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Breastfeeding and New Jersey Maternity Hospitals:

A Comparative Report

Prepared by:

Charles E. Denk, PhD

Lakota K. Kruse, MD MPH

Florence Mojta Rotondo, IBCLC RLC

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For Further Information, Contact:

Florence Rotondo, Breastfeeding Coordinator
WIC Services, PO Box 364, Trenton, NJ 08625-0364
609-777-7746

Summary and Objectives

Breastfeeding is universally accepted as optimal for infant, maternal and public health. Breastfeeding provides superior nutrition, prevents disease, and enhances infant development. The choice to breastfeed is personal, but that choice can either be supported or undermined by what happens in the hospital in the first few days after delivery. The implementation of hospital policies that specifically support breastfeeding have been documented by research to dramatically increase exclusive breastfeeding rates and improve the health of mothers and infants after discharge. The first part of this report summarizes the evidence and rationale for making New Jersey's maternity hospitals the focus of redoubled efforts to increase breastfeeding among all new mothers.

This report replicates methodology, first introduced in 2008, that accounts for patient mix differences among hospitals. The standardized scores in Tables 1 and 2 allow meaningful comparisons among all hospitals, and identify some outstanding hospitals that produce breastfeeding results far beyond expectations based on patient mix. Finally, the report includes a model self-assessment tool and a list of resources that will allow hospitals to begin the process of enhancing breastfeeding through their core maternity care policies and practices.

Background

Breastfeeding is universally accepted as the optimal way to nourish and nurture infants, and it is recommended that infants be exclusively breastfed for the first six months.¹ Extensive research documents the compelling benefits to infants, mothers, families, and society from breastfeeding.^{1,4} Breastfeeding decreases the incidence of infectious diseases (diarrhea, lower respiratory infection, otitis media, bacteremia, and urinary tract infection), obesity, sudden infant death syndrome, asthma, insulin-dependent diabetes mellitus, and chronic digestive diseases. Breastfeeding has been documented to enhance cognitive development. Women who do not breastfeed experience delayed return to pre-pregnancy weight, earlier resumption of ovulation and shorter intervals between births, poor postpartum bone re-mineralization and increased risk of ovarian and premenopausal breast cancer. In addition to the contributions to individual health, breastfeeding has significant social and economic impacts. In the first year after birth, breastfeeding infants generate less health care costs, and their parents miss less work time.

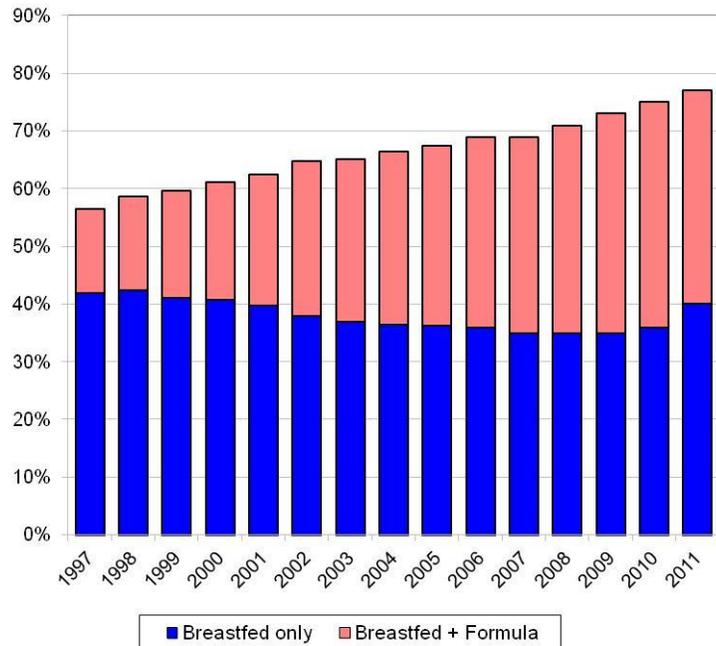
Infants who are exclusively breastfed in the early post-partum period are more likely to continue breastfeeding at six and twelve months. Despite efforts to protect, promote and support breastfeeding, the initiation of breastfeeding in New Jersey's maternity hospitals meets only one of two *Healthy New Jersey 2010* goals:²

- To increase the proportion of mothers who breastfeed their babies (exclusively or in combination with formula) at hospital discharge to at least 75 percent.
- To increase the proportion of breastfeeding women whose infants are breastfed exclusively at hospital discharge to 90 percent.

