Assessment & Monitoring of Breastfeeding-Related Maternity Care Practices in Intrapartum Care Facilities in the United States and Territories

Reinstatement

OMB Control No. 0920-0743

Expiration Date: 03/31/2025

Supporting Statement A

Program Official/Contact

Benjamin Olivari, MPH
Health Scientist
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
P: 404-498-5840
nkm7@cdc.gov

November 20, 2025

TABLE OF CONTENTS

ATTACHMENTS

3e. Screenshots mPINC 2026 Screening B—Spanish
3f. Screenshots mPINC 2026 Survey—English
3g. Screenshots mPINC 2026 Survey—Spanish
4a. Screening Part A—English
4b. Screening Part A—Spanish
4c. Screening Part B—English
4d. Screening Part B—Spanish
5a. Advance Notification Letter—English
5b. Advance Notification Letter—Spanish
5c. Screener Cover Letter Paper—English
5d. Screener Cover Letter Paper—Spanish
5e. Screener Cover Letter Email—English
5f. Screener Cover Letter Email—Spanish
5g. Survey Cover Letter Email—English
5h. Survey Cover Letter Email—Spanish
5i. CDC mPINC Hospital Survey—English
5j. CDC mPINC Hospital Survey— Spanish
5k. Reminder Email—English
5l. Reminder Email—Spanish
5m. Reminder Telephone Call Script—English
5n. Reminder Telephone Call Script—Spanish
6. Privacy Narrative Form
7a. Human Subjects Document—CDC
7b. Human Subjects Document—Contractor
8. Scoring Algorithm

Goal of the study: To gather information about breastfeeding-related maternity care practices in hospitals providing intrapartum care in the United States and territories, and to analyze trends and changes in these breastfeeding-related maternity practices over time.

Intended use of the resulting data: The resulting data are to provide timely and specific, action-oriented information (hospital-specific mPINC Hospital Reports) to participating hospitals in the United States and territories, and to provide aggregated national, regional, and state data to a wide spectrum of national and state-level stakeholders (mPINC National Results Report, mPINC Regional Results Report, and state-specific mPINC State Reports). Data are used by CDC and state health departments to inform programmatic activities and by hospitals to improve breastfeeding-related maternity care practices and policies. Aggregate national, regional, and state reports are posted on the CDC website for use by the general public, and the data are used to answer questions raised by independent researchers, as requested.

Methods to be used to collect: This is a biennial national census of hospitals routinely providing maternity care in the United States and territories. Data are collected via a secure Web-based survey, which assesses specific domains of breastfeeding-related maternity care.

The subpopulation to be studied: Hospitals in the United States and territories that have provided maternity care in the previous year are eligible to participate. Participation in the survey is completely voluntary, and data provided in the mPINC survey are at the hospital-level, related to the organization's practices and policies across the population receiving maternity care.

How data will be analyzed: The mPINC survey data will be analyzed using standard descriptive statistics (e.g., means, frequencies). Given the census design (i.e., surveying all eligible hospitals), statistical significance testing of differences is not warranted. Trend analyses using data from multiple survey years (beginning in 2018) will be completed as well.

JUSTIFICATION SUMMARY

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) requests approval of a Reinstatement from the Office of Management and Budget (OMB) to conduct 2026 and 2028 follow-up surveys of the national Maternity Practices in Infant Nutrition and Care (mPINC) survey. The Reinstatement request is based on previous experience with administration of a baseline mPINC survey in 2007 and follow-up surveys in 2009, 2011, 2013, 2015, and the administration of revised mPINC surveys in 2018, 2020, 2022, and 2024. OMB approval is requested for three years to conduct the 2026 and 2028 mPINC surveys.

There is substantial evidence on the social (*1*), economic (*2,3*), and health benefits of breastfeeding for both the mother (*4-6*) and infant (*7-9*) as well as for society in general (*10-12*). Breastfeeding is inextricably related to mothers' birth experiences and establishing breastfeeding is time-sensitive, thus experiences in the first hours and days of life while in the hospital significantly influence feeding throughout infancy. A Cochrane review found that institutional changes in maternity care practices effectively increased breastfeeding initiation and duration rates (*13*). Birth facilities that have achieved designation as part of the World Health Organization/UNICEF *Baby-Friendly Hospital Initiative* (BFHI) (*14*) typically experience an increase in breastfeeding rates (*15*).

In order to better understand national maternity practices and the change in these practices over time, CDC developed the national mPINC survey. In 2007, OMB approved an initial ICR, Assessment and Monitoring of Breastfeeding-Related Maternity Care Practices in Intrapartum Care Facilities in the United States and Territories (OMB Control Number 0920-0743, expiration date 7/31/2009) to administer a baseline and two-year follow-up survey to maternity facilities and disseminate findings back to participating facilities. The initial survey in 2007 established baseline measures of breastfeeding supportive maternity practices across the United States and territories and the extent to which these practices varied by state. OMB has approved Revision ICRs since then, most recently to field surveys in 2022 and 2024 (OMB Control Number 0920-0743, expiration date 03/31/2025).

Approval from OMB to consistently administer the mPINC survey every two years has allowed CDC to be fully responsive to maternity facilities and other partners in addressing their need for biennial census data as well as to examine changes in maternity care practices over time. Response rates for past survey years have attained or exceeded 70 percent, reflecting hospitals' strong interest in participating in the mPINC survey and their increasing recognition of the survey's value to their work. Additionally, data from the survey can be used by hospital leadership to improve breastfeeding-related maternity care practices and aggregate data can be used by state public health departments and CDC to inform programmatic activities. Data can be used to answer questions raised by independent researchers, as requested.

Thus, CDC requests OMB approval to conduct planned mPINC surveys in 2026 and 2028,

closely matching the methodology of the prior surveys. Authority for CDC to collect this information is granted by Section 301 of the Public Health Services Act (42 U.S.C. 241) (**Attachment 1** Public Health Service Act [42 U.S.C. 241]).

