Findings and Recommendations from the 2011 Meeting of The Interstate Collaborative to Support Widespread Implementation of the Ten Steps to Successful Breastfeeding

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Introduction

Widespread implementation of The Ten Steps to Successful Breastfeeding is known to increase country-level breastfeeding rates.[i] However, hospitals across the United States have been extremely slow to implement these practices. The Ten Steps are a set of evidence-based practices known to increase breastfeeding rates in healthcare systems and beyond, resulting in improved infant health and reduced infectious disease rates on a population level. The Ten Steps were introduced in the 1980s when Wellstart and UNICEF/WHO developed a draft set of ten practices that were later codified in the WHO/UNICEF booklet, "Protecting, Promoting, and Supporting Breastfeeding in Maternity Care."[ii] In the same year, an Interagency Workshop on Health Care Practices Related to Breastfeeding was held by WHO, UNICEF, USAID and Sida, that called for regional centers to support hospital practice changes. These documents contributed to the Innocenti Declaration of 1990, which included four operational targets for consideration in supporting breastfeeding:

1. Regional policy, plan and budget;
2. Global and National Baby-Friendly Hospital Initiative;
3. Code of Marketing
4. Paid maternity leave and work protection[iii]

Presently, there are additional activities underway to enhance implementation of the practices that are needed for full adherence with the Ten Steps. These include: 1) a recent grant from US Centers for Disease Control and Prevention (CDC) to the National Initiative for Children's Healthcare Quality (NICHQ) for a collaborative quality improvement approach to supporting readiness for Baby-Friendly USA designation,[iv] 2) increased action by States/Cities/Agencies, including the Indian Health Service, 3) this Interstate Collaboration supported by Agency for Healthcare Research and Quality (AHRW), Maternal and Child Health Bureau (MCHB) and CDC, and 4) the pledge of the W.K. Kellogg Foundation and Kaiser Permanente Health Systems to further support breastfeeding in the United States.

Several states have created programs to increase effective implementation of the Ten Steps. The Interstate Collaborative meeting that occurred on October 20 and 21, 2011 was the first time these several states and other governmental agencies came together to communicate, identify issues, define remaining problems for further research, and summarize what is known as a basis for advancing progress toward widespread implementation of the Ten Steps.

During the two-day meeting, state-level leaders discussed and defined the opportunities and challenges associated with widespread hospital implementation of the Ten Steps to Successful Breastfeeding and developed evidence-based recommendations for advanced adherence to the Ten Steps. Gathering in one place enabled participants to synergize lessons learned from implementation efforts across the country. These lessons learned were considered in light of existing barriers to and facilitators of breastfeeding in order to develop a set of recommendations to support increased implementation of the Ten Steps. Participants were also asked to generate evidence-based recommendations for monitoring and evaluation, and to draft a research agenda consisting of gaps in the evidence base that, if filled, would support widespread implementation of the Ten Steps.

This meeting was part of an ongoing Working Group Process, in which information is gathered from key stakeholders, summarized and brought to a meeting for refining. Following the meeting, the outcomes were compiled and vetted by sending back to the Collaborative members and nationally-recognized experts in programmatic research and implementation of the Ten Steps to create greater agreement, quality and buy-in. The conference employed a facilitated

consensus-building process, in which each set of activities utilized the previous agreements to forward progress toward consensus. Together, we established a baseline of understanding and awareness of each other's programs and evidence-based practice, learned from presentations of various programmatic models, discussed barriers, developed a list of recommended solutions which served as the basis of a targeted list of practical interventions, and then discussed how to monitor and evaluate the recommended interventions, and finally, a discussed of what research questions remain.

This report summarizes the discussions and recommendations for intervention, monitoring and evaluation, and research and outlines the next actions to be taken toward refining, disseminating, advocating for, implementing and testing the recommendations on the state and national stage.

