations store food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security as per PC.02.02.03.
 - When nutritional products, such as breast milk or baby formula are stored in these refrigerators, refer to evidence-based guidelines from the formula manufacturer's instructions for use (IFU), the Centers for Disease Control and Prevention (CDC), etc. to ensure safe storage.

<https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/environment-of-care-ec/000002115/>

- Tracking System - Protocols capture unique identifiers of PDHM and link to infants' records
 - Staff - Training is key

COST OF A DONOR MILK PROGRAM (CONT')

- Average cost per ounce or milliliter
 - Regional variations, business model specific
 - HMBANA-accredited milk banks range from \$4 to \$6 per ounce or \$.13 to \$.20 per ml
- Average intake per VLBW infant - 175 ounces

Rivera Model Assumptions:

- mean birth weight - 1,000g
- target weight - 2,000g
- avg hosp weight and feeding Rx - 1.5 kg x 160 ml/kg/day = 240 ml/day (\$31 to \$48/day)
- avg weight gain - 15 g/kg/d or 22.5 g/day
- time needed to grow to 2,000g = 44 days

Rivera, A. How Much is Enough? Presentation at 2008 HMBANA Conference, HMBANA Newsletter, Winter, 2008.

DATA NEEDS

NICU census by gestation and acuity

Any human milk at discharge

NEC rates

Morbidity and mortality data

Marketplace competition

CONTINUE TO BUILD YOUR DATABASE

Meet first with your NICU data expert

- VLBW birth rates
- VLBW feeding method at discharge
- NEC rates

Consider a few chart reviews

- Demographics
- Family feeding intention
- Feeding metrics
 - First feeding day
 - Full feeds day
 - First and last days of human milk
 - First day of formula (GA)
- Central line days
- Percentage of mothers' own milk entire stay and at discharge
- Donor milk feeding: Yes/No





START BUILDING YOUR TOOLKIT

- Family engagement
- Staff education
- Patient criteria for PDHM
- Donor milk policy
- Consent form
- PDHM management
- Regulatory issues

Title:	Pasteurized Donor Human Milk
	<input checked="" type="checkbox"/> Policy <input checked="" type="checkbox"/> Procedure <input type="checkbox"/> Guideline <input type="checkbox"/> Other
Patient Population:	<input type="checkbox"/> High Risk OB/Labor, Delivery and Recovery <input type="checkbox"/> Post-partum <input checked="" type="checkbox"/> Low Risk Infant <input checked="" type="checkbox"/> High Risk Infant
Unit(s) Affected:	<input checked="" type="checkbox"/> L&D/BC/Antepartum <input checked="" type="checkbox"/> NICU <input checked="" type="checkbox"/> Postpartum
Ancillary Services:	<input type="checkbox"/> Pharmacy <input checked="" type="checkbox"/> Nutrition <input type="checkbox"/> Respiratory <input type="checkbox"/> Social Work <input checked="" type="checkbox"/> Lactation
Effective Date:	10/10
Revision/Review Date(s):	4/11, 4/12, 5/14, 8/15, 1/18, 3/19

POLICY STATEMENT/SCOPE:

Infants receive improved nutrition and immunologic protection from breastmilk. Not all mothers are able to provide breastmilk for their infant due to physiologic instability, maternal medications, inadequate production to meet infant need, or surrogacy. Pasteurized Donor Human Milk (PDHM) may be used as an alternative in certain circumstances when mother's breastmilk is not available or insufficient.

RELATED POLICIES:

[Breastmilk Collection, Storage and Preparation](#)
[Infant Feeding Prep Room](#)
[Milk Sharing: Breastmilk from an Outside Source](#)
[Misadministration of Breastmilk](#)

I. DEFINITIONS

PDHM: pasteurized donor human milk (from a licensed milk bank)
HMBANA: Human Milk Bank Association of North America
MOMS: Mothers' Own Milk System (Timeless)
DTR: Diet Technician, Registered

II. POLICY

1. Infants are eligible for PDHM if they meet certain criteria. For some infants PDHM is more critical based on their medical condition and priority will given to infants with medical indications.
2. The following conditions are medical indications for PDHM if maternal breastmilk is not available:
 - a. Prematurity < 34 weeks
 - b. Infants < 1500 grams
 - c. Infants with history of bowel injury such as necrotizing enterocolitis (NEC)
 - d. Infant with history of gastroschisis
 - e. Any infant at the discretion of the Attending Physician
3. Infants > 34 weeks may receive PDHM for 3 days (goal) but not to exceed 5 days. See attachment A: *Considerations for Pasteurized Donor Breastmilk Use in Infants >34 Weeks* for additional details.

