Advocating for Pasteurized Donor Human Milk

The Journey for Medicaid Reimbursement in New York State

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ABSTRACT
Background: The American Academy of Pediatrics and the National Association of Neonatal Nurses recognize that federal policies fail to reimburse for the provision of pasteurized donor human milk (PDHM) to the very low birth-weight neonate, and have encouraged members to advocate for the inclusion of PDHM into their respective state Medicaid programs.
Purpose: This article describes what occurred in New York State as advocates worked for reimbursement of PDHM reimbursement by Medicaid.
Method: Tactics utilized in New York have been presented with an advocacy framework to illustrate the necessary strategic foresight required for productive engagement within the healthcare policy arena.
Results: Examination of employed advocacy efforts targeted to remove known cost barriers associated with PDHM.
Implications for Practice: Full utilization of PDHM within intensive care.
Implications for Future Research: The necessity to engage in scholastic/evidence-based advocacy work.
Key Words: advocacy, healthcare policy, Medicaid reimbursement, pasteurized donor human milk

In 2014, advocates in New York State (NYS) formed a working group focused on improving health outcomes for the neonatal population by optimizing nutritional interventions. The group explored the establishment of a nonprofit milk bank in NYS to ensure availability of pasteurized donor human milk (PDHM) to medically fragile neonates. As NYS human milk advocates networked with stakeholders, the working group became concerned that simply increasing the availability of PDHM would not necessarily result in increased access; they would have to address cost as well. This article outlines the advocacy tactics utilized to remove cost barriers associated with PDHM, hence guaranteeing that all medically fragile neonates requiring hospitalization within NYS would have access to PDHM. Actions taken in New York have been described and placed within Coffman and Beer's[1] Advocacy Strategy Framework (ASF) in an effort to assist advocates in other states to successfully increase access to PDHM.

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DOI: 10.1097/ANC.0000000000000685

PASTEURIZED DONOR HUMAN MILK

Pioneering human milk advocate Dr Lois D. W. Arnold succinctly defined donor milk as milk that "has been voluntary expressed by mothers who are not biologically related to the recipient."[2] PDHM is donor milk that has been donated, processed, and distributed in accordance with established evidence-based guidelines.

HISTORICAL CONSTRUCT

The first donor milk bank was established in Vienna in 1909.[3] According to Miracle et al,[4] the first mention of donor milk is credited to Dr Hobbler, who noted the positive effects that "donor banked milk" had on fragile infants in 1914. Acceptance of milk banking has had historical ups and downs. In America, the first milk bank was established in Boston in 1919. During the early 20th century, donor milk grew in popularity, and by 1939 there were 12 established milk banks in North America. During the 1950s and 1960s, natural breastfeeding was seen as inferior to formula, and milk banking in North America declined. By the early 1980s, this trend had shifted, and there were 53 milk banks in North America.[3] At that time, New York's milk bank was located in Manhasset at North Shore University Hospital. During the HIV/AIDS crisis in the mid-1980s, human milk was seen as a potential vector for transmission, and support for donor milk quickly declined once again.[3] By the end of the 1980s, there were only 5 milk banks remaining in the United States.

The Human Milk Banking Association of North America (HMBANA) was created in 1985 to ensure the quality and safety of donor human milk through standardized operations. The HMBANA collaborated with the Centers for Disease Control and Prevention, the US Food and Drug Administration, and the American Academy of Pediatrics (AAP) to identify practices to safely accept, process, store, and distribute human milk. In 1990, the first edition of HMBANA's *Guidelines for the Establishment and Operation of a Donor Human Milk Bank* was published. The guidelines articulated evidence-based practices for safe collection, storage, and distribution of human milk, setting the standard for PDHM.[2] HMBANA's guidelines legitimized the practice of milk banking, allowing donated milk to gain medical acceptance as a therapeutic agent. Swanson observed in her book *Banking on the Body: The Market in Blood, Milk, and Sperm in Modern America* that "increased medical acceptance of banked milk at the turn of twenty-first century" had the observable effect of "a new boom in milk banking."[5]

CURRENT MILK BANK OPERATING STRUCTURES

Milk banks currently operate within 2 frameworks: nonprofit and for-profit. Each framework has been discussed in more detail in the following sections.

Nonprofit

There are currently 23 nonprofit milk banks operating in the United States, all of which comply with HMBANA's standards. These milk banks, as well as 3 operating in Canada, comprise the HMBANA. In 2018, the HMBANA provided 6.5 million oz of PDHM to the vulnerable pediatric population throughout North America.[6] Swanson observed that the HMBANA treats donated milk as "civic property" to be managed for "the public good."[5] Swanson's observations of HMBANA's operations align with the organization's mission: "[to advance] the field of nonprofit milk banking through member accreditation, development of evidence-based best practices, and advocacy of breastfeeding and human lactation to ensure an ethically sourced and equitably distributed supply of donor human milk."[6]

The process to become a donor to an HMBANA milk bank is extensive. The screening process includes multiple phone interviews, the completion of a detailed lifestyle and history review, maternal blood work, and medical clearance for the dyad.[2] HMBANA milk banks do not place a fiscal value on the milk they distribute; however, they do charge a *processing fee* to the ordering entity. The processing fee provides reimbursement for costs incurred to screen donors, effectively pasteurize, and ship the milk (ie, operational and distributive costs). Costs range from $3 to $5/oz.

