Appendix A2

Relevant WIC Policy and Guidance Documents

Appendix A2. Relevant WIC Policy and Guidance Documents includes the following:

1. **Value Enhance Nutrition Assessment (VENA) in the Special Supplemental Nutrition Program for Women, Infants, and Children. (2020).**

2. **"Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages; Final Rule."** Federal Register 79:42 (March 4, 2014) p. 12274-12300.

Value Enhance Nutrition Assessment (VENA) in the Special Supplemental Nutrition Program for Women, Infants, and Children. (2020).

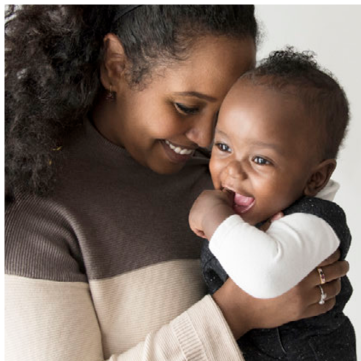
United States Department of Agriculture

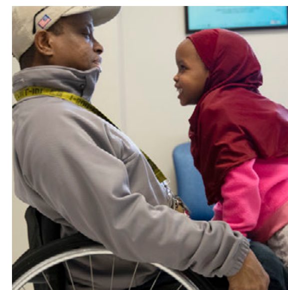
Food and Nutrition Service

VENA

Value Enhanced Nutrition Assessment in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Updated Guidance





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Section 1: Introduction

Nutrition assessment is a required[1] and essential part of the U.S. Department of Agriculture's (USDA) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The **WIC nutrition assessment** is the process of collecting and synthesizing nutrition and health information in order to assess an applicant's nutrition and breastfeeding status, strengths, and needs. It is used to determine eligibility, through the identification of nutrition risks, and to personalize **WIC nutrition services**. The delivery of individualized nutrition counseling, breastfeeding promotion and support, referrals, and food package tailoring based on a nutrition assessment is a unique feature of WIC among the Food and Nutrition Service (FNS) nutrition assistance programs. A WIC nutrition assessment uses the **Value Enhanced Nutrition Assessment (VENA) approach** which is **participant–centered** and **health outcome–based**. It allows staff to engage the participant in dialogue about her needs and goals of healthy behavior. This process is critical in meeting the nutrition education goals of WIC, which are to (1) emphasize the relationship between nutrition, physical activity, and health and (2) assist the individual who is at nutritional risk in achieving dietary and physical activity habits resulting in improved nutritional status and the prevention of nutrition-related problems.[2] A WIC nutrition assessment is the starting point for designing all WIC nutrition services.

[1] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.7 Certification of Participants. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=7a2c252817410a1e102dbbaab0898e9e&mc=true&n=pt7.4.246&r).#se7.4.246_17**

[2] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.11 Nutrition Education. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=7a2c252817410a1e102dbbaab0898e9e&mc=true&n=pt7.4.246&r)**

What Is VENA?

Value Enhanced Nutrition Assessment (VENA) is a participant-centered, health outcome–based approach to WIC nutrition assessment. The VENA approach incorporates a WIC nutrition assessment process with policies, staff competencies, a **Management Information System (MIS)**, and quality improvement strategies that together enhance the delivery of WIC nutrition services. It helps to ensure that WIC staff conduct quality nutrition assessments that enrich the interaction between WIC educator and participant, as well as link collected health and diet information to the delivery of nutrition services relevant to the needs of the participant. The VENA approach enhances nutrition services offered to participants and ensures the integrity of WIC as a premier public health nutrition program.