Models of Implementation at the State Level

Designing and then implementing an effective program is a huge accomplishment. To successfully create and sustain a program to effect positive outcomes, it is important to consider several critical steps of any implementation model. The recommended steps are:

1. Define the problem
2. Assess the needs
3. Set measurable aims
4. Develop the initial Intervention Plan, to include, e.g.,
    - sensitization of key stakeholders
    - training for relevant cadres
    - working groups / summits to support coordination
    - infrastructural / organizational development
5. Design and implement monitoring approaches
6. Operationalize, with ongoing monitoring of outcome and process indicators and modification as needed
7. Evaluate routinely
8. Disseminate findings and best practices for scale up and replication

A panel of five presentations was given by representatives from California, Colorado, Connecticut, Baby-Friendly USA and NICHQ to illustrate the diversity of models of implementation. Handouts from each of the presentations are included in Appendix A.

Barriers to Implementation of the Ten Steps

Participants used a facilitated brainstorming method to generate a comprehensive list of barriers to Ten Steps' implementation. The list includes considerations on all levels of the socio-ecological model, and could be readily categorized as issues with:

- healthcare systems
- government and agencies
- healthcare administrators' and providers' knowledge, attitudes and practices
- cultural norms, and
- ill-informed and/or inadequately supported maternity patients.

Most barriers were associated with healthcare delivery systems in various capacities, confirming that the hospital is an important locus for intervention and home to many critical stakeholders. A detailed listing of barriers can be found in Appendix B.

Summary of Discussions of Recommendations

On Day One, the participants were divided into seven groups to generate preliminary recommendations for supporting widespread implementation of the Ten Steps. The groups considered the strengths and weaknesses of existing models (based on morning panels and pre-meeting report) and identified barriers (based on morning discussion). The groups also emphasized impact, cost-effectiveness, feasibility and user-friendliness in selecting interventions to recommend. Each working group presented three – five recommendations for consideration by the entire group. The reporter had three minutes to present each idea and field questions and comments from other participants.

This list of recommendations from Day One was presented, in written summary, to all participants at the start of Day Two (See Appendix C). Participants refined existing ideas, and added more for consideration after having met in groups organized according to US Food and Nutrition Services' regions on Day Two. What follows is a description of each recommendation, as presented by each working group and discussed by the entire group, and organized according to the five categories identified as critical barriers.

Recommendations Regarding Healthcare Systems

Improvement in individual hospitals and throughout an entire system of healthcare delivery depends on careful consideration of finances and financial-priority alignment, human resources, direct service provision and population-level health management. For the purpose of this discussion, participants distinguished between recommendations for "Healthcare Systems" and "Hospital Administration." Healthcare systems include the organization and coordination within and between institutions, people and resources that mitigate how direct patient care is actualized. As state- and national-level actors, Interstate Collaborative participants advocate for the following recommendations, which are designed to enact change throughout healthcare systems, therein requiring collaborative approaches with an emphasis on population-level health.

Supporting Stewardship and Quality Improvement by Encouraging Collaboration Among Hospitals

All participants at the Interstate Collaborative represented state or large Metropolitan Statistical Area (MSA)-level programs designed to support widespread implementation of the Ten Steps. Most programs aim to incentivize hospital implementation efforts by fostering a public designation program, such as the Louisiana Gift Certification, Texas Ten Step, Colorado Can Do Five or the North Carolina Maternity Center Breastfeeding-Friendly Designation. Representatives report success of designation efforts to raise awareness of the Ten Steps and support hospitals to advance thinking about Ten Steps implementation.

Participants noted that state programs that connect hospital personnel with technical assistance, model policies and procedures, mentorship and champions report greater success in advancing implementation among novice hospitals and those who are already further along in the process. Therefore, supporting collaboration between hospitals is recommended to advance widespread implementation of the Ten Steps.