For-Profit

For-profit milk banks (ie, Prolacta Bioscience, Medolac Laboratories, and Ni-Q) pay for a mother's expressed human milk (~$1/oz). The expressed human milk is used in a lactoengineered patented product exclusive to the for-profit milk bank. For-profit milk banks vary in what they produce; some produce a human-derived milk fortifier (HDMF), while others specialize in creating shelf-stable human milk. Currently, Prolacta Bioscience is the only company capable of producing HDMF. The cost of Prolacta's HDMF is $6.25/mL, and Prolacta sells PDHM for $9.50/oz (C. Schmaltz, oral communication, November 2017). Companies that produce lactoengineered products have been described as following a "market property model, selling bottled milk for the benefit of its shareholders."[5]

WHY DO INFANTS NEED PDHM?

Neonates weighing less than 1500 g are classified as *very low birth weight* (VLBW), a vulnerable subcategory of newborns who are at high risk to develop life-altering sequela related to their premature birth. Necrotizing enterocolitis, a complication attributed to prematurity, can be mitigated through the provision of PDHM.[7-11] Adequate nutritional intake is a vital component of individualized care VLBW neonates receive, designed to mitigate the consequences of prematurity. The World Health Organization, the AAP, the National Association of Neonatal Nurses (NANN), and the Surgeon General all promote the provision of PDHM to the VLBW neonate (<1500 g) when maternal human milk is not available.[12-15]

NEW YORK AND PDHM REIMBURSEMENT

In 2014, individuals in NYS formed a working group focused on utilizing human milk as a nutritional intervention to improve health outcomes for the vulnerable neonatal population. The group consisted of healthcare professionals (3 neonatologists and 1 nurse practitioner) and a lay community member, with a shared goal to increase the utilization of PDHM throughout NYS. Initial meetings resulted in a formalized board tasked with creating and opening an HMBANA milk bank in NYS.

In 2015, as board members engaged in community outreach and purposeful networking, they became aware of a common concern among stakeholders and human milk proponents throughout the state—that a reliable supply of PDHM from an NYS milk bank would not necessarily translate into increased clinical utilization. Human milk proponents explained to board members that the cost of PDHM may be considered prohibitive for hospitals to maintain stock and for healthcare professionals to

utilize the milk. Cost barriers were especially worrisome for clinicians and institutions, which provided services to economically depressed regions in the state. While a milk bank may provide a reliable supply of PDHM, cost barriers were likely to prevent uniform access throughout the state without linking PDHM to a source of reimbursement (ie, Medicaid). Concern regarding potential cost barriers for PDHM use was not isolated to human milk proponents within NYS in 2015. Nationwide, healthcare providers specializing in providing care for vulnerable neonates cited cost as a major limitation to PDHM when mother's own milk was not available.[16]

As the board continued to work toward opening a milk bank in NYS, they recognized that to meet their original goal (ie, *the improvement of health outcomes for vulnerable neonates through utilizing human milk*), efforts should be made to join human milk proponents in NYS to extinguish any barrier between supply and access. Together, board members and human milk proponents began to work in tandem on efforts to obtain Medicaid reimbursement for PDHM.

Initial efforts of networking and community outreach by human milk advocates resulted in expanding the coalition to include NYS legislators, as they became aware of the policy work proposed by Michaelle Solages. Ms Solages, elected into the NYS Assembly in 2012, was a strong proponent of policies that address health disparities, and was a staunch breastfeeding supporter. During the 2015 legislative session, Assemblywoman Solages attempted to mobilize colleagues to support a bill designed to provide reimbursement for PDHM, the first of its kind. New York State Assembly Bill A8511 was introduced on October 9, 2015, and sought "reimbursement for donor human breast milk."[17] Following bill introduction, the proposal was referred to the Standing Committee on Health for consideration. Unfortunately, no action was taken by the committee to advance the proposal for a full NYS Assembly floor vote.