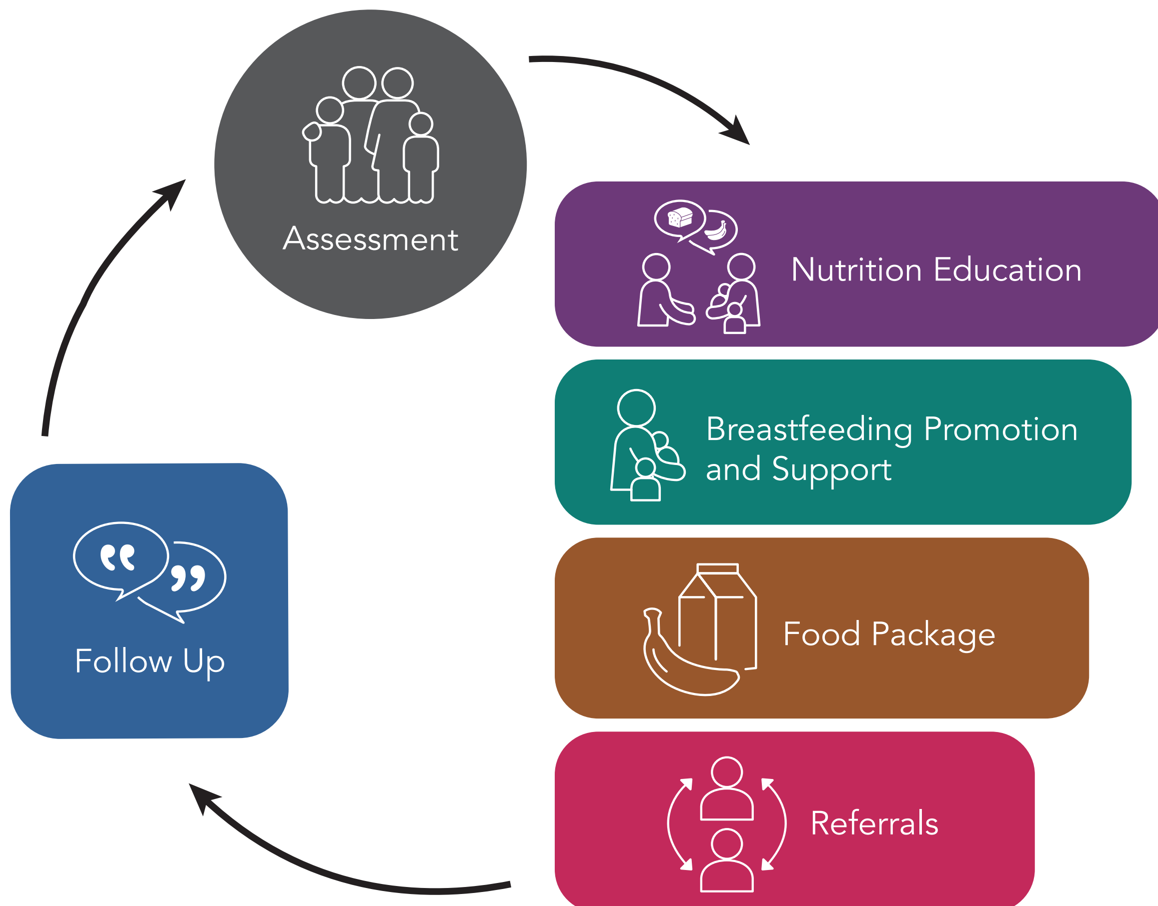
/Definition/

Participant

***Participant**, for the purposes of this document, refers to a WIC participant, an applicant, or a parent/caregiver.*

Figure 1

WIC Nutrition Services



VENA Guidance

VENA Guidance[3] is intended to assist WIC State agencies in developing policies and procedures related to the WIC nutrition assessment. The Guidance supports FNS Regional Offices, State agencies, and local agencies in continuous quality improvement and customer service efforts to strengthen WIC nutrition assessment.

Background

FNS first issued VENA Guidance in 2006. It was developed through a collaboration among FNS, the National WIC Association, and individual WIC State agencies. Both the original VENA Guidance and VENA nutrition assessment policy[4] were developed in response to recommendations made in a report from the Institute of Medicine (IOM)[5], *Dietary Risk Assessment in the WIC Program*[6] While the IOM recommendations were specific to dietary risk assessment, the report also highlighted the

/Definition/

Nutrition risk

***Nutrition risk** refers to conditions that are used as a basis for certification. The categories are:*

(a) Detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements.

(b) Other documented nutritionally related medical conditions.

(c) Dietary deficiencies that impair or endanger health.

(d) Conditions that directly affect the nutritional health of a person, including alcoholism or drug abuse.

(e) Conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, including, but not limited to, homelessness and migrancy.[7]

---

[3] Pursuant to the Congressional Review Act (5 U.S.C. §801 et seq.), the Office of Information and Regulatory Affairs designated this guidance as not major, as defined by 5 U.S.C. § 804(2).

[4] WIC Policy Memorandum #2006 – 5: Value Enhanced Nutrition Assessment-WIC Nutrition Assessment Policy. March 2006. Available from: **https://www.fns.usda.gov/wic/wpm-2006-5**

[5] The Institute of Medicine is now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine.

[6] Institute of Medicine Committee on Dietary Risk Assessment in the WIC Program. Dietary Risk Assessment in the WIC Program. Washington (DC): National Academies Press; 2002.

[7] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

importance of assessing for other **nutrition risks** such as growth issues, iron deficiency, nutritionally related medical conditions as well as social and environmental factors in order to provide targeted nutrition services. The IOM report resulted in FNS identifying the need for comprehensive nutrition assessment guidance – the VENA Guidance.