Rates of **exclusive**

breastfeeding had in fact been declining in New Jersey. Although the initiation of breastfeeding has risen over the past decade, until 2009 this increase was accounted for by infants who were also receiving formula in combination with human milk.³ As shown in Figure 1, the percentage of infants in New Jersey exclusively

Figure 1. Breastfeeding at Hospital Discharge, New Jersey 1997-2011



breastfeeding prior to discharge from the hospital decreased from 42% in 1997 to 35% in 2009, while breastfeeding in combination with formula feeding increased from 15% to 38%. The trend away from exclusive breastfeeding, which had been consistent regardless of the mother’s sociodemographic characteristics, appears finally to have been reversed.

How Do Hospitals Affect Breastfeeding?

Hospital staff and practices play an under-appreciated role in supporting or hindering breastfeeding, despite the belief that the decision lies strictly with the mother.⁴ Because almost all babies are born in the hospital, there is a clear opportunity for hospital personnel to promote the initiation of breastfeeding. Delivery hospitals have widely varying rates of exclusive breastfeeding initiation, due partly to differences in patient composition and partly to differences in maternity care practice.

According to the Maternity Practices in Infant Nutrition and Care (mPINC) Survey⁵ conducted by the CDC, hospital policies that specifically support exclusive breastfeeding also vary widely.⁶ For example, in many hospitals it is common practice to supplement breastfeeding with water or formula, while in others supplementation requires written consent by the mother or an order on the medical chart. What happens in the hospital during the first few days after delivery plays a crucial role in establishing breastfeeding and helping mothers to continue breastfeeding after leaving the hospital. *Ten Steps to Successful Breastfeeding*,⁷ developed and published by WHO/UNICEF, represents a comprehensive plan to optimize parental education, maternity department policies and practices, and post-discharge support.

The Ten Steps To Successful Breastfeeding

- 1 - Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
- 2 - Train all health care staff in skills necessary to implement this policy.
- 3 - Inform all pregnant women about the benefits and management of breastfeeding.
- 4 - Help mothers initiate breastfeeding within one hour of birth.
- 5 - Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
- 6 - Give infants no food or drink other than breastmilk, unless medically indicated.
- 7 - Practice "rooming in" - allow mothers and infants to remain together 24 hours a day.
- 8 - Encourage unrestricted breastfeeding.
- 9 - Give no pacifiers or artificial nipples to breastfeeding infants.
- 10 - Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

From 2004 to 2007, the New Jersey Pregnancy Risk Assessment Monitoring System (NJ-PRAMS), a monthly sample survey of new mothers two to six months post-partum, included eight questions on practices in the hospital that relate to breastfeeding.⁸ Figure 2 reports the estimated effects of five of these practices, after adjusting for the age, education, number of prior children, immigrant status, race and Hispanic origin of the mother. The largest difference was for avoiding supplemental feeding: when a mother reported breastfeeding exclusively until discharge, the odds of any breastfeeding at eight weeks post-partum were 2.9 times greater, and the odds of

exclusive breastfeeding at eight weeks were 6.3 times greater.

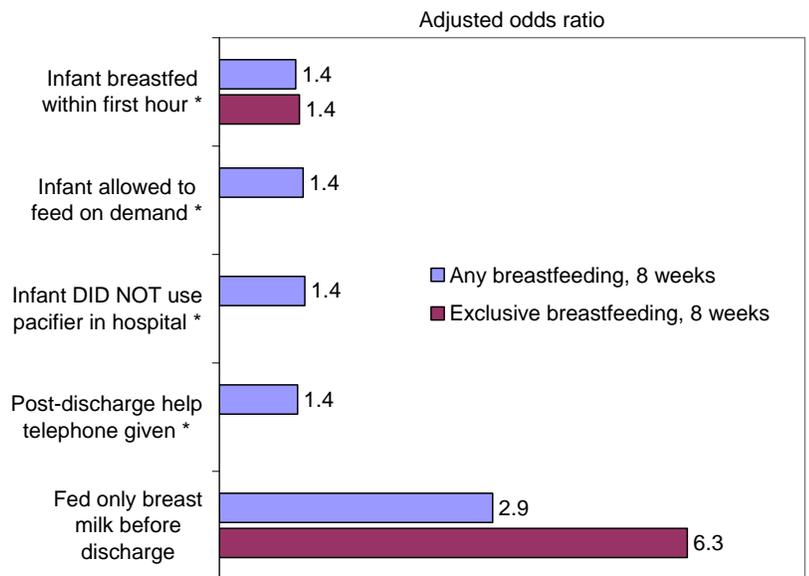
These mothers were also very likely to report adherence to other features of the Ten Steps, for example, breastfeeding within the first hour after delivery and being allowed to feed infants “on demand.”