Witnessing the stalled progress on the legislation, Bill A8511 prompted board members and human milk proponents to reach out to Assemblywoman Solages to prepare for another attempt during the 2016 legislative session. Advocates worked with Assemblywoman Solages performing an informal political scan to become familiar with the political environment they were seeking to influence. The scan also allowed advocates to consider an array of advocacy tactics, which would result in productive interim outcomes, even if future legislation introduced by Assemblywoman Solages remained stalled in the Standing Committee of Health in the NYS Assembly (Table 1). Advocates sought to expand legislative contacts in 2016 and formed working relationships with key legislators who influenced the Standing Committee of Health in the State Assembly, as well as NYS Senators. Networking with individuals who influenced policy and meeting with elected officials proved beneficial, and in 2016 human milk advocates had increased support in both houses of the legislature.

In 2016, legislation designed to increase access to PDHM by providing state Medicaid reimbursement moved forward in a bicameral, bipartisan nature. On November 16, 2016, the final version of the bill was presented to the Governor. Human milk advocates were optimistic about receiving support from the executive branch of NYS, and encouraged community members within their network to contact the Governor's office to express support. However, upon reviewing the bill, the executive branch noted that the policy lacked a clear source of funding and distribution. Despite the Governor's support of and appreciation for the need to provide PDHM to high-risk neonates, the bill was not approved by the executive branch. Prior to the official veto, members of the Governor's staff reached out to stakeholders of the proposal, encouraging advocates to champion for the inclusion of PDHM into NYS Medicaid budget via legislative amendments.

The Governor's veto prompted advocates to redirect their energy into achieving 2 short-term outcomes: (1) the formulation of an estimated payer savings tool (EPS) to describe likely fiscal benefits of reimbursement policies, and (2) becoming familiar with the process of NYS budget construction (Figures 1 and 2, respectively).

The EPS was created as an evidence-based tool to assist the lobbying efforts of the proponents for PDHM. The EPS utilized data from national, state, and local sources in concert with clinical data published in peer-reviewed journals. Data utilized from national, state, and local sources included VLBW survival rates, breastfeeding rates, and occurrences of necrotizing enterocolitis. Clinical data utilized in the EPS included randomized control trials, which measured the effects of a human milk nutritional regimen (maternal human milk supplemented with PDHM and HDMF) versus bovine-based nutritional regimens (maternal human milk supplemented with formulas and nutritional supplements *not* derived from human milk) within the VLBW population. Human milk advocates also formalized the inclusion of the NYS AAP Chapter within their advocacy coalition, and referenced the EPS in letters of support on the AAP letterhead (Figure 3).

With the completion of the EPS, human milk advocates had an evidence-based tool to assist with lobbying efforts during state budget negations. In addition to a new budget-centric lobbying strategy, advocates continued to exercise and strengthen a coalition of policy champions within the NYS legislature. This 2-armed strategy (articulating fiscal benefits associated with PDHM and the formation

TABLE 1. Actions Taken by NYS Advocates Placed Within an Advocacy Framework

Audience Members *(Examples)*	Change Construct	Tactic	Examples From NY
Public (*parents of neonates; individuals with an interest in perinatal outcomes; community organizations with an interest in perinatal outcomes*)	Awareness	Public education communicating and messaging	Outreach to the public by utilizing social media
	Will	Advocacy champion building and community organizing	Empowering individuals articulate the case for PDHM reimbursement policies that draws upon personal experience
	Action	Community mobilization	Presence during public forums, communicating with elected officials
Influencers (*clinicians who are stakeholders in perinatal outcomes*)	Awareness	Influencer education	Outreach to clinicians
	Will	Advocacy champion building	Creating the FAS
		Communicating and messaging	Formatting the FAS into a usable advocacy tool
		Collation building	Partnering with the NYS branch of the AAP
	Action	Lobbying	Utilizing the FAS
Decision-makers (*elected officials responsible for Medicaid*)	Awareness	Policymaker education	Outreach to legislation
	Will	Champion development	Identifying decision-makers with a personal connection to the effort
		Public forums	Participation in the conference
	Action	Model legislation	Legislation introduced for debate
		Regulatory feedback	Feedback from the executive branch

Abbreviations: AAP, American Academy of Pediatrics; FAS, Fiscal Advocacy Statement; NYS, New York State; PDHM, pasteurized donor human milk.