FAMILY ENGAGEMENT

- Include a family member advocate on your team
- Talk to families about NEC
- Standardize your human milk messaging
- Incorporate PDHM education into prenatal breastfeeding/human milk materials
- Use materials that reflect your population, and in languages, they speak

<https://www.neoqicma.org/human-milk-educational-materials>

La Leche Materna es lo Mejor Para Bebés Prematuros

Los bebés nacidos de forma prematura generalmente necesitan permanecer en la unidad de cuidados intensivos neonatales. El mejor alimento que puede darle a su bebé es su leche. Al principio, es posible que su bebé no esté lo suficientemente fuerte para ser amamantado, pero usted puede usar un sacaleches para recolectar toda la leche que su bebé necesita. Los bebés pueden recibir la leche materna de un hisopo de algodón, a través de una sonda de alimentación que pasa por la nariz o la boca y llega hasta el estómago, o de un biberón.

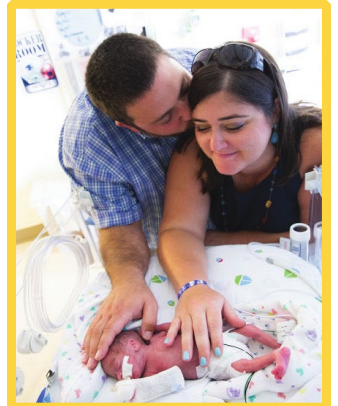
La leche materna es el mejor tipo de alimento para los bebés prematuros porque:

- Es más fácil de tomar que la leche de fórmula.
- Puede ayudar al cerebro a crecer y desarrollarse.
- Puede prevenir infecciones graves.
- ¡La leche materna es un alimento y un medicamento para su bebé prematuro!



¿Cómo puedo producir leche si mi bebé no está lo suficientemente fuerte para succionar mis pechos?

- Mientras su bebé esté en el hospital, usted deberá usar un sacaleches para extraerse leche de sus pechos.
- Use el sacaleches 8 o más veces cada 24 horas. Asegúrese de extraerse leche por la noche. Cuantas más veces se extraiga leche por día, más leche producirá para su bebé.
- Cuando visite a su bebé en el hospital, practique el cuidado “canguro” o contacto piel con piel. Esto es cuando tiene a su bebé desnudo, solo con el pañal, sobre su pecho desnudo. Esto la ayuda a producir más leche y es reconfortante para usted y su bebé.



¿Es suficiente mi leche para ayudar a mi bebé a crecer?

- Cuando los bebés nacen de forma prematura, pueden necesitar nutrientes adicionales agregados a la leche materna. Los médicos y nutricionistas en el hospital ayudarán a decidir si su bebé necesita más nutrientes y en qué momento los necesita.

¿Cómo puedo obtener ayuda para producir leche para mi bebé?

- Producir leche para un bebé prematuro es una tarea difícil, ¡pero muy gratificante!
- Consulte al personal de enfermería o a las asesoras en lactancia si tiene dificultad para extraerse leche 8 o más veces al día.
- Pídale a amigos y familiares que la ayuden preparando comidas o bocadillos, haciendo las tareas del hogar, ayudándola con los niños o simplemente dándole aliento.