When infants were given supplemental formula in the hospital, these other elements were also

more likely to vary, and they had less powerful effects on the persistence of breastfeeding. For example, among infants that received formula before they left the hospital, those that breastfed within the first hour of life were only about 40% more likely to be doing any breastfeeding or be exclusively breastfeeding at eight weeks. Recommended practices such as feeding on demand, avoiding pacifiers, and providing post-discharge telephone help also had modest effects on persistence of any breastfeeding, but no effect on persistent exclusive breastfeeding.

These effects were assessed via mothers’ reports of their own experiences, rather than from hospital-provided practice data. The PRAMS results nevertheless add to the mounting evidence that what hospitals do matters. A comprehensive review of practice improvements and the evidence base supporting them is presented in *The CDC Guide to Breastfeeding Interventions*,⁹ which considers potential interventions for prenatal education, post-discharge support and social acceptance as well as hospital maternity care. Hospitals administrators and practitioners seeking to improve

Figure 2. Hospital Factors Affecting Persistence of Breastfeeding at 8 Weeks (* Among Initiators with Formula Supplementation in Hospital) (Adjusted for maternal factors, n=5,600)



breastfeeding outcomes will find this document a valuable resource. Baby Friendly USA, a WHO affiliate, helps American hospitals achieve the *Ten Steps*. Their program starts with a self-assessment tool available at:

www.babyfriendlyusa.org/eng/docs/2012_Self Appraisal Tool.doc.

Hospital Statistics and Population Adjustment

Breastfeeding statistics for any hospital depend in part on its population of patients. Maternal age, race, Hispanic origin, education, and foreign birth, and delivery characteristics such as plural birth and neonatal intensive care are well known to affect breastfeeding initiation.¹⁰ Variations in patient mix across hospitals can therefore be expected, all else equal, to produce differences in hospitals' individual breastfeeding outcomes. Such differences, by themselves, are outside the hospitals' control, and should not be automatically attributed to variations in healthcare practice.

New Jersey does not at this time collect data describing hospital maternity policies and practice standards that relate to breastfeeding, nor does PRAMS support hospital level assessments of practice. For now, this report has a more limited objective: [a] to compare New Jersey hospitals according to rates of exclusive breastfeeding at discharge; and [b] to present an adjusted measure of hospital rates that minimizes the effect of patient population. Population adjustment methods aim to:

- assess the degree to which a hospital's outcomes match expectations based on its patients' demographic and/or medical characteristics;
- estimate what each hospital might achieve if it had the same patient mix as every other; such approaches are also referred to as *standardization*.

Identifying hospitals that do better than would be expected from their patient mix satisfies two objectives. In the short term, prospective mothers with strong preferences about breastfeeding are guided to hospitals most suited to their needs. In the long term, all hospitals and consumers benefit from discovering and evaluating potential best practices.

Other states have recently produced similar hospital specific breastfeeding reports.^{11, 12} In 2010, The Joint Commission and the National Quality Forum, two leading organizations in measurement of healthcare quality, called for including breastfeeding at discharge as one of five core perinatal care quality indicators. New Jersey has chosen to focus specifically on exclusive breastfeeding, and to address hospital differences in population mix as part of its evaluation. This report uses a technique called logistic regression, with variables routinely available on the electronic birth certificate (EBC), to accomplish this population adjustment. (See Appendix 1 for a complete exposition.) The use of this methodology for breastfeeding was peer-reviewed and published in 2005 in the obstetrical journal *Birth: Issues in Perinatal Care*.⁴ The article documented that, in New Jersey, patient mix accounts for about sixty percent of differences in breastfeeding among hospitals. The other forty percent is presumably where hospital staff and practices play a key role, independently influencing the transition from maternal knowledge and intention to actual discharge outcomes.

Results: Hospital Ratings

Table 1 presents ratings for each hospital, grouped within eight geographic regions. The hospitals are ranked within region from highest to lowest value on the 2011 standardized score.

The specific columns:

- *Births discharged home*: These are normal newborns, excluding those that died or were transferred to neonatal intensive care or another hospital.
- *Exclusive breastfeeding*: The proportion of newborns discharged home who were recorded on the standard birth certificate item as exclusively breastfeeding during the twenty-four hours prior to discharge. Without any adjustment, this is called the “crude” rate.
- *Standardized score*: A ratio measuring how the hospital’s crude exclusive breastfeeding rate compares to expectations based on demographic and medical characteristics of the patient population at that hospital (see the description of methods in Appendix 1). A score of 1.0 indicates an “average” performance compared to the population expectation.
- *Crude exclusive rate for 2010*. This is offered for rough comparative purposes.