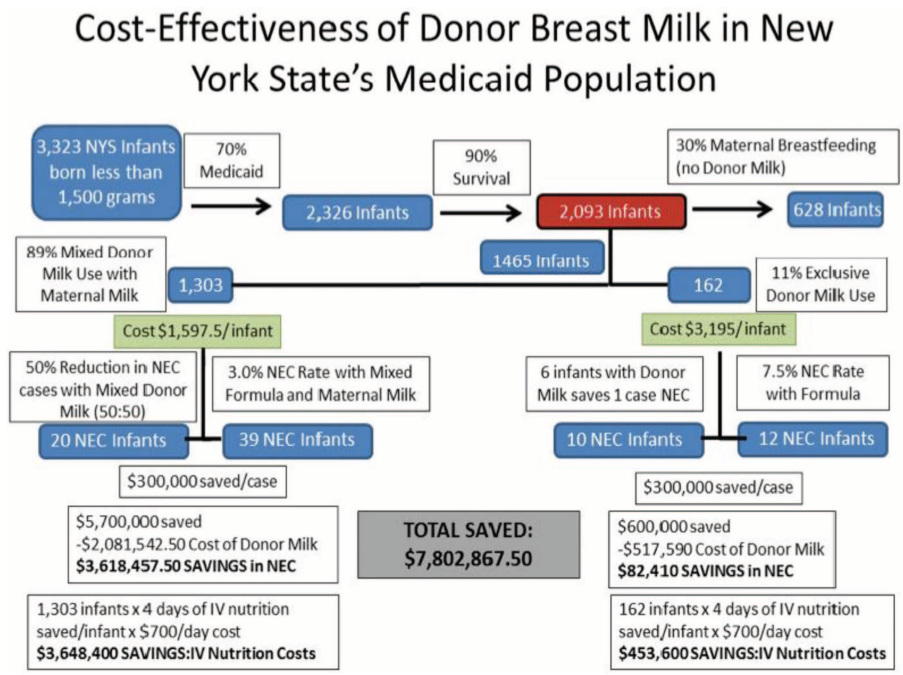
legislative policy champions) resulted in a bipartisan bicameral press conference on March 27, 2017. The Senate Health Committee Chairman, Kemp Hannon (R) was joined by the Assembly Health Committee Chairman, Richard Gottfried (D), along with other legislative policy champions to inform the public on efforts to include PDHM into the 2017-2018 state budget. Elected officials also included a diverse range of stakeholders to articulate a variety of perspectives in support of the proposal. The 2-armed strategy proved successful, and the proposed budget for NYS left the legislative chambers for executive approval. Advocates requested $3 million for PDHM to be provided for VLBW neonates at risk for necrotizing enterocolitis. The budget request resulted in PDHM inclusion for the state budget approved by the legislators. The 2017-2018 state budget was officially signed by Governor Como in April 2017 and on July 1, 2017, PDHM for inpatient use became a covered benefit under the state's Medicaid program in accordance to the enacted state budget.[18]

ADVOCACY FRAMEWORK

The AAP and NANN have recognized that current federal policies fail to secure reimbursement for the provision of PDHM to the VLBW neonate and have encouraged members to advocate for the inclusion of PDHM into their state Medicaid programs.[13,19] Despite the AAP and NANN's emphasis on clinician involvement with policy formation, research has identified a perceived lack of knowledge, skill, and support as barriers that prohibit healthcare professionals from engaging within the policy arena.[20] An advocacy framework can be a useful tool for healthcare professionals seeking to remedy a clinical problem with a policy solution, while also serving as a training aid to provide clinicians with the knowledge and skills necessary to influence the policy arena.

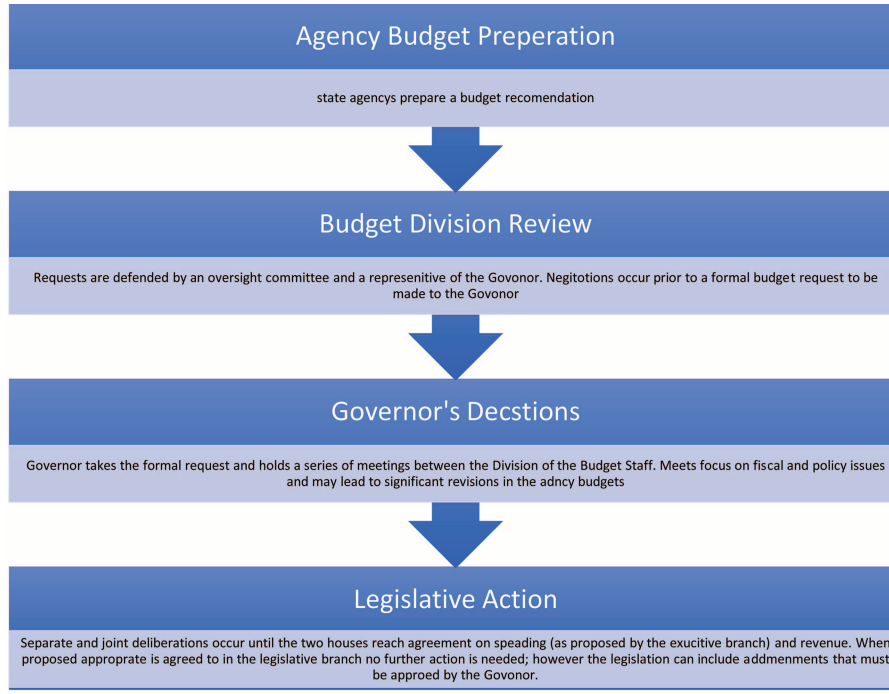
An example of a useful advocacy framework is: *The Advocacy Strategy Framework: A Tool for Articulating an Advocacy Theory of Change*.[1] The ASF emphasizes fluid interplay between the advocate, the policy, and the environment where the strategy will be activated. While the ASF was designed to illustrate "any advocacy strategy," the framework's flexibility and focus on meaningful interim outcomes makes it an ideal framework for advocates engaged in healthcare policy.[1] The ASF requires advocates to formulate 2 strategic constructs that will inform advocacy activities. The first construct is "audiences," and the second construct is "change." Within the ASF, *audiences* are the consumers of the advocacy efforts. Audience includes members of the *public* (general or interested parties);