Participants recommend forming Maternity Care Collaboratives on State and/or regional levels wherein individual hospitals come together at summits to learn from experts, access technical assistance, share quality improvement techniques and share in creative problem solving. This model is likely to be highly cost-effective. In forming state or regional maternity care collaborative, participants recommend considering the following as best practices:

- Engage high-level hospital leaders and critical change champions from each hospital to form the maternity care collaborative, and facilitate necessary support for quality improvement initiatives in-hospital;
- Identify issues and ideas around which this group has energy and build from there;
- Provide easy access to model policies, procedures, staff education modules, and patient education materials, and encourage hospitals to share with each other as they are developed;
- Host regular meetings to encourage genuine partnership and genuine systems-level change;
- Encourage "all-in" partnerships wherein hospital clusters agree to join efforts toward a particular goal (i.e., all hospitals in a region "ban the bags" at once);
- Consider "adoption" or "mentorship" models where more advanced hospitals adopt or mentor more novice hospitals. This could also be done between states (i.e., Massachusetts adopts Connecticut). Attention should be paid to feasibility, political and cultural differences or similarities, etc.;
- Consider recognizing progress toward full adherence to the Ten Steps. Recognition programs are ideally free and voluntary, and provide a conduit for new knowledge and support from the designating organization and/or peer hospitals and the opportunity to learn from failures (see Magnet Mentorship Program);
- Identify and engage key stakeholders and endorsers (i.e., hospital associations or professional organizations);
- Conduct a needs and desires assessment and design the summit plan accordingly;
- Communicate with frequency and mechanisms that members prefer (weekly, monthly, in-person, webinar, newsletter, listserv, etc.)
- Partner with a single influential hospital or health system in a state or region, and support them to develop and share replicable models of Ten Steps implementation (i.e., recent Kaiser announcement);
- Develop new leaders and champions through education, sensitization and healthy competition; and
- Implement robust monitoring and evaluation.

Defining the Maternal-Child Dyad Episode of Care

Policymakers should consider possible innovations in the financing of maternity care practices that support breastfeeding. One possible innovation is to leverage current activities in the broader healthcare environment to make improvements in maternity care, using incentive alignment to pay for maternal-infant dyad care as an 'episode of care.' The maternity 'episode of care' should be broadly defined as conception through the first year of life as this is the true physiologic reproductive continuum. Incentive alignment has been successful in increasing implementation of evidence-based practices and improving continuity of care, which in this case would include implementation of the Ten Steps to Successful Breastfeeding and increased access to clinical lactation specialists. State Medicaid offices and Accountable Care Organizations would be key stakeholders in actualizing this recommendation.

Purchasing Infant Formula to Decrease Indiscriminate Distribution

The great majority of hospitals in the United States accept formula and feeding supplies free of charge from infant formula manufacturers. Most of these hospitals also distribute infant

formula manufacturers' "gift bags" at discharge from the maternity stay, effectively advertising on their behalf. Ready availability of infant formula is known to decrease breastfeeding exclusivity, initiation and duration. To date, a largely hospital-administrative approach has been taken to mitigate these relationships, including national and state-level "ban the bag" initiatives, efforts to promote and enforce the International Code of Marketing of Breastmilk Substitutes and Ten Steps' designation programs requiring that infant formula and feeding supplies be purchased at fair market value (per the Code). Therefore, participants at the Interstate Collaborative recommend implementing measures that would create transparency and a higher standard of ethics between hospitals and infant formula manufacturers.

Participants of the Interstate Collaborative recommend a careful exploration of state, regional or multi-hospital bulk infant formula purchasing agreements to decrease the cost of infant formula for hospitals. participants recommend extreme caution in exploring this option, citing considerable concerns that this approach may inflate the cost of formula up for private consumers, drive bulk purchasing below fair market value (in violation of the International Code), and further entrenching relationships between governmental organizations, healthcare systems and infant formula manufacturers.

The group recommended transparency in infant formula purchasing and pricing, and make technical assistance widely-available to support hospitals in negotiating economically and ethically-acceptable purchasing agreements with formula manufacturers.