A2. Purpose and Use of the Information Collection

CDC works to promote optimal maternal and infant health through increased breastfeeding initiation and continuation. Consistent with this mission, and with clear evidence that breastfeeding-related maternity care practices influence breastfeeding initiation and continuation, it is necessary to monitor hospital practices related to breastfeeding across the United States. These critical data are used to effectively inform state and national programs. The initial mPINC survey, conducted in 2007, established baseline measures of the prevalence of specific practices related to breastfeeding in maternity care facilities across the United States and territories, and trends in these practices were analyzed through 2015. In 2018, the mPINC survey items were redesigned and subsequent survey years allow for analysis of trends, identifying new or on-going priority needs and opportunities for collaboration and improvement.

This Reinstatement ICR includes a sample of recent documents illustrating the variety of ways CDC strives to ensure full use of the data provided by participating maternity hospitals and support for partners and other stakeholders' ability to examine their own data to determine how best to improve their maternity care practices related to breastfeeding. **Attachment 3a** (CDC Survey Website) provides an overview of the dedicated website CDC created for hospitals responding to the mPINC survey, state partners, researchers, and other interested stakeholders. The website is updated as needed and provides links to the national, regional, and state reports. The mPINC Hospital Report is the customized information and technical report that CDC creates and provides to every maternity hospital that participates in the mPINC survey. An example of the 2024 Hospital Report is shown in **Attachment 3b** (2024 mPINC Hospital Report). CDC has published studies based on mPINC data in the Morbidity and Mortality Weekly Report (*16-22*), and researchers use the data to gain a better understanding of the relationships between hospital characteristics, maternity-care practices, state level factors, and breastfeeding initiation and continuation rates. In 2020 CDC researchers published a manuscript describing how the mPINC survey has been used for surveillance, quality improvement, and research and its value as a tool for hospitals, organizations, governments, and researchers to improve breastfeeding support provided to mothers and infants (*23*).

To facilitate completion of the questionnaire, hospital respondents will be able to access a page with answers to frequently asked questions, and an example is included in **Attachment 3c**. Screenshots of the 2026 mPINC screening B and survey are in **Attachments 3d/e (English/Spanish)** and **Attachment 3f/g (English/Spanish)**, respectively.

Maternity care practices related to breastfeeding are changing across the United States, and the rate of change in these practices has increased substantially in the past few years (*22*,*24*). The purpose of the reinstated ICR is to continue gathering information about hospitals' maternity care practices related to breastfeeding and analyze trends and changes by continuing the

established pattern for follow-up surveys of all eligible hospitals in 2026 and 2028 in all U.S. states and territories. The design of this survey remains a national census of hospitals routinely providing maternity care, based on careful review of advantages and limitations of various survey designs and extensive input from partners and experts in evaluation of hospital maternity care practices. Several issues highlight the need for a national census of maternity hospitals, including:

- The ability to address variation in breastfeeding rates and maternity care practices at the state and local level is needed: Breastfeeding rates vary widely across U.S. counties and states and highlight the need for state and local-level data. A national census design allows for state-level analysis to address individual local research and policy needs and is especially important for small states and states with few hospitals.
    - Breastfeeding attitudes and beliefs differ significantly by geography (*25,26*) and are likely manifested in maternity care practices related to breastfeeding.
    - Maternity care practices differ by state (*18*), geographic region (*18,19*), and hospital size (*19*).
    - The proportion of hospitals implementing 10 practices that serve as the basis for the WHO/UNICEF Baby-Friendly Hospital Initiative, the Ten Steps to Successful Breastfeeding (Ten Steps), differ by state (*21,24*).
    - State health departments have voiced a need to be able to conduct state- and local-level analyses of the mPINC data to tailor public health breastfeeding interventions to their particular needs and attain public health breastfeeding goals.
- Tailored information is needed: Participating hospitals receive their hospital-specific technical report with their own data compared to aggregate data (national, regional, and hospitals with a similar number of annual births). A national census design allows for hospital-specific data to inform quality improvement efforts. Many hospitals have used their mPINC data to understand how their maternity practices compare with ideal practices, to make changes to improve the quality of care they provide, and to help them work toward earning the Baby-Friendly designation.
- A census is needed to learn about different types of hospitals: Maternity care hospitals in the United States can be quite different from one another in terms of volume of births, levels of neonatal care offered, etc. (*24*). Sampling would limit the ability to stratify the collected data; as stated previously, stratifications by state and other variables like level of neonatal care are important to partners. Therefore, a national census design is needed to capture the spectrum of maternity care provided.

Since implementing the first mPINC survey in 2007, the national census design has enabled CDC to provide timely and specific, action-oriented data to hospitals nationwide as well as to a wide spectrum of state-level stakeholders. This has spurred substantive and valuable changes at the hospital and state level.

- Provision of mPINC data has prompted concrete action from state health departments, statewide breastfeeding coalitions, and other statewide partners that has directly resulted in improved maternity care practices. Examples of state actions include:
    - At least five states use state-specific mPINC data to inform their state's recognition program designed to acknowledge hospitals for implementing a portion or all of the Ten Steps to Successful Breastfeeding (*23*).
    - At least four states have used their mPINC data to inform state-based quality improvement initiatives. An example of state-based quality improvement initiative is Healthy Tennessee Babies which developed a breastfeeding toolkit to help hospitals improve their breastfeeding practices (*23*).
- Participating hospitals have used their mPINC Benchmark Reports to initiate internal improvement processes and prioritize these activities (*23*).