FIGURE 1



An estimate of payer savings following adoption of PDHM policies. PDHM indicates pasteurized donor human milk.

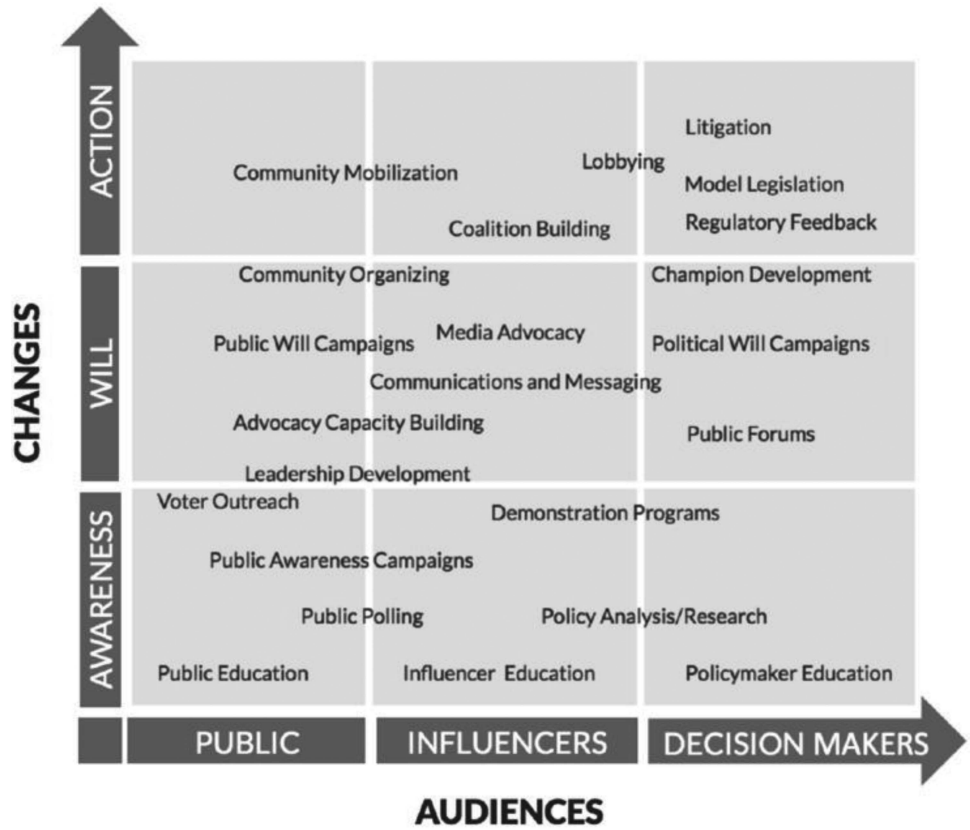
FIGURE 2



[a]State agencies submit a budget request to the Budget Department. The Budget Department then provides oversight to the requests, and finalizes the requests that are presented to the Executive. The Executive is responsible for creating a budget proposal, which the legislature modifies and passes into law. The NYS fiscal year runs from April 1 to March 31. However, the actual funding that is approved in the budgetary process allows agencies to operate for 27 months (9 months prior and 6 months after the fiscal year).

The budgetary process in New York State.[a]

FIGURE 3



A pictorial representation of Coffman & Beer's ASF. ASF indicates Advocacy Strategy Framework.