EDUCATE STAFF ABOUT PDHM SAFETY AND QUALITY

- Share best practices and research
- Find your champions
- Update staff knowledge about human milk benefits, quality, & safety
- Share unit data
- Build references for your program



CURRENT RECOMMENDATIONS FOR PDHM USE

- Surgeon General Call to Action (2011)
- AAP Donor Milk Policy (2017)
- AAP/ACOG Perinatal Guidelines (2017)
- AAP Nutrition Book (2020)
- HHS Dietary Guidelines (2020)
- AAP Red Book (2021)
- AAP Human Milk and VLBW (2021)
- AAP Breastfeeding Clinical Report (2022)

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Promoting Human Milk and Breastfeeding for the Very Low Birth Weight Infant

Margaret A. Perker, MD, MPH,¹ Jo M. Stollwagner, MD,^{1*} Lawrence Noble, MD,^{1*} Jac J. Kim, MD, PhD,² Brenca J. Pinchester, MD,³ Karen M. Ruppold, MD, PhD,⁴ SECTION ON BREASTFEEDING, COMMITTEE ON NUTRITION, COMMITTEE ON FETUS AND NEWBORN

Provision of mother's own milk for hospitalized very low birth weight (VLBW) (≤ 1500 g) infants in the NICU provides short- and long-term health benefits. Mother's own milk, appropriately fortified, is the optimal nutrition source for VLBW infants. Every mother should receive information about the critical importance of mother's own milk to the health of a VLBW infant. Pasteurized human donor milk is recommended when mother's own milk is not available or sufficient. Neonatal health care providers can support lactation in the NICU and potentially reduce disparities in the provision of mother's own milk by providing institutional supports for early and frequent milk expression and by promoting skin-to-skin contact and direct breastfeeding, when appropriate. Promotion of human milk and breastfeeding for VLBW infants requires multidisciplinary and system-wide adoption of lactation support practices.

STATEMENT OF PROBLEM

Provision of mother's own milk for hospitalized very low birth weight (VLBW) (≤ 1500 g) infants in the NICU provides short- and long-term health benefits. Mothers of very preterm infants face many challenges in the provision of breast milk. The goal of this clinical report is to provide neonatal clinicians up-to-date information regarding NICU lactation support for mothers of VLBW infants.

abstract

Department of Pediatrics, Boston Medical Center, School of Medicine, Boston University, Boston, Massachusetts; ²University of California Health-Milken, San Diego, California; ³Department of Pediatrics, University of California, San Diego, California; ⁴Department of Pediatrics, Mount Sinai Hospital of Massachusetts, New York, New York; ⁵New York City Health + Hospitals/Bronx, Fordham University, Division of Neonatology, University of Medicine and Dentistry of New Jersey, Newark, New Jersey; ⁶Department of Pediatrics, University of Michigan, Ann Arbor, Michigan; ⁷Department of Pediatrics, University of Washington School of Medicine, University of Pennsylvania, and ⁸Department of Pediatrics, Harvard Medical School, Boston, Massachusetts

Dr. Perker, Stollwagner, and Noble drafted the original manuscript, and all authors provided intellectual input and reviewed, edited, and approved the final version of this article.

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PDHM NICU PROVISION

Infants are eligible for PDHM if they meet certain criteria. Medical conditions dictate the priority of PDHM for specific infants. The following conditions are medical indications for PDHM if maternal breastmilk is not available:

- Prematurity < 34 weeks
- Infants < 2000 grams
- Infants with a history of bowel injury such as NEC
- Infant with a history of gastroschisis
- Any infant at the discretion of the physician

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PDHM CONSENT

- Variable practice across institutions
- Discuss with risk management staff
- Consider if parents will be present when PDHM is offered
- Think about consent as patient education
- Consider prenatal consent for high-risk families
- **Highly** recommend that RN, LC staff, and providers be able to obtain consent
- Some use an 'opt-out' phrase for liability

UC San Diego Health



USE OF PASTEURIZED DONOR HUMAN MILK CONSENT OR REFUSAL

Patient Identification

Breast milk provides the best nutrition, helps with normal growth and development, and reduces the risk of your baby getting sick. Cow's milk formula does not have any of the unique immune or infection fighting ingredients of breast milk. When mother's own milk is not available or there is not enough, pasteurized donor human milk from a donor milk bank is often the next best choice. Pasteurized donor human milk has many of the unique properties that protect your baby from infection and is easier to digest than infant formula.