VENA Guidance Update

While the intent of the updated Guidance remains the same (i.e., the personalization of WIC nutrition services), it builds on the experiences of State and local agencies in the implementation of VENA and emphasizes nutrition and health determinants, objectives, and outcomes; behavior change; the use of technology in WIC; and the importance of continuous improvement through observation and evaluation of the VENA approach. Additionally, science of behavior change also has influenced the assessment process[8,9,10] as have changes to WIC federal regulations (e.g., food package changes, extension of the certification period for children to 1 year) since the issuance of the original guidance.

/Definition/

Competent Professional Authority (CPA)

Competent Professional Authority (CPA) *refers to WIC staff members authorized to conduct the nutrition assessment, determine nutrition risk, and prescribe supplemental foods. Federal WIC regulations define the CPA as a physician, nutritionist, registered nurse, dietitian, or medically trained State or local health official, or a person designated by physicians or medically trained State or local health officials.*[11]

For this update of the VENA Guidance, FNS collected input from a range of stakeholders and experts, including staff in WIC State agencies and FNS Regional Offices as well as nutrition assessment and counseling professionals. The update was also shaped by a review of studies and publications on nutrition assessment.

Summaries of key concepts in the updated VENA Guidance appear below:

- VENA is a participant-centered, health outcome–based approach to conducting nutrition assessments in WIC. Using the VENA approach, WIC staff can more easily identify and build on participants' strengths to help them achieve their nutrition- and health-related goals.
- In the health outcome–based approach, the WIC **Competent Professional Authority (CPA)** identifies nutrition risks and strengths (**health determinants**) that affect health outcomes. The staff then considers how best to support participants' needs and strengths depending on each participant's identified nutrition risks/ health determinants, interests, **motivations**, preferences, and information needs.
- The VENA approach emphasizes a collaborative partnership between CPAs and participants. Participant engagement and interaction are integral parts of the nutrition assessment process.
- VENA allows the CPA to identify each participant's needs and provide individualized nutrition services that may include customized information sharing, **guided goal setting**, tailored food packages, breastfeeding support, and referrals for additional resources or services.

[8] Spahn JM, Reeves RS, Keim KS, et al. State of the evidence regarding behavior change theories and strategies in nutrition counseling to facilitate health and food behavior change. J Am Diet Assoc 2010;110(6):879-891. doi:10.1016/j.jada.2010.03.021

[9] Marley SC, Carbonneau K, Lockner D, et al. Motivational interviewing skills are positively associated with nutritionist self-efficacy. J Nutr Educ Behav 2011;43(1):28-34. doi:10.1016/j.jneb.2009.10.009

[10] Whaley SE, McGregor S, Jiang L, et al. A WIC-based intervention to prevent early childhood overweight. J Nutr Educ Behav 2010;42(3):S47-S51. doi: 10.1016/j.jneb.2010.02.010

[11] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd &mc=true&n=pt7.4.246&r=PART&ty=HTML #se7.4.246_12**

- CPAs take consistent steps during the assessment to collect and analyze information and use **critical thinking** to prioritize topics for discussion, recommend food packages, and identify resources for referrals.
- MIS and other electronic tools used for assessment may be helpful in collecting and synthesizing data but can become a barrier to participant engagement if not used appropriately.
- The VENA approach encourages WIC staff to support participants as they set realistic goals and act on small steps that can lead to better health outcomes.
- Ongoing staff training on nutrition assessment skills will improve CPAs' confidence and proficiency as they continue to apply participant-centered approaches to the assessment process.
- Quality improvement efforts that include direct observation of assessment practices are essential to evaluating the implementation of VENA.

The updated VENA Guidance is divided into seven sections:

- **Section 1** provides an introduction to the VENA approach and the Guidance.
- **Section 2** describes the VENA approach as being participant centered and health outcome based.
- **Section 3** describes how to apply the VENA approach to the nutrition assessment process.
- **Section 4** discusses ways to use assessment data to guide nutrition services.
- **Section 5** offers guidance for designing assessment tools and the appropriate use of MIS and other technology tools used to carry out assessments.
- **Section 6** contains information on the skills staff need to implement VENA successfully.
- **Section 7** describes suggestions for ongoing quality improvement activities with an emphasis on direct observation to evaluate the implementation of VENA.

Using the VENA Guidance

The VENA Guidance is designed to assist State and local agencies in their efforts to provide high-quality nutrition services. The *WIC Nutrition Services Standards*[12] outline nutrition services components to guide State agencies in establishing policy and practices. The VENA Guidance complements the Nutrition Services Standards and other WIC policy and guidance documents.