The availability of detailed, hospital-level data on maternity practices has been an invaluable element of pandemic and disaster response. During the 2009 H1N1 pandemic, mPINC data about the prevalence and locations of facilities with separate newborn nurseries and/or rooming-in for mothers and infants during the birth hospitalization informed CDC's development of H1N1 guidance to help U.S. hospitals continue safely caring for mothers and infants. During the early phases of the global COVID-19 pandemic, routine maternity care practices (e.g., maternal–infant rooming-in) were disrupted over concerns of transmission of the coronavirus from an infected mother to her newborn. A supplemental mPINC questionnaire was administered to the hospitals which completed the 2018 mPINC survey to understand how infection prevention and control practices associated with the coronavirus pandemic may have impacted breastfeeding supportive maternity care (Paperwork Reduction Act waiver approved 6/24/2020 under Section 319 of the Public Health Service Act [42 U.S.C. 247d]). The CDC published the findings of the survey in the *Morbidity and Mortality Weekly Report* (*21*).

The 2026 and 2028 surveys will allow examination of changes in breastfeeding supportive maternity practices over time. Specifically, goals of the mPINC survey are to:

- Examine point-in-time variation in breastfeeding-related maternity care practices across 50 states and territories and by other hospital characteristics such as size (e.g., number of annual births).
- Examine changes over time in practices reported by hospitals every two years, using 2018 as the baseline survey.
- Provide feedback to CDC, state health departments, and hospitals to inform programs and practices.

Without this information, CDC and state health departments are unable to know the extent to which hospitals implement specific breastfeeding-related maternity care practices that have been identified as supportive based on extensive empiric evidence.

CDC will use information from the mPINC surveys to identify, document, and share information related to incremental changes in practices and care processes over time at the hospital, state, and national levels. Data are also used by researchers to better understand the relationships between hospital characteristics, maternity-care practices, and state level factors.

The planned methodology for the 2026 and 2028 mPINC survey will closely match that of the previously administered mPINC surveys. The planned methodology includes contacting all hospitals in the United States and territories that provide maternity care services to invite participation in the mPINC survey, which includes conducting a brief screening interview by telephone or email to confirm each hospital's contact information (see **Attachment 4a/4b**, Screening Part A—English/Spanish) and eligibility (**Attachment 4c/d,** Screening Part B—English/Spanish). Supporting materials to provide an overview of the project and invite the hospital's participation include an advance notification letter (**Attachment 5a/b**, Advance Notification Letter—English/Spanish), a screener cover letter (**Attachment 5c/d**, Screener Cover Letter Paper—English/Spanish; **Attachment 5e/f,** Screener Cover Letter Email—English/Spanish), and a survey cover letter once screened in (**Attachment 5g/h**, Survey Cover Letter Email—English/Spanish). The purpose of the survey and information about the protection of the privacy and confidentiality of information is included in the mPINC survey instrument (**Attachment 5i/j** CDC mPINC Hospital Survey—English/Spanish) and in follow up contacts (**Attachment 5k/l** Reminder Email—English/Spanish; **Attachment 5m/n,** Reminder Telephone Call Script—English/Spanish).

Changes described in this Reinstatement include:

- Deployment of 2026 and 2028 mPINC hospital surveys.
- Use of an updated American Hospital Association (AHA) database to identify hospitals not currently on the list for recruitment.
- Revision of 2026 and 2028 survey items to streamline the survey and ensure survey questions are consistent with implementation guidance from professional and public health organizations. Revisions include removal of hospital level race and ethnicity and delayed cord clamping questions and addition of questions about vitamin K administration and prenatal breastfeeding education.
- Initial contact of hospitals with recent survey participation will happen via email (as opposed to telephone); all hospitals will complete survey screening online (as opposed to via telephone).
- Within the REDCap system, respondents will be able to select a language for completion of the survey instruments (English or Spanish).
- Distribution of hospital reports to multiple people within a hospital (previously, reports were sent to one person per hospital).

A3. Use of Improved Information Technology and Burden Reduction

As part of CDC's broader ongoing data modernization efforts, DNPAO will utilize updated systems to screen hospitals, administer the survey, process and analyze the data, and report results starting with the 2026 mPINC data collection cycle. These efforts include the use of the CDC-hosted Research Electronic Data Capture software (REDCap®) for data collection coupled with the contractor's hospital contact system (HCS) for screening and recruiting hospitals. For the 2026 and 2028 surveys, all screening will be completed using these web-based systems. The contractor (currently Abt Global) will send hospitals that participated in the previous cycle an email invitation to complete the screening instrument online. For those hospitals identified as potential respondents to the mPINC survey that did not participate in the previous cycle or for whom business contact information is no longer valid, the contractor will use their local data collection platform as the mPINC HCS. They will use this system to contact hospitals by phone in order to collect their business contact information needed to initiate screening. The purpose of the screening is to: 1) verify that the hospital provided maternity care in the previous calendar year, 2) determine the most appropriate contact person(s) for that hospital, and 3) obtain business contact information about the contact person identified. Use of an online screening instrument and the contractor's HCS may reduce the burden to the contact person by reducing the amount of time necessary to complete the screening and capturing the data more accurately.

The hospital will complete the survey using a web-based system from which each hospital's data are electronically submitted via a secure server. Use of the web-based system will minimize burden and improve data quality and efficiency by obtaining data entered directly by the hospital into the system. This web-based system is designed to support an ongoing infrastructure for subsequent data collection cycles.

A4. Efforts to Identify Duplication and Use of Similar Information

The CDC mPINC survey is the only national source of information that provides hospital-specific data for the vast majority of hospitals in each state to assess and monitor breastfeeding-related maternity care practices across the United States and territories. This type of information is not captured via birth certificate data or any other federal survey capturing hospital practices or women's experiences during the intrapartum period. To our knowledge, no other existing national system captures this type of hospital-level practice information in U.S. maternity care settings.

Since 2003, CDC has convened several expert panels and sought to identify other data sources. Experts agreed that no similar data collection system existed, while the need for such data is high. In the time since fielding the 2007 survey, hospitals, state health departments, researchers, and other partners have come to identify CDC as their expected source for information on breastfeeding-related maternity care practices in hospitals.