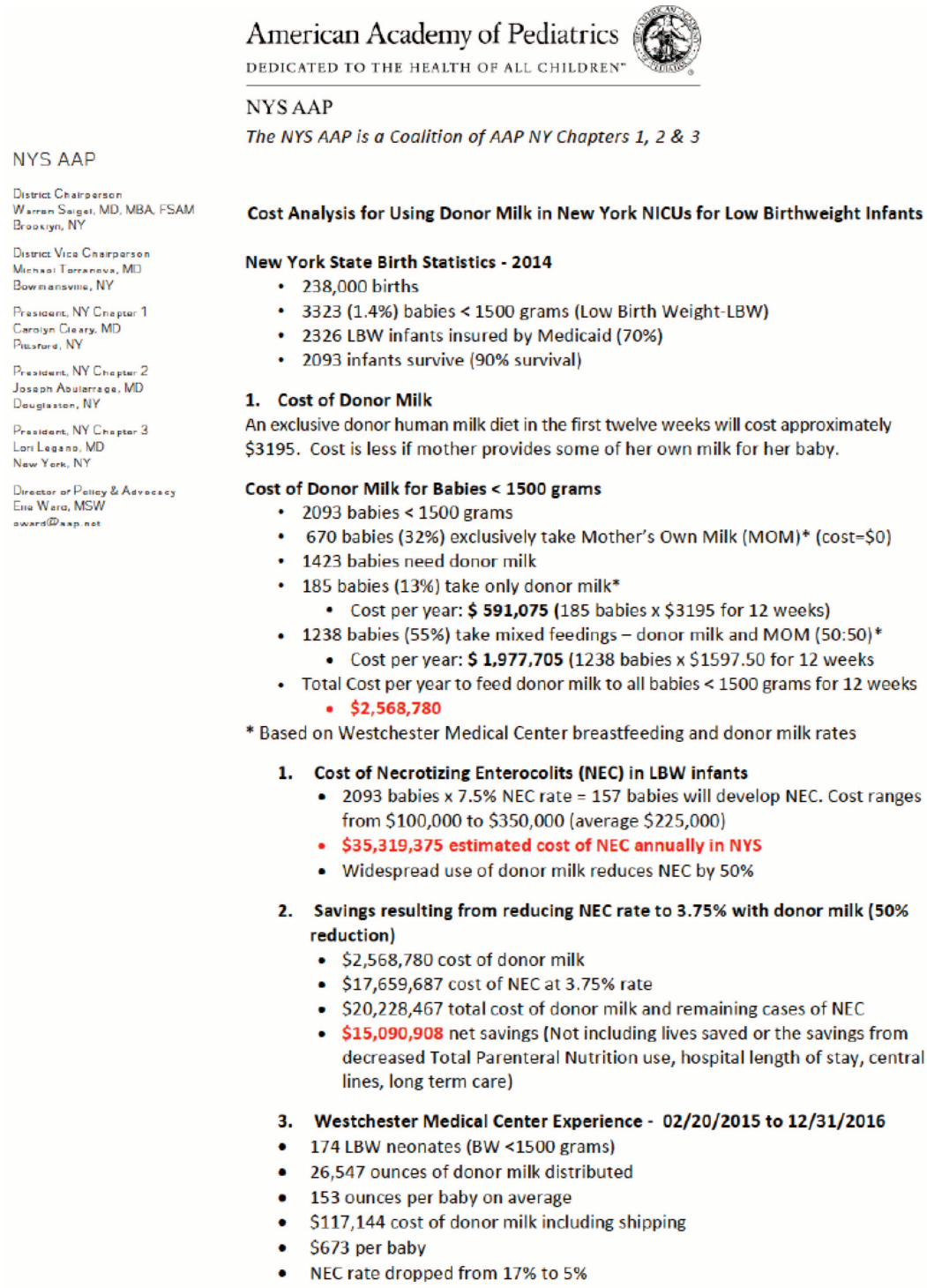
influencers of policy (media, businesses, and collations); and *decision-makers* (individuals or groups responsible for policy adoption). *Change*, the second construct within the ASF, is described as "the result [of] an advocacy effort aim[ed]" at progressing the audience toward a policy goal.[1] Within the ASF, change is conceptualized as a continuum, starting with *awareness*, which grows into *will* and finally results in *action* (Figure 4).

Following the formulation of the 2 strategic constructs (audiences and change), advocacy efforts can be articulated within the framework. The ASF refers to advocacy efforts as *tactics*—purposeful action utilized by the advocate aimed to produce forward momentum within the change construct. Ideally, tactics are designed and presented for a specific audience. Once audience members become engaged with the designated tactic, the advocate can move the audience along the change construct (Table 2). The ASF recognizes that achieving a policy goal is never attributed to a singular tactic; rather, the goal is achieved by utilizing a variety of appropriate tactics. Appropriate tactics result in favorable interim outcomes, which move the policy toward the ultimate goal (Table 3). Because interim outcomes refer to the desired changes in audience members, interim outcomes also have the capability to serve as an assessment tool for the effectiveness of the tactics. Strategies, which acknowledge the importance of interim outcomes, are capable of maintaining forward momentum, even if a policy requires years of advocacy work to be achieved.

Prior to designing an advocacy campaign built upon the ASF, experts emphasize the importance of clearly defining what the advocate is lobbying for and why. Utilizing scientifically derived data as the motivation and foundation for lobbying for a policy change has been described as evidence-based advocacy.[21] Fortifying the ASF with evidence is particularly essential for healthcare professionals.