It is intended that State agencies use this document to:

- Develop policies and procedures related to nutrition assessment.
- Evaluate and enhance their nutrition assessment processes by conducting a self-evaluation of current nutrition assessment policies and practices.

Operationalizing VENA Guidance

Additional information is available throughout the VENA Guidance to help State and local agencies apply it in their work.

Tips From the Field: Suggestions from State and local WIC staff on the topic area.

Additional Information to further explain and reinforce content.

Definitions: Key terms to improve comprehension.

The Importance of Language: Recognizing the impact of terminology and highlighting the importance of **plain language** and participant-centered phrasing.

- Evaluate current training and staff development offerings and add new strategies and trainings to build staff skills as needed.
- Assess use of MIS and other technology tools to ensure they fit with the VENA approach, allow users to tailor services within a consistent framework, and promote **continuity of care**.
- Review opportunities to incorporate direct observation of staff performance to ensure the VENA approach is operationalized.
- Identify areas of support needed at the State or local level to promote adoption of the VENA approach and communicate support needs to the FNS Regional Offices.

Although some key terms are defined throughout the document, a comprehensive list of terms is available in the **Appendix A: Glossary of Terms**.

[12] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

Section 2. VENA Approach—Participant-Centered and Health Outcome–Based

VENA incorporates two approaches: participant-centered and health outcome–based. By utilizing these two distinct but complementary approaches, CPAs are able to create a welcoming and affirming environment while elucidating necessary information from the participant, and help guide the participant to the appropriate nutrition and health goals.

Participant-Centered Approach

The VENA approach is participant-centered. The WIC Nutrition Services Standards defines participant-centered as “a systems approach designed to focus on topics and issues that are relevant to the participant. This approach puts the participant’s needs and the goal of healthy behaviors at the core of WIC services delivery and focuses on a person’s capacities, strengths, and developmental needs, not solely on the problems, risks, or negative behaviors. Participant-centered services encourage staff to engage the participant/caretaker in dialogue, information exchange, listening, and feedback in order to translate the assessment into action and customize the nutrition services provided.”[13]

Characteristics of Participant-Centered Approach

Characteristics of a participant-centered approach include:

- **Collaboration.** The VENA approach involves a partnership between CPAs and participants. Participant engagement and interaction are essential parts of the nutrition assessment process.

Tips From the Field—Building Rapport and Trust

Feeling welcomed can build a sense of trust and foster good rapport. When participants feel safe and accepted, they are more likely to share honestly. Honest communication will lead to the most effective assessments. CPAs can build rapport and trust through open communication and demonstrations of respect. Sometimes the simplest actions demonstrate respect, such as making eye contact, addressing a participant by name, or starting by asking, “How are you today?” These small demonstrations of respect can help ensure that participants have a positive experience and do not feel like they are just another number as they go through the assessment process.

[13] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

- **Optimism.** The VENA approach recognizes that participants have hopes and desires for themselves and their families related to nutrition and health. One goal of the process is to draw forth these internal motivations from the participant.
- **Nonjudgmental environment.** Participants are more likely to talk openly and honestly about their behaviors, motivations, and challenges in an accepting and nonjudgmental atmosphere.
- **Empowerment.** The VENA approach can build participants' confidence in their own abilities. CPAs find and affirm strengths and positive practices in order to ensure participants continue them and build additional healthy habits.

CPA and Participant Roles in Participant-Centered WIC Nutrition Assessments

In the VENA approach, both the participant and the CPA contribute to an assessment's overall success. The CPA is a facilitator, guiding the participant through a process that is driven by their unique circumstances. CPAs work with participants to identify their nutrition-related needs and concerns in order to prioritize topics for the nutrition counseling discussion. CPAs honor **autonomy**, recognizing that the decision about whether to explore potential behavior change rests with the participant.

Although CPAs have expertise in nutrition, breastfeeding, and health, participants are experts on their own situation and what will be best for themselves and their family. In addition, WIC participants are often exposed to many nutrition messages in a variety of media. By assessing what the participant already knows about a topic, CPAs can affirm and build on the existing knowledge. The ongoing partnership with participants, built on trust and mutual respect, allows WIC to have a lasting impact on behaviors.

Every aspect of WIC services has the potential to affect the relationship between the participant and WIC staff and influence the success of the interaction. Factors such as clinic appearance, customer service, wait time, and nutrition promotion materials will influence a participants' feelings toward WIC and their engagement in services.[14,15] For more information on training tools for staff on

The Importance of Language

Terms, phrases, regulatory definitions, and acronyms unique to WIC (i.e., jargon) serve to make communication between co-workers easier; however, it may not be effective language to use with participants.