A5. Impact on Small Businesses or Other Small Entities

Since the survey population includes all hospitals in the United States and territories, it may include some small businesses. Extensive effort has been made to minimize the burden of the survey on small businesses. In designing the survey instrument, the number of questions has been held to the minimum necessary for addressing the objectives of the survey. Skip patterns built into the survey allow hospitals to answer only the sections that apply to the types of care they provide, thereby reducing the burden on hospitals. For example, questions on surgical births (Cesarean sections) and neonatal intensive care are skipped by those that do not perform surgical births or provide neonatal intensive care. Many smaller hospitals may fall into this category, thus these hospitals will have less response burden and fewer items to which they need to respond. Additionally, the use of a secure, online screening instrument and web-based survey reduces the burden on participating small businesses.

According to the U.S. Small Business Administration, a medical and surgical hospital is considered a small business if they have less than $47.0 million in receipts annually (*27*). For the 2026 and 2028 survey administration, we estimate that the proportion of hospitals included in this survey that meet the criteria of being a small business will be nominal.

A6. Consequences of Collecting the Information Less Frequently

The initial survey in 2007 was the first of an ongoing, systematic data collection for the assessment of breastfeeding-related maternity care practices. Administration of the 2009, 2011, 2013, and 2015 surveys provided continued assessments of practices nationwide and allowed opportunities to examine changes in practices over time. The mPINC survey was revised in 2018, and since 2022, subsequent data have allowed for analysis of trends so that hospitals, partners, and stakeholders can identify priority needs and opportunities for collaboration and improvement. Monitoring hospital practices every two years continues to be important to assess the impact of unprecedented events (e.g., COVID-19 pandemic, 2022 nationwide infant formula shortage (*21*,*28*)) on maternity care, breastfeeding rates, and infant health. These data will help CDC, partners, and stakeholders understand what types of technical assistance and resources may be needed to help hospitals continue to support breastfeeding in the context of pandemics or future emergencies.

A further and vitally important role of administering and reporting on surveys is to maintain relationships and expected services among our partners. The positive response rate to the mPINC survey suggests that hospitals find value in participating. One benefit of participation may be receiving a individualized report that compares their data to peer hospitals. State-level partners also report that receiving their state's data compared to hospitals across the nation is useful. Biennial data from this survey have now become important elements of activities and initiatives by national and community partner organizations and clinical and public health stakeholders. These partners and stakeholders now rely on mPINC data because they are predictable, reliable, and well-suited to unifying communication and analysis of activities across multiple audiences.

Changes in maternity care practices related to breastfeeding evolve over time. While our partners would prefer annual assessment of hospitals' practices, CDC has thus far determined biennial assessment to be adequate to characterize the major issues of concern without excessive loss of point-in-time data and to minimize the burden as much as possible on survey respondent hospitals. Assessment less frequently than every two years would not be able to fully capture practice changes as they occur in real time, making public health program planning more difficult. Recent events like the COVID-19 pandemic and the 2022 nationwide infant formula shortage demonstrate how rapidly maternity care practices and the infant feeding environment can change.

The goal of this work is not only to continue biennial assessment of hospital practices related to breastfeeding as part of CDC's national system for monitoring, but to fully utilize the data gathered to date and provide meaningful results to participating hospitals, CDC, states, and other stakeholders.

There are no legal obstacles to reduce the burden.

A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This survey complies fully with the guidelines of 5 CFR 1320.5. No exceptions to the guidelines are requested.

A8. Comments in Response to Federal Register Notice and Efforts to Consult Outside the Agency

Part A: PUBLIC NOTICE

A 60-day Federal Register Notice was published in the *Federal Register* on June 16, 2025, Docket No. CDC-2025-0021, vol. 90, No. 114, pp. 25280-25281 (**Attachment 2a**, 60-day Federal Register Notice). CDC received five substantive comments. The public comments and the CDC response is provided in **Attachment 2b,** Summary Public Comments.

Part B. CONSULTATION

CDC benefits from ongoing exchange, dialogue, and coordination among all federal agencies whose work involves infant feeding. In response to the Surgeon General's 2011 *Call to Action to Support Breastfeeding,* the Federal Interagency Breastfeeding Workgroup was established and holds regular meetings to discuss and collaborate on issues related to breastfeeding support. Discussion of the mPINC survey is a consistent priority to meet shared and related information needs across multiple federal agencies. Relevant staff from the following federal departments are members: U.S. Department of Agriculture, U.S. Department of Defense, U.S. Department of Health and Human Services, and U.S. Department of Labor.

CDC has a history of consulting with non-CDC experts on breastfeeding, surveillance, and public health program needs related to breastfeeding supportive maternity care practices including

- 2003: CDC brought together diverse experts to provide input on the survey design. Based on their input, CDC determined a census of maternity care facilities was needed.
- 2014–2018: Non-CDC experts provided feedback on the availability of data, frequency of data collection, clarity of instructions, reporting and reporting formats, and data elements to conduct a major revision to mPINC survey between 2015 and 2018 survey administrations.
- 2018–2024: CDC and non-CDC experts provided feedback on selected data elements during minor questionnaire and methodology revisions.

Table A1 lists the non-CDC experts consulted about the mPINC survey since 2022.