Recommendations for Governmental Agencies

Participants acknowledged the efforts of federal and state governmental agencies to create an environment where women can meet their breastfeeding intentions, most recently evidenced by launching the Surgeon General's Call to Action to Support Breastfeeding, continued support for the Business Case for Breastfeeding, funding a national collaborative for advancing Ten Steps implementation in 65 hospitals, and even in funding the meeting of the Interstate Collaborative itself. Participants recommend that state and federal governmental agencies consider the following as specific mechanisms for advancing implementation of the Ten Steps:

- Legislate and fund full-time state breastfeeding coordinators with standardized roles and responsibilities and accountability measures. This would enable increased inter-state coordination;
- Require high-quality monitoring and evaluation of all federally and state-funded activities, and make findings widely available to increase scale-up and replication of cost-effective models; and
- Increase access to prenatal breastfeeding education and preparation for early breastfeeding through WIC enrollment, anticipatory guidance in Medicaid-funded visits and other entitlement programs with which maternity patients regularly come in contact
- Encourage state mandated adoption of all breastfeeding measures established by hospital accreditation organizations.

Recommendations for Hospital Administrators

Hospitals, and administrators, more specifically, often benefit from individualized technical assistance to identify strengths and weaknesses in Ten Steps implementation. Technical assistance varies depending on the hospital's stage of development in their breastfeeding support and maternity care practices. In particular, hospitals and administrators will require different

assistance if they are in the contemplation phase of Ten Steps implementation or if they are in the operational phase or beyond. Participants recommend the implementation of the following:

- Encourage collaboration among administrators from different hospitals to catalyze the process of Ten Steps Implementation and discuss ways to decrease costs for hospitals;
- Increase hospitals' access to policy development resources and technical assistance before they formalize their intent to become Baby-Friendly (in the contemplation phase). The development of policy can be very cumbersome and overwhelming, especially without the right resources. Access to sample breastfeeding policies is not as effective as one-on-one support as hospital needs and norms vary; and
- Provide education and marketing toolkits that will help hospitals create marketing campaigns to increase community awareness of evidence-based maternity care practices. A marketing toolkit will help families know what care they should expect during the birth and postpartum experience as well as educating the community at large about what is normal.

Recommendations for Healthcare Providers

Health care providers have a substantial influence on a woman's decision to breastfeed and on her ability and success in continuing to breastfeeding. However, many well-intentioned healthcare providers lack the knowledge and skills to support breastfeeding. Moreover, some healthcare workers contend that breastfeeding provides only modest benefits, that infant formula is not a significantly inferior choice, and that small amounts of supplementation are not harmful. Participants recommend the following ideas for addressing barriers at the healthcare provider level:

- Develop a statewide plan to fund and implement widespread, low cost training for healthcare providers in breastfeeding support. Training, particularly Train the Trainer models, can be effective in increasing the knowledge of health professionals and is an important component of a Ten Step program. Such models must include job aids and other efforts to sustain the impact beyond the initial trainings. Education to improve the knowledge, attitudes, and skills of health care providers could be a key strategy for improving breastfeeding rates;
- Identify content-area specialists and trainers who will form a Speaker's Bureau to be utilized at summits, conferences, hospital trainings, etc.;
- Provide techniques for verifying the competencies of healthcare staff in breastfeeding support, and ensuring that competent breastfeeding support provided according to these competencies is a critical component of maternity care staff job descriptions; and
- Develop a toolkit for providers that would include training manuals, model scripts for nurses to use in certain situations, bibliographies on various research topics and quick reference guides for solving common breastfeeding problems

Recommendations for Changing the Culture of Infant Feeding

In the United States today, formula use remains the cultural norm in infant feeding and the formula industry is the major provider of information on infant feeding. Families have the right to receive accurate, information, free of commercial bias, so that they can make informed infant feeding decisions. Normalizing breastfeeding makes it a more feasible choice for many women, who often see it as an unattainable ideal. Furthermore, it is important to empower mothers and families to advocate for evidence-based care and support, thereby enabling them to achieve their

infant feeding and parenting goals. Participants recommend considering the following for changing cultural norms:

- Develop a media campaign aimed at mothers, families, and others with a goal of normalizing breastfeeding. This can include increasing positive images of breastfeeding in mass media, engaging a highly visible spokesperson, using YouTube and social media to normalize related care practices, etc.
- Develop and integrate a breastfeeding curriculum into K-12 education.
- Improve public awareness to create demand for the Ten Steps to Successful Breastfeeding and empower mothers to advocate for these evidence-based practices as the standard of care. Both media and healthcare providers can market this concept.