For example, a participant may understand the words "food benefits" more readily than "food package" or "low blood iron" rather than "low hematocrit." CPAs are encouraged to use plain language that is positive and participant-centered, including easily understood words and inoffensive terms, when talking with participants.

/Definition/

Plain language

Plain language *is communication that your audience can understand the first time they read or hear it. There are many techniques that can help you achieve this goal. Among the most common are using:*

- *Logical organization with the participant in mind.*
- *"You" and other pronouns.*
- *Short sentences.*
- *Common, everyday words.*

[14] Deehy K, Hoger FS, Kallio J, et al. Participant-centered education: building a new WIC nutrition education model. J Nutr Educ Behav 2010;42(3 Suppl):S39-S46. doi:10.1016/j.jneb.2010.02.003

[15] Isbell MG, Seth JG, Atwood RD, et al. A client-centered nutrition education model: lessons learned from Texas WIC. J Nutr Educ Behav 2014;46(1):54-61. doi:10.1016/j.jneb.2013.05.002

the topics of customer service and rapport building, visit the **WIC Works Resource Center**.

For more information about plain language, please visit the **U.S. Government plain language website**.

Health Outcome–Based Approach

While keeping the participant at the center of nutrition assessment, the VENA approach uses a health outcome–based approach as a framework to organize the assessment. The health outcome–based approach to a WIC nutrition assessment focuses the conversation on a positive health goal (health outcome) while discussing how other areas of a participant's life may influence the health outcome. This framework is consistent with two national public health initiatives:

- U.S. Department of Health and Human Services' Healthy People[16] — a plan to promote, strengthen and evaluate the nation's efforts to improve the health and well-being of all people that is updated every ten years.
- Bright Futures,[17] a set of health supervision guidelines to "promote and improve the health, education, and well-being of infants, children, adolescents, families, and communities."

The VENA health outcome–based approach consists of a desired health outcome, nutrition and health objectives, and health determinants. These elements of the health outcome framework are described as follows:

- Desired health outcome—WIC's overarching health goal for each category of participant. The specific goals for each participant category can be found in **Table 1**.

Table 1. Participant Category and WIC Desired Health Outcome

Participant Category	WIC Desired Health Outcome
Pregnant Woman	Delivers a healthy, full-term infant while maintaining optimal health status.
Breastfeeding Postpartum Woman	Achieves optimal health during the childbearing years and reduces the risk of chronic disease.
Non-breastfeeding Postpartum Woman	Achieves optimal health during the childbearing years and reduces the risk of chronic disease.
Infant	Achieves optimal growth and development in a nurturing environment and develops a foundation for healthy eating practices.
Child 12-60 Months of Age	Achieves optimal group and development in a nurturing environment and begins to acquire dietary and lifestyle habits associated with a lifetime of good health.

[16] Office of Disease Prevention and Health Promotion. Healthy People 2030. September 2020. Available from: **https://health.gov/healthypeople**.

[17] American Academy of Pediatrics. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. 2017. Available from: **https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**

- Nutrition and health objectives—actions, practices, and settings that make it more likely for the health goal to be achieved.
- Health determinants—a range of behavioral, biological, socioeconomic, and environmental factors that affect the nutrition and health objectives and overarching goal.[18] Determinants that promote a positive health outcome are protective factors, while those that may hinder a positive health outcome are WIC nutrition risks and other related barriers or needs.

Using the VENA approach, CPAs start the assessment with the desired health outcome in mind. For example, the desired health outcome for a pregnant woman is “Deliver a healthy full-term infant while maintaining optimal health status.” This desired health outcome is more likely to occur when a woman meets/achieves the following health objectives:

- Consume a variety of foods to meet energy and nutrient requirements and remain free from foodborne illness.
- Receive ongoing health care, including prenatal care.
- Achieve the recommended weight gain.
- Remain free from nutrition-related illness or complications.
- Avoid alcohol, tobacco, and drugs.
- Make an informed decision about breastfeeding.
- Receive adequate community and family support.

The determinants that affect the above health objectives and the overall health goal are explored with the participant by collecting and evaluating relevant information during the WIC nutrition assessment. For example, data on weight, height, pre-pregnancy weight, and week of gestation are collected and evaluated to assess whether the pregnant woman is achieving the recommended maternal weight gain.