UC San Diego Health (UCSDH) provides donor human milk from an approved Human Milk Banking Association of North America (HMBANA) donor milk bank. This milk bank follows guidelines to make sure the safest milk possible is provided. Women who donate milk have blood tests similar to when blood is donated. The breast milk that is donated by healthy mothers is carefully tested. It is heat treated – pasteurized – to kill any germs that could cause disease. This process destroys all human cells and most bacteria and viruses in the milk. The milk is tested after heating to check again for any bacteria. There is a very small chance that your baby could become sick from germs in the donor human milk. Please discuss any questions or concerns with your baby's health care team.

Your baby's UCSDH care team recommends donor human milk if your milk supply is not meeting your baby's needs. Donor milk will be provided for:

- premature babies until the baby reaches 34 weeks gestation.
- babies whose mother does not have enough milk for baby.

This benefit will depend on the donor human milk supply available. Premature and sick babies will receive donor human before healthy babies. UCSDH does not provide donor human milk upon discharge.

I have received this education about donor human milk and the UCSDH staff have answered my questions about donor human milk. If my baby needs a supplement in addition to my breastfeeding, I prefer that the following be provided:

CHECK ONE: **I CONSENT** the use of donor human milk for my child.

OR

I REFUSE the use of donor human milk for my child and want my child to receive cow's milk formula if additional nutrition is required.

Parent/Authorized Guardian Signature _____ Parent/Authorized Guardian Print Name _____ Date _____ Time _____ AM / PM

If Interpreted: Telephone Video Interpreter Sig: OR ID# _____ Language _____ Date _____ Time _____ AM / PM

NUTRITION PREPARATION

- Milk lab logistics
- Milk lab staff education
- Feeding preparation
- Milk handling
- Review human milk and feeding policies



Best Practices for Handling and Administration of Expressed Human Milk and Donor Human Milk for Hospitalized Preterm Infants

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The importance of human milk for the preterm infant is well established (1–3). However, the feeding of human milk to preterm infants is typically much more complicated than the more act of breastfeeding (3, 4). The limited oral feeding skills of many preterm infants often results in human milk being administered via an enteral feeding tube (4). In addition, fortification is commonly required to promote optimal growth and development—particularly in the smallest of preterm infants (2, 4, 5). Consequently, a mother's own milk must be pumped, labeled, transported to the hospital, stored, tracked for appropriate expiration dates and times, thawed (if previously frozen), fortified, and administered to the infant with care taken at each step of the process to avoid microbial contamination, misadministration (the wrong milk for the wrong patient), fortification errors, and waste (1–5). Furthermore, the use of pasteurized donor human milk (DHM) for preterm infants when a mother's own milk is not available has been endorsed by many organizations (1). Therefore, appropriate procurement, storage, thawing (if received frozen), fortification, labeling, and administration must occur with the same considerations of preventing contamination and fortification errors while ensuring the correctly prepared final product reaches the correct patient (1). Many professional organizations have published best practices to provide hospitals with guidelines for the safe and accurate handling and preparation of expressed human milk (EHM) and DHM feedings for preterm infants (1–5). These best practices emphasize the importance of preparation location, trained staff, proper identification of human milk to prevent misadministration, and strategies to prevent fortification errors (1–6). The purpose of this mini-review article is to summarize current published best practices for the handling of human milk for preterm infants within the hospital setting (1–6). Emphasis will focus on the use of aseptic technique with proper sanitation and holding times/temperatures to limit microbial growth; use of technology to prevent misadministration of human milk and fortification errors as well as for tracking of expiration dates/times and lot numbers; and workflow strategies to promote safety while improving efficiencies (1–7).

Keywords: human milk handling, infant feeding preparation, human milk bar code scanning, aseptic technique, feeding preparation, safety and human milk

OPEN ACCESS

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Steele C (2018) Best Practices for Handling and Administration of Expressed Human Milk and Donor Human Milk for Hospitalized Preterm Infants. *Front. Nutr.* 5:76.