Monitoring and Evaluation

Monitoring is the ongoing review of a program's processes to ensure that the plans are being followed; monitoring may lead to course corrections based on the program design. Monitoring demands clearly defined program benchmarks and the establishment of standardized manner to measure the benchmarks. In sum, monitoring answers the question: "Are we proceeding as planned?" Evaluation, on the other hand, aims to assess if the program achieved its aims and goals. Evaluation outcomes may lead to redesign and adaptation of the program approach. Evaluation answers the question: "Is this program succeeding in achieving our planned outcomes and outputs?"

The discussion considered monitoring of hospital and state level programming separately. The group recommends:

- Development of standardized definitions of 1) the practices in the Ten Steps, 2) all breastfeeding patterns, 3) human milk, 4) medical indications for supplementation and 5) other terms related to breastfeeding support.

At the hospital level, monitoring should have:

- Defined benchmarks for internal implementation of innovations
- Planned discussions and regular review of rates of breastfeeding or rates of other supportive practices. Other suggested benchmarks include not only whether the infant was given formula, but also the age of the infant when the first formula is given, and who gave it;
- All benchmarks should be included in Electronic Medical Records where possible
- Review at regular meetings of a multi-disciplinary team. The hospital team should include professional leadership at all levels: active involvement of doctors and nurses, hospital and clinical administrators, and, where possible, consumers. In addition a representative of a nearby hospital with similar interests might be considered.

At the state level, it is recommended that monitoring includes:

- Regular reporting on defined benchmarks, such as hospital reports of response to state-level calls for action, collaborative discussions and planning sessions, hospital levels of exclusive breastfeeding, patient satisfaction, shared innovations, social marketing efforts to support demand creation for patients to have expectations of the Ten Steps.
- Engaging decision-makers and other key stakeholders so that issues of costs and effects, as well as licensing of LCs, may result in greater interest in the program. Inclusion of Medicaid and WIC leadership were common themes and milk banks were mentioned.

Evaluation at the hospital level and state level may occur annually. The annual evaluation addresses whether or not the program achieved the changes that it set out to achieve. Assessment of other changes in related programs across the state might influence future planning. Evaluation is strengthened by including stakeholders, such as professional organizations, insurers, media, state epidemiologist and other related state agencies, consumers and institutions in the review.

Participants at the Interstate meeting recommend evaluation include:

- Auditing at the state level using existing surveillance instruments, such as immunization surveillance systems,
- Review of ongoing monitoring and the concomitant adjustments, as well as the achievement of planned change,
- Rates of completion of the mPINC survey with the goal of increasing the number of hospitals and scores,
- Numbers of hospitals striving for state or national designation,
- State or county level exclusive breastfeeding survey data, and,

Research needs

Research needs were discussed separately for the hospital, state program levels, and general issues related to the Ten Steps. ***Many of the research questions that arose have been addressed to some degree in the literature, but clearly, there remains a need to bring together the evidence on each and further define what questions remain*.** There was also stated concern that some of these questions might not have answers that are generalizable, but would have to be repeated in various settings.

The research questions were word-smithed, then sent to Collaborative members and respected programmatic researchers for vetting. In this process, reviewers were asked to consider whether each question was clear, able to be answered through research, likely to support widespread implementation, likely to result in findings that would be readily implementable and addressed under-served or under-privileged populations. Reviewers were also asked to rank each question in order of "priority," however they chose to define that. The scores were consistently high, and no questions scored so poorly as to indicate exclusion from this set of recommended research questions.