In a WIC nutrition assessment, it is important to view the participant holistically. The health outcome–based approach helps the CPA to understand the participant’s needs in the context of health determinants. During the exploration of each health determinant, nutrition risks are explored and further probed to identify potential causes such as knowledge, skills, attitudes and beliefs, cultural practices, family and social environment resources, and access to food and health care. (See **Appendix 5. Sample Springboard Assessment Questions and Probing Questions for Nutrition/Health Objectives** for more information.) In addition to nutrition risks, the CPA identifies and reinforces strengths, motivations,

[18] Office of Disease Prevention and Health Promotion. Healthy People 2030. September 2020. Available from: **https://health.gov/healthypeople**.

healthy practices, accomplishments, and developmental progress. This approach to assessment allows the participant to gain a greater appreciation of how to attain good health and recognize her own needs and/or an infant's or child's needs for health improvement, and can ultimately lead to more effective WIC interventions. See **Section 4. Using Assessment Data to Guide Nutrition Services** for more information on how to use assessment data to personalize nutrition services.

Table 2 shows how the nutrition assessment is organized using health outcomes and health determinants and the CPA's role in assessment. Please note that the examples of nutrition risks and needs and protective factors are not a complete list. The roles listed are examples and do not represent an exhaustive list of all the actions a CPA will take to complete a nutrition assessment. See **Appendix 2. Health Outcome–Based WIC Nutrition Assessment by Participant Category** for similar tables for all five participant categories.

Table 2. Health Determinants and CPA Role in WIC Nutrition Assessment for a Pregnant Woman

Desired health outcome: Deliver a healthy full-term infant while maintaining the mother's optimal health status				
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Nutrition/Health Determinants: Examples of Potential WIC Nutrition Risks/ Needs*	Nutrition/Health Determinants: Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role†
Consume a variety of foods to meet energy and nutrient requirements, and remain free from foodborne illnesses	Dietary Intake/ Nutrition Practices	• Consumes a diet very low in calories and/ or essential nutrients • Compulsively ingests nonfood items • Inadequate vitamin/mineral supplementation • Food insecurity	• Eats a variety of fruits and vegetables, lean proteins, and whole grains • Takes prenatal vitamins or multivitamins with adequate folic acid • Practices food safety behaviors	• Assess current nutrition practices • Assess current and potential impact on nutritional intake and nutritional needs • Assess factors that may affect meal pattern • Identify misconceptions about ideal nutrition practices • Assess potential for foodborne illnesses
Receive ongoing health care, including prenatal care a) Achieve recommended maternal weight gain	Health/Dental Care Weight Height Status (Anthropometric)	• Lack of adequate prenatal care • Lack of medical or dental home • Underweight • Overweight • Low maternal weight gain • High maternal weight gain • Lack of physical activity	• Established a medical home • Enrolled in a health insurance plan • Receives regular oral health care • Eats a variety of foods to meet energy requirements • Engages in physical activity	• Assess barriers to obtaining care • Ask about dental status and treatment already in progress • Assess level of access to follow-up medical care • Assess possible contributors to weight gain/loss (e.g., knowledge and attitudes regarding weight gain, physical activity level, appetite, stress)

Table 2. Health Determinants and CPA Role in WIC Nutrition Assessment for a Pregnant Woman *(continued)*

Desired health outcome: Deliver a healthy full-term infant while maintaining the mother's optimal health status				
Nutrition/ Health Objective	**Nutrition/ Health Determinant Category**	**Nutrition/Health Determinants**		**Competent Professional Authority's (CPA's) Role†**
		Examples of Potential WIC Nutrition Risks/ Needs*	**Examples of Protective Factors***	
Remain free from nutrition-related illness or complications	Clinical/Health/ Medical	• Low hematocrit/ low hemoglobin • Nutrition deficiency diseases • Diabetes Mellitus	• Eats high iron foods • Takes prenatal vitamins/minerals as prescribed by health care provider • Monitors and manages blood glucose levels	• Assess factors that may affect hemoglobin/ hematocrit levels • Assess whether it is likely to be a nutritional or physiological anemia • Assess/reinforce compliance with treatment plan from health care provider
Avoid alcohol, tobacco, drugs, and other harmful substances	Substance Use	• Alcohol and substance use • Nicotine and tobacco use	• Does not smoke • Avoids alcohol, drugs, and other harmful substances	• Assess understanding of the potential dangers to herself and her pregnancy • Assess attitude toward treatment/cessation programs • Assess awareness of available help and readiness to access/ accept it
Make an informed decision about breastfeeding	Infant Feeding Decisions	• Experienced breastfeeding complications previously • Lack of breastfeeding support	• Is knowledgeable about different feeding options • Has an existing support network for breastfeeding	• Assess for more information/participation in breastfeeding peer counseling and other breastfeeding support resources • Assess for contraindications to breastfeeding
Has environmental and family support to thrive	Social Support/ Home Environment	• Homelessness • Recipient of Abuse	• Has access to adequate food preparation and food storage resources • Has access to safe and adequate water • Lives in a supportive and safe environment	• Assess food preparation and food storage equipment • Assess home environment • Identify referral opportunities

*The nutrition/health determinants listed are examples of some of the potential determinants that a CPA could identify during a WIC nutrition assessment. They do not represent an exhaustive list of WIC nutrition risks nor protective factors.