For example, among the six North Jersey hospitals The Valley Hospital reported 78% of infants discharged home as exclusively breastfeeding, and earned a standardized score of 1.52—because calculations based on its patient mix predicted only a 51% crude rate ($68/50=1.37$). The Valley Hospital improved from a 68% crude rate in 2010. Comparing crude rates over short time intervals is a little more intuitive than comparing the standardized scores; since each hospital’s population component rarely changes much from year to year the inferences are likely to be about the same.

Within the North Jersey region St. Mary’s Hospital in Passaic had the highest standard score, 1.71, indicating that its crude rate of 51% (third best) was much higher than predicted by patient mix (30%). St. Joseph’s Regional Medical Center, a large, urban, high-tech hospital serving a disproportionately minority population, exemplifies how the standardized score can identify problems with routine breastfeeding care. St.

Table 1

1-Hackensack/North Jersey Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
St. Mary's Hospital Passaic	983	1.71	51%	30%	25%
The Valley Hospital	2,213	1.52	78%	51%	68%
Englewood Hospital and Medical Center	1,607	1.41	62%	44%	50%
Hackensack University Medical Center	4,830	0.80	33%	41%	33%
Holy Name University Medical Center	1,220	0.72	28%	39%	17%
St. Joseph's Regional Medical Center	2,588	0.67	20%	29%	19%

2-Morristown Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
Hackettstown Community Hospital	157	1.67	79%	47%	84%
Newton Memorial Hospital	426	1.44	64%	44%	63%
Morristown Memorial Hospital	3,300	1.38	64%	46%	62%
Saint Clare's Hospital/Denville	1,240	1.09	50%	46%	37%
Chilton Memorial Hospital	838	0.79	38%	49%	45%

3-Newark Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
UMDNJ - University Hospital	1,279	2.26	52%	23%	42%
The Mountainside Hospital	968	1.60	61%	38%	52%
Palisades Medical Center - New York Presbyterian Healthcare System	1,324	1.22	40%	33%	17%
Saint Barnabas Medical Center	4,011	0.95	43%	45%	39%
Meadowlands Hospital Medical Center	548	0.77	28%	36%	21%
Hoboken University Medical Center	1,368	0.72	26%	35%	32%
Liberty HealthCare System, Inc. - Jersey City	1,404	0.50	16%	31%	15%
Christ Hospital	1,266	0.35	11%	30%	18%
Clara Maass Medical Center	1,516	0.26	7.80%	30%	7%
Newark Beth Israel Medical Center	2,583	0.22	5.70%	26%	9%

4-New Brunswick Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
Somerset Medical Center	1,030	1.67	68%	41%	53%
Raritan Bay Medical Center	1,169	1.49	44%	29%	20%
Overlook Hospital	2,112	1.31	62%	47%	61%
Hunterdon Medical Center	753	1.06	53%	50%	51%
Robert Wood Johnson University Hospital	1,706	1.00	39%	39%	36%
Trinitas Hospital	2,073	0.93	25%	26%	7%
Saint Peter's University Hospital	4,104	0.88	37%	42%	29%
JFK Medical Center	2,473	0.47	18%	39%	19%

Table 1

5-Trenton Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
Capital Health Regional Medical Center (Fuld)	40	2.58	63%	24%	
Capital Health Medical Center (Hopewell)	1,529	1.96	66%	34%	38%
University Medical Center at Princeton	1,673	1.24	56%	45%	53%
RWJ University Hospital at Hamilton	1,114	0.93	36%	39%	32%

6-Toms River Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
CentraState Healthcare System	1,461	1.47	67%	46%	58%
Monmouth Medical Center	3,829	1.43	66%	47%	68%
Meridian Hospitals Corporation - Jersey Shore	1,472	1.00	44%	44%	43%
Community Medical Center	1,462	0.90	40%	44%	39%
Meridian Hospitals Corporation - Riverview	1,314	0.85	42%	49%	42%
Meridian Hospitals Corporation - Ocean County	939	0.76	36%	47%	33%
Southern Ocean County Hospital	338	0.76	33%	43%	31%
Kimball Medical Center	944	0.12	4.60%	37%	57%

7-Camden Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
Kennedy University Hospital- Washington Twp	1,044	1.56	63%	40%	55%
Virtua Memorial Hospital of Burlington County	2,386	1.45	59%	41%	44%
Our Lady of Lourdes Medical Center	848	1.12	31%	28%	34%
Virtua West Jersey Hospital - Voorhees	4,521	1.11	54%	48%	51%
Underwood Memorial Hospital	853	0.91	38%	42%	30%
The Cooper Health System	1,526	0.82	25%	31%	27%