Date Consulted	**Name**	**Title**	**Affiliation**	**Phone**	**E-mail**	**Role**
OUTSIDE CONSULTANTS						
2022	Jason Brinkley	Data Scientist Principal	Abt Atlanta, GA	919-294-7745	Jason_Brinkley@abtassoc.com	Subject Matter Expert: Validation of the survey
2023	Stephanie Chester	Principal Public Health	MITRE McLean, Virginia	703-983-0239	schester@mitre.org	Subject Matter Expert: Modernizing data systen
2023	Daniel Chudnov	Lead Data Scientist	MITRE McLean, Virginia	703-983-9044	dlchudnov@mitre.org	Subject Matter Expert: Modernizing data systen
2023	Kelsi Gardner	Human-Centered Design Engineer	MITRE McLean, Virginia		kgardner@mitre.org	Subject Matter Expert: Use of reports by hospitals and state partners
2023	Ida Sahlu Nagler	Senior Epidemiologist	MITRE McLean, Virginia	703-983-0483	isahlu@mitre.org	Subject Matter Expert: Modernizing data systen
2023	Thomas Strassner	System Architect, Software Engineer	MITRE McLean, Virginia		tstrassner@mitre.org	Subject Matter Expert: Modernizing data systen
2023	Paul Ursino	Data Scientist	MITRE McLean, Virginia		pursino@mitre.org	Subject Matter Expert: Modernizing data systen
2024	Eileen FitzPatrick	Executive Director	Baby-Friendly USA, Inc. Albany, NY	518-621-7982	efitzpatrick@babyfriendlyusa.org	Subject Matter Expert: Survey items related to the Ten Steps to Successful Breastfeeding
ACADEMIC INSTITUTIONS						
2024	Lisa Stellwagen	Medical Director	University of California Health Milk Bank San Diego, CA		lstellwagen@health.ucsd.edu	Subject Matter Expert: Survey items related to donor human milk
2024	Alison Wolf	Executive Director	University of California Health Milk Bank San Diego, CA		akwolf@health.ucsd.edu	Subject Matter Expert: Survey items related to donor human milk

2024	Diane Spatz	Helen M. Shearer Professor of Nutrition	University of Pennsylvania School of Nursing	215-898-8100	spatz@nursing.upenn.edu	Subject Matter Expert: Survey items related to in-hospital breastfeeding

Table A1. External Consultations

Table A2 lists the CDC experts consulted about the mPINC survey since 2022.

Table A2. Consultations within CDC

Date Consulted	**Name**	**Title**	**Affiliation**	**Phone**	**E-mail**	**Role**
2024	Shin Kim	Lead Epidemiologist	Division of Birth Defects and Infant Disorders	770-488-6281	dgx5@cdc.gov	Subject Matter Expert: Survey items related to Neonatal Abstinence Syndrome (NAS)
2024	Laura Pabst	Lead Health Scientist	Division of Birth Defects and Infant Disorders	404-639-6082	lnw9@cdc.gov	Subject Matter Expert: Survey items related to Neonatal Abstinence Syndrome (NAS)
2024	Shawn Thomas	Epidemic Intelligence Service Officer	Division of Birth Defects and Infant Disorders		urg6@cdc.gov	Subject Matter Expert: NAS survey items
2024	Carrie Shapiro-Mendoza	Branch Chief	Division of Reproductive Health	770-488-6263	ayn9@cdc.gov	Subject Matter Expert: Infant safe sleep survey items
2024	Sharyn Parks Brown	Senior Scientist	Division of Reproductive Health	770-488-4058	svp2@cdc.gov	Subject Matter Expert: Infant safe sleep survey items
2025	Maria Elena Jefferds	Epidemiologist	Division of Nutrition, Physical Activity, and Obesity	770-488-5862	mnj5@cdc.gov	Subject Matter Expert: Vitamin K survey items
2025	Alyson Goodman	Medical Officer	Division of Nutrition, Physical Activity, and Obesity	404-498-6269	iym3@cdc.gov	Subject Matter Expert: Vitamin K survey items
2025	Suzanne Gilboa	Division Director	Division of Birth Defects and Infant Disorders	404-498-4425	suz0@cdc.gov	Subject Matter Expert: Vitamin K survey items

A9. Explanation of Any Payment or Gift to Respondents

No monetary or non-monetary incentives will be provided.

A10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

This submission has been reviewed by the NCCDPHP Information System Security Officer and the CDC Privacy Officer. The Privacy Narrative Form (**Attachment 6**) is attached. The Privacy Act does not apply.

Because the mPINC survey is administered to hospitals and not to individuals, all data provided in the mPINC survey are at the hospital level, related to organizational practices across the entire population under that hospital's care. The items of information to be collected are hospital size and other characteristics; maternity care and infant feeding practices; the nature of breastfeeding education and support the health care facility makes available to mothers; training of maternity staff; and prevalence of specific hospital policies that have been identified as influential for breastfeeding and maternal and infant health. No information on individual patients is collected.

Through the screening process, a contact person at each participating hospital is identified as the survey recipient. Minimal information in identifiable form (IIF) is collected from this contact person and is used as a means to invite participation, deliver instructions and a unique link for completing the survey using the web-based system, distribute the Hospital Report, and inform the contact person about survey related opportunities. The IIF collected is business contact information including name, position, telephone number, official hospital e-mail address, and mailing address. CDC does not collect any information that allows identification of the individual(s) who completes the web-based survey for a given hospital. Although this often is the 'point person,' this is not necessarily the case. As such, the IIF for each hospital's contact person has no analytic or empiric value in connection to that hospital's data. It is therefore maintained securely for routing purposes only and is kept separate from all analytic files.

The contractor screens eligible hospitals and gathers hospitals' data on behalf of CDC. Care is taken to treat the survey data in a secure manner. Contractor staff receive training in data management and security.

The contractor assigns a unique study identifier code to each respondent hospital. Although the web link to the survey is sent to the contact person at that hospital, the completed survey (electronic data files containing the survey response data) is identified only by the study identifier code and does not include any names or IIF. Hospitals are informed that data may be

used for additional approved research purposes under approved data use agreements with CDC.