†The roles listed are examples of actions that a CPA will perform during a WIC nutrition assessment. They do not represent an exhaustive list of all the actions a CPA will take to complete a WIC nutrition assessment.

WIC Nutrition Risk and the Health Outcome–Based Approach

The WIC nutrition risks align with the health outcome–based approach in that they are important determinants to health. **The Index of Allowable Risk Criteria** is a complete listing of nutrition risk criteria that are used to determine eligibility for WIC. The listing is on the FNS PartnerWeb community for State agencies.[19] These policy documents assist CPAs in identifying, documenting, and addressing nutrition risks that affect nutrition and health outcomes. Each nutrition risk document includes a definition, scientific justification, targeted nutrition messages, and references. Categories of risk criteria include anthropometric, biochemical, breastfeeding, clinical/health/medical, dietary, and other risks. Having a centralized list and supporting material allows for a consistent understanding and application of risks across State and local agencies and is a resource when training staff. For a listing of nutrition risk criteria aligned with each health objective in the health outcome based framework, please see **Appendix 3. Crosswalk of Health Objective and WIC Nutrition Risks**.

FNS develops WIC nutrition risk criteria through a work group called the Risk Identification and Selection Collaborative (RISC). RISC membership includes National WIC Association–appointed State and local agency staff, along with the FNS National Office and Regional Office staff. This work group manages the ongoing review, revision, and addition of WIC nutrition risk criteria. RISC ensures that criteria are evidence based, practical for WIC application, and nutritionally linked or related to the nutrition services provided by WIC. For more information about the use and management of the FNS-issued nutrition risk criteria by WIC State agencies, please consult **WIC Policy Memorandum 2011-5: WIC Nutrition Risk Criteria**.

/Definition/

The Index of Allowable Risk Criteria

The Index of Allowable Risk Criteria *is a tool that lists nutrition risk criteria permitted for use in determining WIC eligibility and providing nutrition services (nutrition education, food packages, referrals, and breastfeeding support). The nutrition risk explanations are a source of technical assistance to State and local agency WIC staff, providing an evidence-based definition and justification for risk assignment as well as nutrition education messages for each criterion.*[20]

Identifying Strengths, Positive Practices, and Motivations

The VENA approach to assessment emphasizes healthy behavior change and positive health outcomes. Rather than focusing exclusively on a participant's deficiencies, the VENA approach helps CPAs identify a participant's strengths, positive practices, and motivations for change. Research has shown that using the assessment process to only identify deficiencies can be less effective.[21] Often this practice

[19] For a complete listing of the most up-to-date WIC risk criteria, please access the **WIC Nutrition Risk PartnerWeb**.

[20] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

[21] Rollnick S, Miller W, Butler C. Motivational Interviewing in Healthcare. New York (NY): Guilford Publications; 2007.

Tips From the Field—Assessing for Strengths

Just as important as finding out participants' risks is learning what strengths they have that can help them adopt healthy behaviors. In fact, bringing out and acknowledging participants' qualities will make those qualities even stronger. Sometimes these strengths are apparent during the conversation and can be affirmed or reflected by the CPA (e.g., "You don't give up," "You're sensitive to her feeding cues," "You know a lot about nutrition"). CPAs can also ask questions to call forth strengths. CPA questions can focus on emotional strengths, positive resources, or ways participants have successfully faced the same barrier in the past. Some examples might include:

- Tell me about the support you have at home to help you after the baby is born.
- When you weaned your last child, what was helpful?
- What part of feeding your child do you feel most confident about?

makes people feel judged and lowers their overall confidence, thus reducing the likelihood that they will adopt new habits.

By harnessing strengths and supportive healthy behaviors, VENA builds participants' **self-efficacy** to make small, but meaningful, positive nutrition and health choices for themselves and their family. Participant strengths may include personality characteristics (e.g., optimism, creativity), talents, interests, education or knowledge around food and nutrition, or existing resources (e.g., a strong support system at home, access to opportunities for physical activity).

/Definition/

Self-efficacy

***Self-efficacy** refers to a participant's belief about their ability to succeed in reaching specific goals.*

Section 3. The Process of the WIC Nutrition Assessment

The WIC nutrition assessment is a core process of WIC nutrition services that CPAs use to determine program eligibility, and identify and draw out participants' interests, needs, desires, motivations, concerns, and current health and nutritional status. It is the foundation for subsequent nutrition services, including customized nutrition education, breastfeeding promotion and support, guided goal setting, relevant referrals, and tailored food packages.