PDHM MANAGEMENT

- Ordering process
- Receipt of milk
- Temperature verification
- Milk tracking in the hospital
- Cold storage
- Labeling
- Inventory management
- Milk misadministration
- Retention of records

Title:	Breast milk: Collection, Storage and Preparation
	<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Guideline <input type="checkbox"/> Other
Patient Population:	<input checked="" type="checkbox"/> High Risk OB/Labor, Delivery and Recovery <input type="checkbox"/> Post-partum <input type="checkbox"/> Low Risk Infant <input type="checkbox"/> High Risk Infant
Unit(s) Affected:	<input checked="" type="checkbox"/> L&D/BC/Antepartum <input checked="" type="checkbox"/> NICU <input checked="" type="checkbox"/> Postpartum
Ancillary Services:	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Nutrition <input type="checkbox"/> Respiratory <input checked="" type="checkbox"/> Nutrition <input checked="" type="checkbox"/> Lactation
Effective Date:	10/92
Revision/Review Date(s):	8/94, 11/96, 3/98, 6/98, 7/01, 10/04, 10/05, 2/08, 3/08, 10/10, 9/11, 11/12, 8/15, 9/17, 2/18, 4/19, 5/20

POLICY STATEMENT/SCOPE:

This policy provides guidance for the safe collection, storage, and handling of breast milk outside of the Infant Feeding Prep Room within Women and Infant Services.

RESOURCES:

[MOMS Milk System Tutorial Videos](#)

RELATED POLICIES:

Women and Infant Services Policy

- [Breast Pump Use and Cleaning of Breast Pump Parts and Reusable Feeding Supplies](#)
- [Breastmilk: Misadministration](#)
- [Pasteurized Donor Human Milk](#)
- [7.2 Neonatal Nutrition: Procurement, Preparation, and Delivery of Breastmilk](#)

I. **DEFINITIONS:**

Mother: Biological, including mothers that are adopting out, surrogate carriers

Mothers' Own Milk System (MOMS): Bar-coded human milk tracking system

Milk Warmer: Equipment that will warm or thaw breast milk feedings

DTR: Diet Technician, Registered

IFPR: Infant Feeding Prep Room

PDHM: Pasteurized Donor Human Milk

II. **POLICY**

- A. Women and Infants Services RNs will be trained on the MOMS system including printing labels, managing patient/mother profiles, managing orders, preparing/splitting milk, feeding, quick feed, disposal and discharge procedures.

REGULATORY ISSUES

- Institutional rules
- Tissue bank licensure requirements
- Regional public health department
- The Joint Commission
- FDA recall