8-Atlantic City Region

	2011				Exclusive BF rate 2010
	Births discharged home	Standardized score	Exclusive BF rate	Population component	
South Jersey Regional Medical Center - Vineland	1,851	1.80	53%	29%	49%
South Jersey - Elmer	310	1.79	86%	48%	84%
AtlantiCare Regional Medical Center	1,673	1.18	41%	34%	38%
Shore Memorial Hospital	1,013	1.05	46%	43%	45%
Cape Regional Medical Center	486	0.92	32%	35%	30%
The Memorial Hospital of Salem County, Inc.	151	0.39	9.90%	26%	11%

Joseph's standardized score of 0.67 suggests that if it could do just an "average" job with the population it serves—i.e., raise its standardized score to 1.0—it would raise its crude rate from 20% to 29% exclusive breastfeeding.

Each region had at least one hospital with a standardized score well above 1.0, but these hospitals were not all the same. Some are basic care facilities in nonurban settings with a low volume of deliveries (e.g., Hackettstown Community Hospital), while others were quite different. The hospital with the highest standardized score was UMDNJ University Hospital (Newark Region), an urban teaching facility serving a large minority population, where the predicted rate would have been 21%. This is their third year at the top, after major policy changes adopted after previous years of poor performance.

The ability to identify hospitals that produce relatively good outcomes with populations not predisposed to breastfeeding is a major strength of standardization. Several other hospitals serving New Jersey's neediest populations can also claim positive outcomes, notably South Jersey Regional Medical Center in Vineland (Atlantic City region) and Capital Health System at Mercer (Trenton region).

New Jersey's Baby Friendly Hospital Initiative

In 2008, the New Jersey Office of Nutrition & Fitness in the Department of Health and Senior Services developed a statewide public-private partnership called **ShapingNJ** to promote obesity prevention in New Jersey. In June 2010, the Centers for Disease Control and Prevention made a grant to the Office under its "Communities Putting Prevention to Work" initiative to begin statewide implementation of the Baby-Friendly Hospital Initiative. At that time, New Jersey had no Baby-Friendly hospitals.

Ten hospitals across the state were selected (through a competitive RFA) to participate in this quality improvement program. The New Jersey chapter of the American Academy of Pediatrics sponsored a program of training and technical assistance at these hospitals and at twelve associated pediatric office practices. To date, one grantee has received Baby-Friendly certification (Capital Health - Hopewell) and at least two more are expected. The other seven grantees implemented at least two of the Ten Steps during the year-long program.

Cautions

Several caveats should be attached to this collection of statistics, as to most others. First, while large differences in rankings between crude rate and standardized score for an individual hospital suggest that practices there may be especially well (or especially poorly) adapted to their distinctive populations, smaller differences may not be as meaningful. Our main goal has been to distinguish hospitals doing the very best job, taking into account the populations they serve.

Second, every population adjustment model is incomplete. Extreme scores in either direction are likely to be under-adjusted, and therefore overstated. Some unique

population profiles may be inadequately captured. Therefore, the most positive standardized scores are only suggestive of potential “best” practices. The purpose of such measures is to identify candidates for imitation or intervention, not to crown winners and losers.

Third, statistical measures like these are only as good as the reporting done by hospitals on the electronic birth certificate. Some extremely low scores or wide discrepancies may be attributable to incorrect (or recently improved) coding. One of the benefits of public reports like this one is to increase the incentive for quality of reporting. Future versions of this report may see a dramatic decline in unusually low scores.

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the Gap in Exclusive Breastfeeding Rates.

<http://www.calwic.org/storage/documents/pk!/2008/bfhospital2008.pdf>.

12. Massachusetts: Breastfeeding Report Card from the Massachusetts Breastfeeding Coalition. <http://www.massbfc.org/providers/reportCard.html>.

Policy Statements and Resources on the Web

National Women's Health Information Center.

<http://www.womenshealth.gov/breastfeeding/> (Includes HHS blueprint and breastfeeding policy statements)

United States Breastfeeding Committee. <http://www.usbreastfeeding.org/>

WHO/UNICEF Baby-Friendly Hospital Initiative.

<http://www.babyfriendlyusa.org/eng/01.html>

American Academy of Pediatrics initiatives page. <http://www2.aap.org/breastfeeding/>

The Academy of Breastfeeding Medicine clinical protocols.