The contractor manages all survey recruitment efforts through their local Hospital Contact System (HCS), which they use to send survey invitations and reminders via email and conduct follow-up calls to non-responding hospitals to identify the participant to complete the survey. The contractor's HCS is independently assessed at the FISMA Moderate level and is built on Amazon Web Services (AWS) using only AWS components that are compliant with Federal Risk and Authorization Management Program (FedRAMP) requirements. The contractor sends hospitals a unique link to complete the survey in CDC's REDCap, where survey data are stored, processed and analyzed. Data files containing the database of hospitals and hospital contact logs are transferred to CDC using secure file exchange and are password protected. Access to the project files at the contractor site is limited to authorized project staff.

There is no website content directed at children under 13 years of age.

No IIF or hospital names are ever used in any published reports of this survey. CDC presents all survey reports and findings in aggregate so individual hospitals' responses cannot be identified. Data are treated in a secure manner, unless disclosure is otherwise required by law.

A11. Institutional Review Board (IRB) and Justification for Sensitive Questions

CDC and Abt have both determined that this project does not constitute research with human subjects (**Attachment 7a, Attachment 7b**).

No questions regarding topics that are typically considered to be of a sensitive nature, or any other topic of a sensitive nature will be asked in this survey. Topics typically considered to be of a sensitive nature include personal sexual practices, alcohol or drug use, religious beliefs or affiliations, immigration status, and employment history.

We do not anticipate that the respondent hospitals will consider any of the questions about hospital practices to be sensitive; however, if they do, all questions on the survey are optional and they can elect not to answer. The processes described above have been implemented as further safeguards to survey recipient privacy.

A12. Estimates of Annualized Burden Hours and Costs

Estimates of Annualized Burden Hours

Respondents are hospitals that offer maternity care. We base all estimates on numbers of hospitals contacted, burden hours, and costs on our data and experience fielding the mPINC survey in 2024. Table A12A summarizes estimated annualized burden hours and costs for two cycles of data collection in 2026 and 2028, annualized over the three years of the current clearance request.

Potential respondent hospitals will be screened to confirm eligibility (**Attachment 4a/4b**, Screening Part A—English/Spanish and **Attachment 4c/4d**, Screening Part B—English/Spanish). There were 2,836 hospitals on the 2024 facility list. While contact information for most hospitals will be taken from past surveys, we estimate that approximately

30% (851) of the 2,836 hospitals will participate in an initial screening lasting three minutes or less in order to identify a contact person knowledgeable about maternity care practices (**Attachment 4a/4b**, Screening Part A—English/Spanish). Of these 2,836 hospitals, an estimated 93.7% (2,657) will complete the screening process (based on the proportion of completed screenings in 2024) (additional burden of two minutes per respondent; **Attachment 4c/4d**, Screening Part B—English/Spanish). We then anticipate that 77.9% (2,070) of the 2,657 that completed the screening process will respond to the survey itself (**Attachment 5i/j**, CDC mPINC Hospital Survey—English/Spanish). This estimate is based on the 2024 survey response rate of 77.9%. The burden for each mPINC Hospital Survey is 30 minutes.

To annualize these estimates, the number of hospitals that respond for one cycle were multiplied by the two cycles and divided by the three years of OMB coverage [e.g., (2,836 respondents for Part A * 2 cycles)/3 years of OMB coverage)]. The 851 responding to Screening Part A was annualized to 567; the 2,657 responding to Screening Part B was annualized to 1,771; and the 2,070 completing the survey was annualized to 1,380. Annualized numbers were rounded to the nearest whole number. The total estimated annualized burden hours are 777, as summarized below in Table A12A.

Table A12A: Estimated Annualized Burden (Hours)

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Maternity Hospitals	Screening Part A	567	1	3/60	28
Maternity Hospitals	Screening Part B	1,771	1	2/60	59
Maternity Hospitals	mPINC Hospital Survey	1,380	1	30/60	690
Total					777

Estimated Annualized Burden Costs

We estimate the total annualized cost to respondents to be $34,882.56, as summarized below in Table A12B. We anticipate that staff responding to the Screening and returning the Hospital Survey on behalf of their hospital will be Registered Nurses or equivalent general medical and surgical hospital employees. The U. S. Department of Labor, Bureau of Labor Statistics estimates their average hourly wage rate at $47.32 (*29*).

Table A12B: Estimated Annualized Burden Costs

Type of	Form Name	No. of	Total Annual	Average	Total

Respondents		Respondents	Burden Hours	Hourly Wage Rate	Respondent Labor Cost
Registered Nurses	Screening Part A	567	28	$47.32	$1,324.96
Registered Nurses	Screening Part B	1,771	59	$47.32	$2,791.88
Registered Nurses	mPINC Hospital Survey	1,380	690	$47.32	$32,650.80
Total					$36,767.64

A13. Estimate of Other Total Annual Cost Burden to Respondents and Record Keepers

The data collection entails no other costs to respondents and record keepers.

A14. Annualized Cost to the Federal Government

The surveys were designed in collaboration with Abt Global. Abt Global is contracted (Contract No. 47QRAD20DU131; Order No. 75D30124F19970) to implement the 2026 mPINC survey and may implement the 2028 mPINC survey, dependent upon the execution of an Option Period – Optional Task. The execution of an Option Period – Optional Task is at the discretion of the Government when exercised through a modification with review and approval by CDC.

Each cycle of data collection and analysis takes approximately eighteen months to complete (see Estimated Timeline – Table A16) with reporting occurring in the last three to six months following data collection. The estimated annualized cost to the government to conduct two biennial surveys including administration and reporting is $685,783.14. The annualized CDC costs are estimated as follows: Salary $158,931.00. The cost of the Abt Global contract for the 2026 survey is $877,604.70 and for the 2028 survey is $702,951.71 (a decrease as systems will have already been built and put in place in 2026). Contracts cover the cost of survey administration, data collection, coding and data cleaning, and reporting.