Photo courtesy of UC San Diego Milk Tech staff

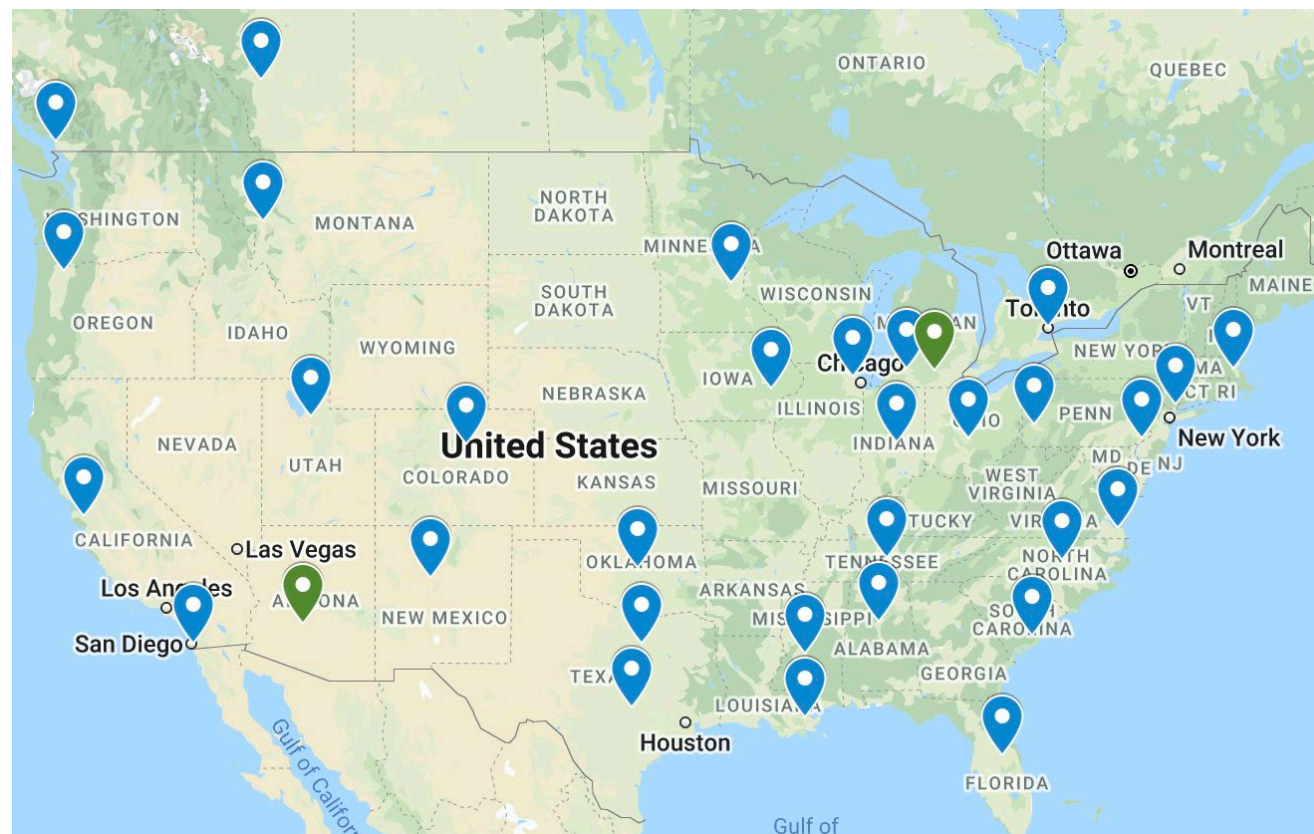
PROVIDING PDHM FOR YOUR HOSPITAL

- Improved VLBW infant outcomes
- Reduce inequities in human milk feeding
- Cost effective
- Increases mothers' own milk provision at DC



HMBANA Member Milk Banks

- 31 accredited nonprofit milk banks
- 9.2 million ounces dispensed in 2021
- 37+ year safety record
- Find a milk bank



[HMBANA.org](https://www.hmbana.org)

COMING SOON!

Implementing A Donor Milk Program: How to Get Started

Resource Guide

- Will be available on the HMBANA website post-webinar



RESOURCE LINKS





- [Academy of Breastfeeding Medicine](#)
- [American Academy of Pediatrics](#)
- [American Nutrition and Dietetics - blue book](#)
- [America's Essential Hospitals - Use of Donor Human Milk](#)
- [Baby Friendly NICU Toolkit](#)
- [Center for Disease Control](#)
- [Neonatal Quality Improvement Collaborative of Massachusetts-neoQIC](#)
- [Nec Society](#)
- [PATH](#)
- [The Joint Commission](#)
- [UCSD SPIN Program](#)
- [UCSF NICU Toolkit for Black Families](#)
- [UCSF NICU Toolkit for Hospitals and Birth Centers to Better Support Black Families](#)
- [United States Breastfeeding Coalition](#)
- [WHO - World Health Organization](#)

Current Recommendations for PDHM Use

- [Surgeon General Call to Action \(2011\)](#)
- [AAP Donor Milk Policy \(2017\)](#)
- [AAP/ACOG Perinatal Guidelines \(2017\)](#)
- [AAP Nutrition Book \(2020\)](#)
- [HHS Dietary Guidelines \(2020\)](#)
- [AAP Red Book \(2021\)](#)
- [AAP Human Milk and VLBW \(2021\)](#)
- [AAP Breastfeeding Clinical Report \(2022\)](#)