<http://www.bfmed.org/Resources/Protocols.aspx>

American Academy of Family Practice policy statement.

<http://www.aafp.org/online/en/home/policy/policies/b/breastfeedingpositionpaper.html>

CDC breastfeeding resources webpage. <http://www.cdc.gov/breastfeeding/>

New Jersey Division of Family Health Services, Breastfeeding resource page.

<http://www.state.nj.us/health/fhs/newborn/feed.shtml>

International Lactation Consultant Association clinical guidelines.

<http://www.ilca.org/files/resources/ClinicalGuidelines2005.pdf>

La Leche League international website. <http://www.la lecheleague.org/>

ShapingNJ website: www.shapingnj.gov

NJ Baby Friendly Hospital Initiative as implemented by the NJ Pediatric Council on Research and Education (PCORE).

<http://www.aapnj.org/showcontent.aspx?MenuID=1389>

Appendix 1: Data Source and Methods

New Jersey's Electronic Birth Certificate (EBC) collects, for all live births: ⁸

- Feeding method in the twenty-four hours prior to hospital discharge: exclusive breastfeeding, formula feeding, combination, other, or unknown).
- Maternal race, Hispanic origin, birthplace, age, marital status, education.
- Number of previous births (parity), prenatal care utilization, and neonatal intensive care admission.
- Hospital delivery volume was aggregated from EBC records.
- Perinatal designation level of the hospital was obtained from state administrative data.

To focus attention on situations where breastfeeding is most feasible, records were included only for singleton newborns that were discharged directly from the delivering hospital to home, and excluded for newborns that were admitted to the neonatal intensive care unit (NICU), were transferred to another hospital for any reason or duration, died before ever being discharged or were twins or higher plurality.

Population Adjustment Method

Population adjustment methods are designed to isolate the demographic and/or medical effects of patient mix from overall aggregate outcomes for a hospital, and then to compute a *residual* effect for each hospital to allow controlled comparison.⁴ Such adjustments are required because patients are not randomly assigned to hospitals, and often the patient profiles of particular hospitals are differentially prone to certain outcomes. The goal of population adjustment may be restated as estimating what each

hospital could be expected to achieve if it had the same patient mix as every other, so such approaches are also referred to as *standardization*. Conceptually, if not technically, the terms are equivalent.

Population adjustment (or standardization) is performed in three steps.

1) A general model to predict individual breastfeeding outcomes, based only on individual characteristics, in the entire population.

The outcome to be standardized is the proportion of infants who are breastfed exclusively at discharge (BFED) at each delivery hospital. In the first stage individual model we use logistic regression to predict this outcome for individual newborns, with maternal race, Hispanic origin, native or foreign birth, age, education, parity, plurality (twins, etc.), month of first prenatal care visit, and marital status as predictors. These variables were selected because they are known to have large independent effects on individual breastfeeding decisions,^{4,7,8} and because they represent the patient mix differences that hospitals cannot (indeed, should not) control.

Severe delivery complications and newborn conditions that would most likely inhibit breastfeeding are mostly excluded by the case selection criteria: singletons discharged to home with no NICU utilization.

Exhibit 1 presents the analytical results for this logistic regression model. The effects of each variable are expressed as *adjusted odds ratios*, an estimate of the relative difference in the likelihood of breastfeeding for a newborn in one category compared to the *reference category*, assuming all other factors are the same. For example, compared to newborns with native-born white mothers, most others are only about 40-60% as likely to breastfeed exclusively at discharge (all but two categories have adjusted odds ratios between .43 and .58). All of the variables in this model are

statistically significant, which means that the odds ratios are very unlikely to show the differences they do only by chance. Other opportunities to assess the strength and validity of the model will be noted below.

2) Crude rates and a *population component* computed for each hospital.

The predicted probability of BFED produced by the logistic regression procedure was computed for each newborn, and then averaged for all births at each hospital. This quantity is called the *population component*. Other statistics, such as the proportion of newborns discharged as exclusively breastfeeding, are also computed for each hospital during this step.

3) The final, *standardized score*.

The ratio of the crude hospital rate to the population component is the most directly useful measure of the hospital's net contribution to the outcome measure, after isolation and removal of population influences. A score of 1.0 is the baseline, indicating that outcome exactly matches expectation. In other applications of this methodology a further transformation is often applied to the ratio to improve the score's symmetry or other properties. None seems necessary in this case.

Exhibits 2-3 describes the relationship between the crude BFED rate, the population component and the standardized score. Exhibit 4 displays the relationship between standardized scores in 2007 and 2009. These exhibits suggest that the measurement approach is robust and fairly stable over time.