Table A14A. Estimated Annualized Federal Government Cost Distribution

	Annualized Cost
Federal Staff	$158,931.00
GS-13 or equivalent at 50% FTE, $44,260.00	
GS-13 or equivalent at 50% FTE, $44,260.00	
GS-13 or equivalent at 50% FTE, $44,260.00	
GS-14 or equivalent(s) at 25% FTE, $26,151.00	

Contractor Cost	$526,852.14
Total Cost to the Federal Government	$685,783.14

A15. Explanation for Program Changes or Adjustments

This Reinstatement ICR reflects an increase in the survey response rate (78%, mPINC 2024 vs. 70%, mPINC 2018 survey) but a reduction in the time to complete Screening Part B (from 4 minutes to 2 minutes) and the number of hospitals completing Screening Part A (projected 30% vs. 100%), resulting in an overall annualized decrease of 28 burden hours for a total of 777 burden hours.

The most recent OMB approval covers two cycles of data collection in 2022 and 2024 (OMB No. 0920-0743, exp. 3/31/2025). In this Reinstatement ICR, we request OMB approval to support two cycles of data collection in 2026 and 2028. There is no change to the estimated burden per response for survey completion (30 minutes).

The planned methodology for the 2026 and 2028 surveys closely matches that of the previously administered mPINC surveys. There is no change to the estimated burden per response for participating in the mPINC survey (30 minutes). There are minor changes to survey content for the 2026 and 2028 surveys based on experience in fielding the 2022 and 2024 surveys. The revised CDC mPINC hospital survey instrument for 2026 and 2028 is in **Attachment 5i/j**.

Changes described in this Reinstatement include:

- Deployment of 2026 and 2028 mPINC hospital surveys.
- Use of an updated American Hospital Association (AHA) database to identify hospitals not currently on the list for recruitment.
- Revision of 2026 and 2028 survey items to streamline the survey and ensure survey questions are consistent with implementation guidance from professional and public health organizations. Revisions include removal of hospital level race and ethnicity and delayed cord clamping questions and addition of questions about vitamin K administration and prenatal breastfeeding education.
- Initial contact of hospitals with recent survey participation will happen via email (as opposed to telephone); all hospitals will complete survey screening online (as opposed to via telephone).
- Within the REDCap system, respondents will be able to select a language for completion of the survey instruments (English or Spanish).
- Distribution of hospital reports to multiple people within a hospital (previously, reports were sent to one person per hospital).

A16. Plans for Tabulation and Publication and Project Time Schedule

Table A16. Estimated Time Schedule for Project Activities

Activity	Timeline
2026 Survey	
Identify hospitals to be surveyed	1 month after OMB approval
Conduct screening outreach (email/phone)	2 months after OMB approval
Conduct survey	2-8 months after OMB approval
Data coding, entry, and cleaning	9 months after OMB approval
Data analysis	10 months after OMB approval
Create and distribute hospital reports	10-12 months after OMB approval
2028 Survey	
Identify hospitals to be surveyed	24 months after OMB approval
Conduct screening outreach (email/phone)	26 months after OMB approval
Conduct survey	26-32 months after OMB approval
Data coding, entry, and cleaning	33 months after OMB approval
Data analysis	34 months after OMB approval
Create and distribute hospital reports	34-36 months after OMB approval

As with prior surveys, upon completion of the data analysis, a separate technical report is prepared for each hospital (**Attachment 3b**), each state (State mPINC Reports), regions (Regional mPINC Report), and the nation (National mPINC Report). The results of the survey are also disseminated to stakeholders through the CDC mPINC website, publication of manuscripts in peer-reviewed journals, conference presentations, webinars, and research briefs.

For most analyses, the unit of analysis will be the hospital. The survey data may be analyzed using standard univariate and bivariate descriptive statistics (e.g., means, frequencies) and multivariate analyses. Trend analyses utilizing data from multiple surveys will be completed as well. The following types of variables are examples of data that will be examined, including hospital practices (e.g., routine newborn procedures), policies, and characteristics (e.g., number of annual births).

The algorithm used for scoring mPINC surveys is provided in **Attachment 8**. Indicator variables will be constructed using one or more survey questions to reflect the extent to which hospitals have policies and practices associated with breastfeeding initiation and continuation. For each indicator variable, we will create a score from 0 to 100, with higher scores reflecting more consistent application or more positive policies and practices. Indicator variables are then combined and averaged to create broader domain scores, which also range from 0 to 100. The mPINC scoring algorithm has remained the same since 2018 and the domains included in the scoring are: 1) Immediate postpartum care, 2) Rooming-in, 3) Feeding practices, 4) Feeding

education, 5) Discharge support, and 6) Institutional management.

Each hospital participating in the survey receives an individualized report containing its scores on indicators and domains, compared to hospitals of a similar size and those in the same region and across the nation. An example of the 2026 Hospital Report is provided in **Attachment 3b**.

Univariate distributions and summary statistics are generated to describe hospital characteristics across the United States. Univariate analyses are conducted on items in the remaining sections of the questionnaire in order to describe hospital maternity care practices and policies related to breastfeeding.

Bivariate analyses are conducted to: 1) obtain hospital subgroup percentages or means on survey measures, 2) test for subgroup differences on those measures, and 3) test for associations between hospital characteristics and practice and policy measures. In planning and conducting these analyses, hospital characteristics (e.g., number of births, hospital type) can be referred to as independent variables. Practice (e.g., 24-hour rooming-in, medical record documentation of intention to breastfeed), and policy (e.g., having a formal written policy or policies on breastfeeding) can be referred to as dependent variables.

Beginning in 2022, univariate and bivariate analyses were carried out to evaluate changes in hospital practices over time using data from the mPINC 2018 survey as a baseline (*24*). For hospitals that participate in multiple survey cycles, a comparison of scores and/or domain scores given in each year of participation can be done using a consistent hospital identification number to show where there have been improvements. National and state reports can also be used to examine trends.