However, in the arena of policy advocacy, awareness of need is insufficient for championing change. For healthcare professionals to exercise the full value of their knowledge, they must embrace the agency afforded to them. Embracing agency is synonymous to utilizing a voice that "accurately represents the

FIGURE 4



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Cost Analysis for Using Donor Milk in New York NICUs for Low Birthweight Infants

New York State Birth Statistics - 2014

- 238,000 births
- 3323 (1.4%) babies < 1500 grams (Low Birth Weight-LBW)
- 2326 LBW infants insured by Medicaid (70%)
- 2093 infants survive (90% survival)

1. Cost of Donor Milk

An exclusive donor human milk diet in the first twelve weeks will cost approximately $3195. Cost is less if mother provides some of her own milk for her baby.

Cost of Donor Milk for Babies < 1500 grams

- 2093 babies < 1500 grams
- 670 babies (32%) exclusively take Mother's Own Milk (MOM)* (cost=$0)
- 1423 babies need donor milk
- 185 babies (13%) take only donor milk*
  - Cost per year: **$ 591,075** (185 babies x $3195 for 12 weeks)
- 1238 babies (55%) take mixed feedings – donor milk and MOM (50:50)*
  - Cost per year: **$ 1,977,705** (1238 babies x $1597.50 for 12 weeks
- Total Cost per year to feed donor milk to all babies < 1500 grams for 12 weeks
  - **$2,568,780**

* Based on Westchester Medical Center breastfeeding and donor milk rates

1. Cost of Necrotizing Enterocolits (NEC) in LBW infants

- 2093 babies x 7.5% NEC rate = 157 babies will develop NEC. Cost ranges from $100,000 to $350,000 (average $225,000)
- **$35,319,375 estimated cost of NEC annually in NYS**
- Widespread use of donor milk reduces NEC by 50%

2. Savings resulting from reducing NEC rate to 3.75% with donor milk (50% reduction)

- $2,568,780 cost of donor milk
- $17,659,687 cost of NEC at 3.75% rate
- $20,228,467 total cost of donor milk and remaining cases of NEC
- **$15,090,908** net savings (Not including lives saved or the savings from decreased Total Parenteral Nutrition use, hospital length of stay, central lines, long term care)

3. Westchester Medical Center Experience - 02/20/2015 to 12/31/2016

- 174 LBW neonates (BW <1500 grams)
- 26,547 ounces of donor milk distributed
- 153 ounces per baby on average
- $117,144 cost of donor milk including shipping
- $673 per baby
- NEC rate dropped from 17% to 5%

A letter of support from the NYS AAP Advocacy team in support of PDHM reimbursement. NYS AAP indicates New York State American Academy of Pediatrics; PDHM, pasteurized donor human milk.

experience of the" vulnerable, "as well as the experience of those who" provide care to the vulnerable.[22] Policy experts have stated that healthcare professionals become the "voice of reason" within the policy arena capable of articulating change based upon evidence.[21]

Although important, scientifically derived data are not the only form of evidence required for a healthcare

TABLE 2. Definition of Tactics[a]

Term	Definition
Advocacy capacity building	Using financial support, training, coaching, or mentoring to increase the ability of an organizer or group to lead, adapt, manage, and technically implement an advocacy strategy
Champion development	Recruiting high-profile individuals to adopt an issue and publicly advocate for it
Stronger coalitions	Unifying advocacy voices by bringing together individuals, groups, or organizations that agree on a particular issue or goal
Communicating and messaging	Transmitting information to target audiences to influence how an issue is presented, discussed, or perceived
Community mobilization	Creating or building on community-based groundswell of support for an issue or position
Community organizing	Working with people in communities to develop the capacity to advocate on their own behalf
Demonstration programs	Implementing a policy proposal on a small scale in one or several sites to show how it can work
Influencer education	Telling people who are influential in the policy area about an issue or position, and about its broad or impassioned support
Leadership development	Increasing the capacity (through training, coaching, or mentoring) of individuals to lead others to take action in support of an issue or position
Litigation	Using the judicial system to move policy by filing lawsuits, civil actions, and other advocacy tactics
Media advocacy	Pitching the print, broadcast, or electronic media to get visibility for an issue with specific audiences
Model legislation	Developing a specific policy solution (and proposed policy language) for the issue or problem being addressed
Policy analysis and research	Systematically investigating an issue or problem to better define it or identify possible solutions
Policymaker education	Telling policymakers and candidates about an issue or position, and about its broad or impassioned support
Political will campaign	Communications (in-person, media, social media, etc) to increase the willingness of policymakers to act in support of an issue or policy proposal
Public awareness campaigns	Communication with the public that increase recognition that a problem exists or familiarity with a policy proposal
Public education	Telling the public (or segments of the public) about an issue or position, and about its broad or impassioned support
Public forums	Group gathers and discussions that are open to the public and help to make an advocacy case on an issue
Public polling	Surveying the public via phone or online to collect data for use in advocacy messages
Public will campaign	Communications to increase the willingness of a target audience (nonpolicymakers) to act in support of an issue or policy proposal
Regulatory feedback	Providing information about existing policy rules and regulation to policymakers or others who have the author to act on the issue and put change in motion
Voter outreach	Conveying an issue or position to specific groups of voters in advance of an election