The results were tallied to create a score for each question. The questions are presented here in order of highest to lowest score, as determined by this process. Here, *highest* refers to most clear, most likely to be able to be answered by research, etc. And, *lowest* refers to least clear, least likely to be able to be answered by research, etc.

Research re: Hospital Practices

1. What is cost-benefit of Ten Steps implementation at the hospital level?
2. Are there best practices for documenting infant feeding and mother-baby care practices?
3. Does the type of personnel engaged to initiate implementation impact likelihood of progress/success (e.g., administration vs. physician vs. LC; NICU vs. well-baby care, etc.)?
4. Is there a maximally effective ratio of IBCLCs to mother-baby couplets recommended for Ten Steps implementation?
5. Does the use of an outside consultant help speed change?
6. Does a hospital require adding staff to achieve the Ten Steps?

Research re: State Level Programs

1. What is the cost-benefit to Medicaid for reimbursement of lactation support?
2. What are the costs of implementing the Ten Steps vs. the costs of not implementing the Ten Steps at the state/national level?
3. Would state support for increasing the number of IBCLCs improve breastfeeding rates?
4. How many milk banks are needed to address all needs for donor human milk as supplement of choice for all newborns in the hospital?

Research re: Acceptance of the Ten Steps

1. Can social marketing create consumer demand for Ten Steps?
2. How does Ten Steps implementation impact patient satisfaction and what factors ensure a positive correlation?
3. What is the best manner to address myths and encourage best practices among health professionals?
4. What is the impact of promoting the Ten Steps on health professionals' attitudes and beliefs about breastfeeding?
5. How do we best address the myths and misperceptions of consumers and patients related to the Ten Steps?
6. What can be done to increase the racial/ethnic diversity of the IBCLCs?

Suggested White Paper Reviews / Policy Analyses

1. How can we reduce formula company influence at all levels?
2. What can state agencies do to motivate hospitals and other state agencies to decide to change?
3. What are the most important things that can be done by State government agencies to support implementation of the Ten Steps? By volunteer coalitions?
4. How does Ten Steps implementation impact hospital staff satisfaction and what factors ensure a positive correlation?
5. What cost-effective approaches exist to assess readiness for change? To identify obstacles to change?

In sum, many programmatic questions were raised that merit, minimally, review of the literature and compilation of that review for ready access. Following such review, a consultative interstate group could decide on the final specific questions that would most help state level organizations succeed in supporting hospital level change.

Moving Forward

The Working Group Process Approach

The Interstate Collaborative is employing the Working Group Process Approach that has resulted in the recommendations above. The next stage in the Working group approach is to have an iterative process on the set of recommendations, including: 1) a written and disseminated set of recommendations for state-by-state consideration and adaptation for cost-effective action, 2) user-friendly implementation of The Ten Steps in healthcare systems throughout the United States; 3) a research agenda for reducing costs and increasing effectiveness of this intervention; and a research agenda for related identified breastfeeding issues.

The process will include the following steps:

1. Send summary of these recommendations to participants for comment.
2. Refine, based on comments
3. Send refined summary to a larger audience for review. Note: while participants at the conference are primarily public health professionals and community organizers, the outcomes of this conference will also be important to consumers, patients, clinicians, institutions, health care systems purchasing and infrastructure, policymakers in all sectors, and researchers, alike. Furthermore, the products of this conference have the potential to inform future research, policy, practice, training of health services researchers, and to enhance collaborative relationships between state-level stakeholders. as including suggestions from the post meeting survey.

After these iterative tasks of vetting and refining are completed, the final recommendations will be disseminated, advocated, and where possible, implemented. This set of steps in the Working Group Process Approach will be carried out over the next few months.