A17. Reason(s) Display of OMB Expiration Date is Inappropriate

No exemption from display of expiration date is requested.

A18. Exceptions to Certification for Paperwork Reduction Act Submissions

No exceptions to certification are sought.

REFERENCES

1. Kuzela AL, Stifter CA, Worobey J. Breastfeeding and mother-infant interactions. Journal of Reproductive and Infant Psychology. 1990;8(3):185-94.
2. Cohen R, Mrtek MB, Mrtek RG. Comparison of maternal absenteeism and infant illness rates among breast-feeding and formula-feeding women in two corporations. Am J Health Promot. 1995 Nov-Dec;10(2):148-53.
3. Montgomery DL, Splett PL. Economic benefit of breast-feeding infants enrolled in WIC. J Am Diet Assoc. 1997 Apr;97(4):379-85.
4. Binns C, Lee M, Low WY. The long-term public health benefits of breastfeeding. Asia Pac J Public Health. 2016 Jan;28(1):7-14.
5. Labbok MH. Health sequelae of breastfeeding for the mother. Clin Perinatol. 1999 Jun;26(2):491-503.
6. Swinburn BA, Caterson I, Seidell JC, et al. Diet, nutrition and the prevention of excess weight gain and obesity. Public Health Nutr. 2004 Feb;7(1A):123-46.
7. Chen A, Rogan WJ. Breastfeeding and the risk of postneonatal death in the United States. Pediatrics. 2004 May;113(5):e435-9.
8. Howie PW, Forsyth JS, Ogston SA, et al. Protective effect of breast feeding against infection. BMJ. 1990 Jan 6;300(6716):11-6.
9. Patnode CD, Henrikson NB, Webber EM, et al. Breastfeeding and health outcomes for infants and children: A systematic review. Pediatrics. 2025 Jul 1;156(1).
10. Lowe NK. The Surgeon General's call to action to support breastfeeding. J Obstet Gynecol Neonatal Nurs. 2011 Jul-Aug;40(4):387-9.
11. Office of Women's Health. HHS Blueprint for Action on Breastfeeding. In: US Department of Health and Human Services, editor. Washington, D.C. 2000.
12. Victora CG, Bahl R, Barros AJ, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet. 2016 Jan 30;387(10017):475-90.
13. Fairbank L, O'Meara S, Renfrew MJ, et al. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. Health Technol Assess. 2000;4(25):1-171.
14. World Health Organization/UNICEF. Protecting, Promoting, and Supporting Breastfeeding: The Special Role of Maternity Services. 1989 [cited April 24, 2017]; Available from: http://www.who.int/nutrition/publications/infantfeeding/9241561300/en/.
15. Philipp BL, Merewood A, Miller LW, et al. Baby-friendly hospital initiative improves breastfeeding initiation rates in a US hospital setting. Pediatrics. 2001 Sep;108(3):677-81.
16. Boundy EO, Anstey EH, Nelson JM. Donor human milk use in advanced neonatal care units - United States, 2020. MMWR Morb Mortal Wkly Rep. 2022 Aug 19;71(33):1037-41.
17. Boundy EO, Perrine CG, Nelson JM, et al. Disparities in hospital-reported breast milk use in neonatal intensive care units - United States, 2015. MMWR Morb Mortal Wkly Rep. 2017 Dec 8;66(48):1313-7.
18. Centers for Disease Control and Prevention. Breastfeeding-related maternity practices at hospitals and birth centers--United States, 2007. MMWR Morb Mortal Wkly Rep. 2008 Jun 13;57(23):621-5.
19. Centers for Disease Control and Prevention. Vital signs: hospital practices to support breastfeeding--United States, 2007 and 2009. MMWR Morb Mortal Wkly Rep. 2011 Aug 5;60(30):1020-5.

20. Lind JN, Perrine CG, Li R, et al. Racial disparities in access to maternity care practices that support breastfeeding - United States, 2011. MMWR Morb Mortal Wkly Rep. 2014 Aug 22;63(33):725-8.
21. Perrine CG, Chiang KV, Anstey EH, et al. Implementation of hospital practices supportive of breastfeeding in the context of COVID-19 - United States, July 15-August 20, 2020. MMWR Morb Mortal Wkly Rep. 2020 Nov 27;69(47):1767-70.
22. Perrine CG, Galuska DA, Dohack JL, et al. Vital signs: improvements in maternity care policies and practices that support breastfeeding - United States, 2007-2013. MMWR Morb Mortal Wkly Rep. 2015 Oct 9;64(39):1112-7.
23. Nelson JM, Grossniklaus DA, Galuska DA, et al. The mPINC survey: Impacting US maternity care practices. Matern Child Nutr. 2021 Jan;17(1):e13092.
24. Marks KJ, Gosdin L, O'Connor LE, et al. Changes in maternity care policies and practices that support breastfeeding as measured by the Ten Steps to Successful Breastfeeding - United States, 2018-2022. BMC Pregnancy Childbirth. 2024 Jul 12;24(1):475.
25. Boundy EO, Nelson JM, Li R. Public belief in the maternal health benefits of breastfeeding - United States, 2018 and 2021. Prev Chronic Dis. 2023 Aug 24;20:E75.
26. Li R, Fridinger F, Grummer-Strawn L. Public perceptions on breastfeeding constraints. J Hum Lact. 2002 Aug;18(3):227-35.
27. US Small Business Administration. Size standards tool. 2024 [cited 2025 June 5]; Available from: https://www.sba.gov/size-standards/index.html.
28. U.S. Department of Health and Human Services. Information for families during the formula shortage. 2022 [cited 2024 15 Nov]; Available from: https://www.hhs.gov/formula/index.html.
29. US Bureau of Labor Statistics. Occupational employment and wage statistics. 2024 [cited 2025 June 5]; Available from: https://www.bls.gov/oes/current/oes291141.htm.