[a]*Adapted from Coffman and Beer.*[1]

professional to consider while planning for an evidence-based advocacy campaign. Skilled policy negotiators have noted that advocates are to understand the institutional realities (eg, the process for budgetary allocation) and political realities, which require consideration prior to activating an advocacy campaign.[23] Integrating scientifically derived data along with institutional and political realities is a necessary form of evidence for

TABLE 3. Interim Outcomes[a]

Interim Outcome	Definition
Changed attitudes or beliefs	Target audiences' feelings or affect about an issue or policy proposal
Collaborative action among partners	Individuals or groups coordinating their work and acting together
Increased advocacy capacity	The ability of an organization or coalition to lead, adapt, manage, and technically implement an advocacy strategy
Increased knowledge	Audience recognition that a problem exists or familiarity with a policy proposal
Increased or improved media coverage	Quantity or quality of coverage generated in print, broadcast, or electronic media
Increased political will or support	Willingness of a (nonpolicymaker) target audience to act in support of an issue or policy proposal
Increased public will or support	Willingness of policymakers to act in support of an issue or policy proposal
New political champions	High-profile individuals who adopt an issue and publicly advocate for it
Stronger coalitions	Mutually beneficial relationships with other organizations or individuals who support or participate in an advocacy strategy
Successful mobilization of public voices	Increase in the number of individuals who can be counted on for sustained advocacy or action on an issue

[a]*Adapted from Coffman and Beer.*[1]

healthcare professionals to utilize while creating and implementing an advocacy strategy.

DISCUSSION

Implications for Practice

No singular advocacy action ensures policy adoption, rather policy adoption requires singular focus. Creating a strategy with a central focus, rather than a central action, permits the advocates to adjust their tactics in accordance to audience feedback. Understating how advocates in NYS won Medicaid coverage of PDHM may prove beneficial to healthcare professionals in other states who have chosen to answer the call of the AAP and NANN to advocate for the inclusion of PDHM into their respective state Medicaid programs. Healthcare professionals seeking to design an evidence-based advocacy plan should note the importance of building a solid foundation, which integrates state-specific clinical data alongside government processes and regulations. Integrating evidence within a flexible advocacy strategy is necessary, as healthcare professionals enter the arena of healthcare policy.

Summary of Recommendations for Practice and Research

What we know:	• It is recommended to provide PDHM for neonates when mother's own milk is unavailable. • Neonates who receive PDHM rather than formula are at less risk for developing necrotizing enterocolitis. • Cost barriers to PDHM have been reported. • Advocates at the state level have successfully activated strategies designed to utilize Medicaid reimbursement to ameliorate cost barriers associated with the provision of PDHM.
What needs to be studied:	• What would be the most effective way to advocate for reimbursement policies for PDHM in states with existing cost barriers? • Has the adopted policy in NYS had a clinical impact?
What we can do today:	• The scholarship of advocacy should be embraced by healthcare professionals seeking to influence healthcare policy. • Nurses prepared at the doctoral level are uniquely qualified to integrate evidence within the healthcare policy proposals. • Appropriate metrics should be utilized as a method to evaluate policy implementation.

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Editor Spotlight: Elizabeth Schierholz

Elizabeth has been a neonatal nurse practitioner for 12 years and prior to that practiced as a neonatal nurse for 7 years. Her recent clinical experience includes NNP roles at level 3 and 4 NICUs in San Diego, the greater Denver area, and Philadelphia, and leading the AirLife Neonatal Transport Team in Denver, CO. She is a recent PhD graduate from the Center for Health Outcomes and Policy Research at the University of Pennsylvania's School of Nursing. She currently practices as a neonatal nurse practitioner in the NICU at Children's Hospital Colorado and is a research fellow at the University of Colorado School of Medicine in the Data Science to Patient Values Program. She joined NANN in 2006 and joined the editorial board for Advances in Neonatal Care in 2010. She joined the editorial board during her clinical and leadership time as a Neonatal Transport Team member in order to represent neonatal transport nurses and nurse practitioners and increase attention to issues and care of the neonate during transport. She believes that each of us that care for infants in the NICU have a story to share and publishing in ANC allows us to share that story so that together we can learn from our collective community of neonatal nurses and nurse practitioners.

She loves spending time hiking, running, and exploring Colorado with her white golden retriever, Isla. She is a certified yoga instructor and unwinds on a yoga mat. She can be bribed with French press coffee made from locally roasted beans and loves to frequent farm to table restaurants.