Exhibit 1. Results of Risk Adjustment Analysis, 2007-09

Logistic Regression Analysis

	adjusted odds ratio	joint test chi- square	joint test p- value
<i>Marital race/ethnicity/birthplace</i>		6683.97	<.0001
US-born white, not Hispanic	1.00		
US-born black, not Hispanic	0.49		
US-born Hispanic	0.57		
Foreign-born Hispanic	0.43		
Asian, not Hispanic	0.45		
Other foreign-born other/DK	0.72 0.85		
<i>Marital status</i>		2518.42	<.0001
married	1.00		
not married	0.57		
<i>Maternal education</i>		3831.11	<.0001
lt HS	0.90		
HS grad	1.00		
college	1.84		
<i>Maternal age at delivery</i>		70.42	<.0001
teen	0.88		
20-24	0.97		
25-29	1.00		
30-34	1.01		
35+	0.94		
<i>Number of previous births</i>		272.65	<.0001
high for age	1.09		
3, over age 25	0.97		
2, over age 18	1.00		
first birth	1.15		
<i>First prenatal care visit</i>		417.82	<.0001
never	0.35		
1st trimester	1.00		
2nd trimester	0.91		
3rd trimester	0.77		

Exhibit 2. Standardized Score by Hospital Crude Rate, 2009

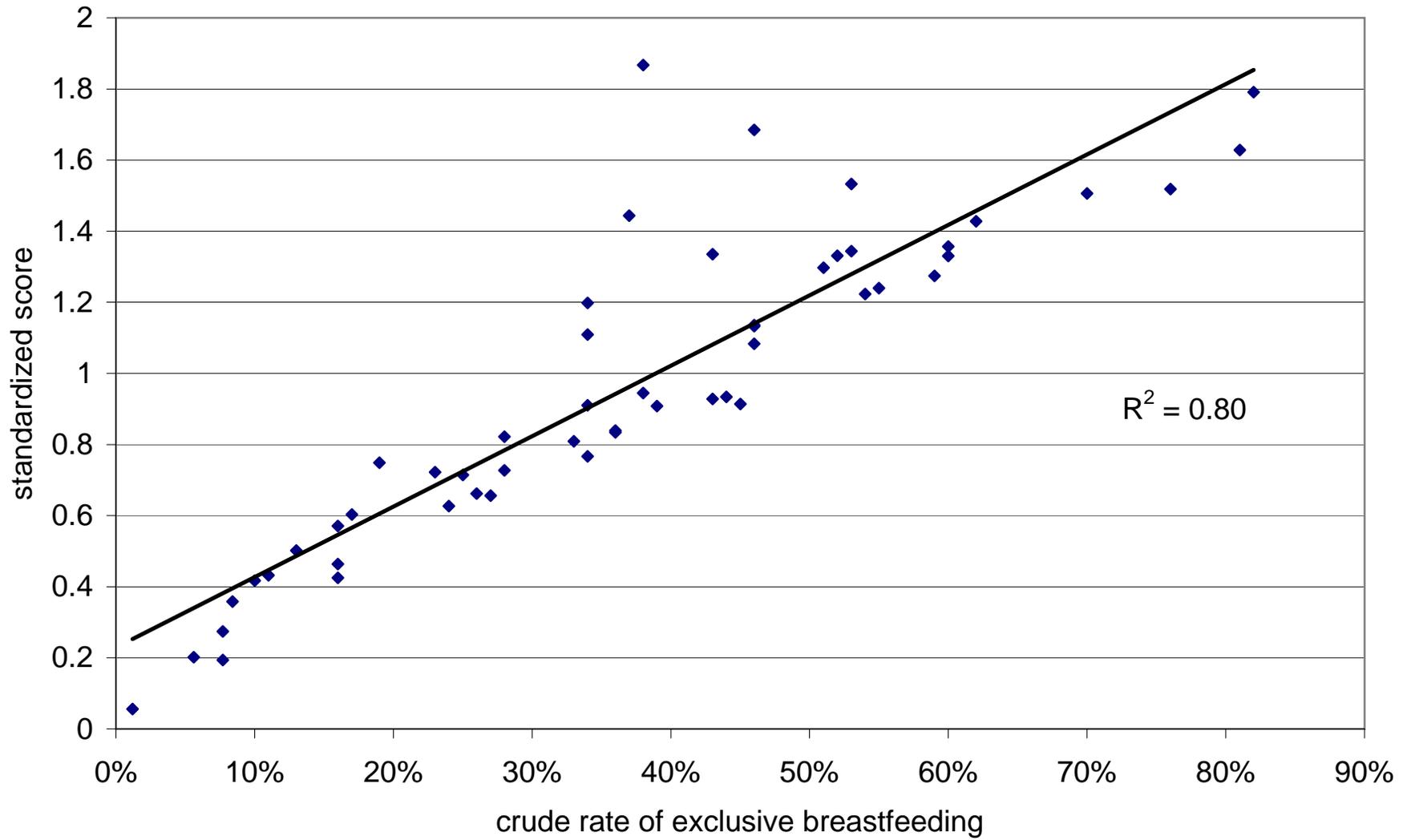


Exhibit 3. Distribution of Standardized Score by Population Component, 2009

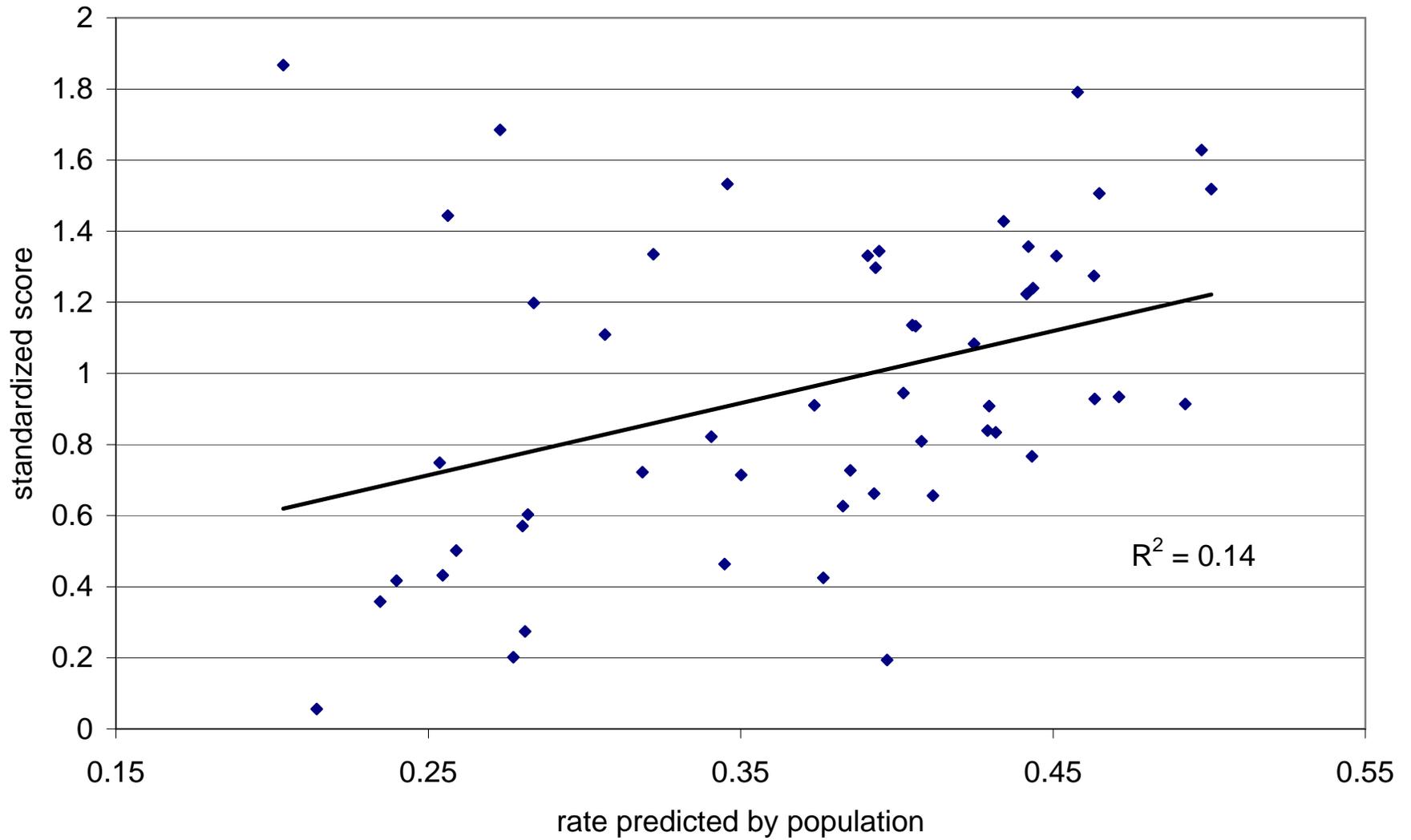


Exhibit 4. Change in Standardized Score, 2007-09