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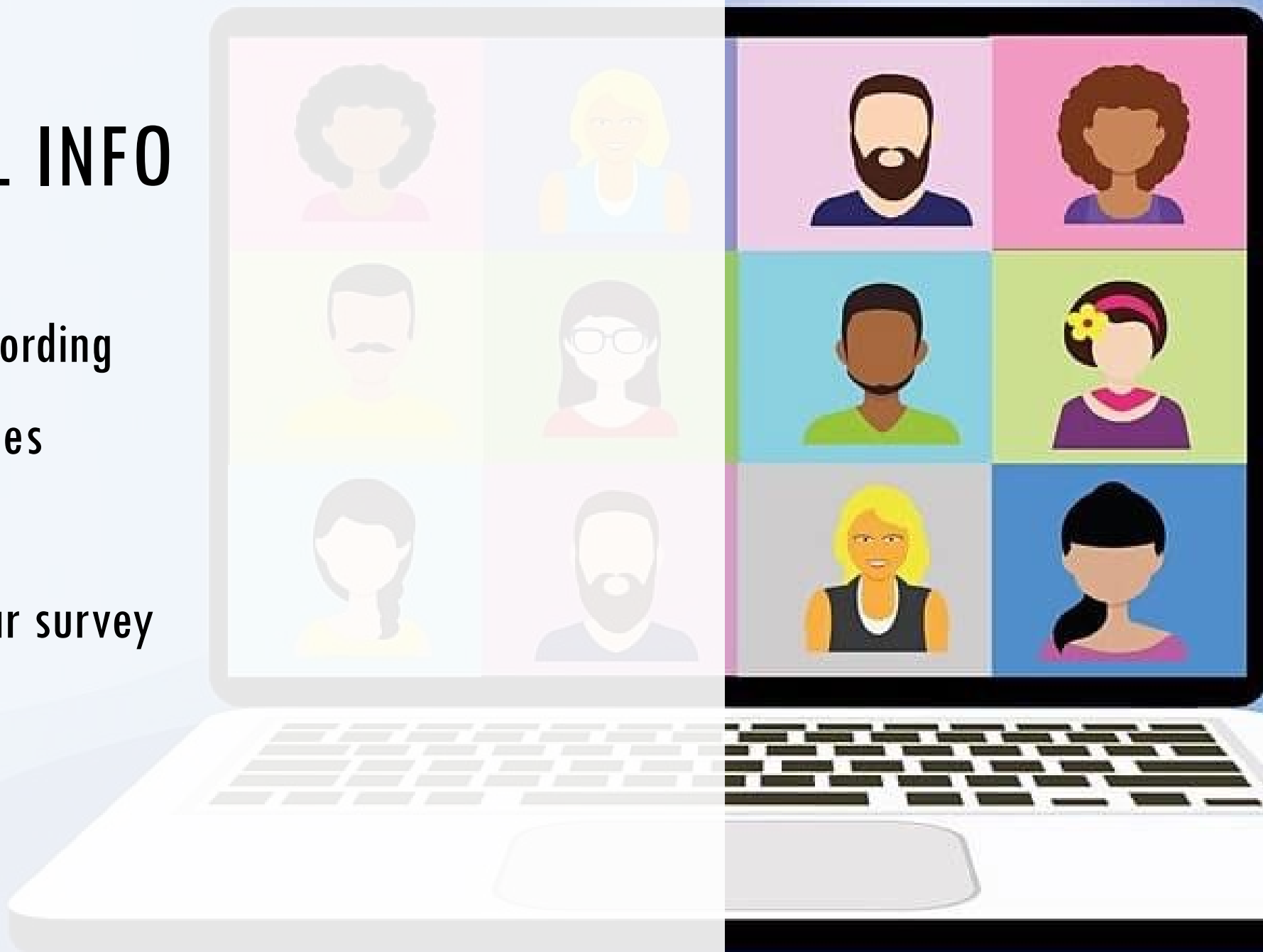


Find your nearest HMBANA milk bank.

Thirty-one member milk banks throughout the United States and Canada.

HELPFUL INFO

- Webinar recording
- Copy of slides
- L-CERP info
- Post-webinar survey



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QUESTIONS