The final recommendations that emerge from this process will then be incorporated into an overall report for wide dissemination. This report will include

- the refined and vetted recommendations, achieved through the process above,
- the discussion of real and perceived barriers to implementing The Ten Steps in respective locations, and
- evidence-based solutions to real and perceived barriers to implementing The Ten Steps in healthcare systems throughout the United States;
- a discussion of effective roles of government and civil society in implementation of hospital-based breastfeeding support.

The report will be posted on the Interstate Sakai internal website for comment, finalized and submitted for publication, and offered on the CGBI website. In addition, all members of the collaborative will be encouraged to post on their own websites.

Ongoing Interstate Collaboration

Based on the outcomes of this process, as outlined above, we propose to support state-level implementation of the final recommendations. Each state will be encouraged to develop a plan of action, with monitoring benchmarks, and an evaluation/advisory group based on these outcomes. Monitoring of the implementation processes at each state will continue to be carried out at the State level to ensure that programs are being implemented as planned. States will also be encouraged to follow this with evaluation of the impact of the programs and processes to further inform all and to insure continuous quality improvement.

Three complementary collaborative activities are envisioned, pending resource availability:

1. The Interstate Collaborative will create a “Consultants’ Bureau” made up of representatives from State (and City) efforts to communicate with non-participating states and other interested parties about the co-created collaborative approach to implementing the Ten Steps to Successful Breastfeeding.
2. The Interstate Collaborative will facilitate communication amongst states by creating an electronic forum.
3. The Interstate Collaborative will facilitate state to state-partnering, so that small groups will similar issues might share concerns and lessons learned.

Making Change

The recommendations from the Interstate Collaborative, given the process outlined above, are based on practical evidence and expert opinion. While many are "lessons learned" from states that have experienced success with a particular approach, others are novel concepts ripe for implementation. CGBI will facilitate the Collaborative members in applying the Institute for Healthcare Improvement's Breakthrough Series Model to implement recommendations, test their cost-effectiveness, and make rapid improvements. By using this model featuring small-scale implementation and frequent tests of change, we will make rapid quality improvements and learn more so that we can continuously refine the recommendations we disseminate to the public.

The implementation support activities will focus special efforts on states with very low rates of breastfeeding, which are also the states with higher-than-average proportions of racial and ethnic minorities. That said, no state in the Collaborative will be excluded.

The Collaborative will determine which activities to implement, in what order. Then, CGBI will facilitate ongoing Webinar-based learning sessions on each of the Collaborative's recommendations to bring all actors to the same understanding. The states may then each have an "action phase" of testing the recommendation(s) to assess their applicability in varied settings. They will revise their approach according to the results of the tests, and report back on monthly progress using standardized reporting tools. State reports will be aggregated and shared in advance of quarterly webinar to discuss the outcomes, and refine the recommendations for dissemination.

CGBI will convene a second national in-person meeting of the Interstate Collaborative after 18 months of active dissemination and change implementation, as funded by the W.K. Kellogg Foundation. All states with active programs will be included. Together, we will revisit barriers and facilitators, determine continued relevance and/or adaptations of recommendations, and finalize recommendations for widespread implementation of the Ten Steps throughout the United States.

NOTE: Appendices A and B are posted as separate documents, accompanying this report, on the Carolina Global Breastfeeding Institute website: www.sph.unc.edu/breastfeeding

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[i] World Health Organization [WHO]. (1998). *Evidence for the ten steps to successful breastfeeding* (rev. ed., WHO/CHD/98.9). Geneva, Switzerland.

[ii] WHO/UNICEF. Protecting, Promoting, and Supporting Breastfeeding: The special role of maternity services. WHO, Geneva, 1989.

[iii] WHO/UNICEF. Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding. [Online]. 1990 [Cited March 2012]. Available from URL: http://www.unicef.org/programme/breastfeeding/innocenti.htm

[iv] National Initiative for Children's Healthcare Quality. Best Fed Beginnings. 2011 [cited March 2012]. Available from: http://www.nichq.org/our_projects/cdcbreastfeeding.html