The VENA approach helps CPAs support each participant reach their desired health outcome by collecting and synthesizing relevant information (e.g., dietary practices, desire for or aversion to breastfeeding, interest in weight loss). With a holistic view of the participant, CPAs use critical thinking to identify topics for nutrition education, as well as potential food package tailoring and referral needs. CPAs assess several factors (i.e. health determinants), including:

- **Health and nutrition status.**[22] Categories of information for assessment include anthropometric (body measurement- and proportion-related), biochemical, breastfeeding, clinical, dietary, and environmental. The CPA's objective is to identify health determinants that will affect health outcomes, including WIC nutrition risks, medical conditions, diet, and health concerns.
- **Potential barriers to desired health outcome.** CPAs also identify barriers that are not WIC nutrition risks but could affect participants' ability to achieve their desired health outcome (e.g., lack of physical activity). Participants may face serious environmental or socioeconomic barriers that may get in the way of successful outcomes. When the CPA identifies a potential barrier, further probing questions are necessary to elicit whether there is an internal motivation for change, there is a need for information sharing, or a referral is necessary.
- **Strengths, knowledge, and capabilities.** CPAs identify and build on strengths by affirming existing positive practices and supporting participants in taking action steps that will address barriers and advance toward goals. Examples of protective factors could be exercising regularly or eating the recommended amount of fruits and vegetables each day.
- **Values, cultural practices, and environmental factors.** CPAs learn what is important to each participant, which will help determine where CPAs focus their efforts. Factors to consider include cultural practices and customs as well as environmental and family influences that affect behavior.
- **Interests and current nutrition-related knowledge.** CPAs identify each participant's interests and knowledge. Personalizing the conversation and information to the participant's interests and current knowledge encourages them to engage in the process.
- **Motivation.** CPAs listen for "motivation language" in order to recognize a participant's internal motivation for change. Motivation language may come in many forms, such as stating a desire ("I want to breastfeed my baby for as long as I am able"), emphasizing something the participant values ("Having family meals together is important to us"), or expressing dissatisfaction ("I hate that she is so picky"). State and local agencies can help CPAs evoke, recognize, and respond to

[22] It is required to document height/length and weight, and hematological test for anemia measurements. Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.7(e)(1) Certification of Participants. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=7a2c252817410a1e102dbbaab0898e9e&mc=true&n=pt7.4.246&r).#se7.4.246_17**

different forms of motivation language through training, mentoring, and other staff development activities. CPAs can have a significant influence on positive behaviors by encouraging, listening for, and responding to motivation language.

Not only is the collection and assessment of relevant information vital to the WIC nutrition assessment process, but *how* CPAs conduct the process is equally important. Some of the skills that are of particular significance to a participant-centered assessment are (see **Section 6. Staff Competencies and Training** for more information):

- Using critical thinking.
- Listening.
- Asking **open-ended questions**.
- Affirming.
- Reflecting.
- Summarizing.
- Empathizing.
- Collaborating.
- Identifying the stage of change.
- Building rapport.

In order to provide high-quality assessments, it is important to adequately define and develop a systematic assessment process. This helps to ensure quality and consistency across assessment activities while creating a framework where WIC staff can function with confidence. A systematic assessment process has advantages, but it cannot be so rigid as to reduce the assessment to a series of questions or data collection points that limit the CPAs' critical thinking and make it more difficult to build rapport with participants.

A WIC nutrition assessment can find balance between standardization and flexibility through the use of a systematic process, shown in **Figure 2**, and the CPA's rapport building skills.

The VENA approach contains elements of both art and science. It requires the use of the CPA's skills in communication and rapport building and the systematic approach to collect and evaluate information elicited from the participant.

Additional Information—Standardized Process Versus Standardized Care

"A standardized process refers to a consistent structure and framework used to provide nutrition care, whereas standardized care infers that all patients/clients receive the same care. This process supports and promotes individualized care, not standardized care." (American Dietetic Association, August 2003)[23]

Figure 2

VENA Approach to WIC Nutrition Assessment

[23] Lacey K, Pritchett E. Nutrition Care Process and Model: ADA adopts road map to quality care and outcomes management. J Am Diet Assoc. 2003;103(8):1061-1072. doi:10.1053/jada.2003.50564

Set the Agenda

CPAs actively involve the participant in the assessment process through dialogue, information exchange, listening, and feedback. Starting the appointment by first setting the agenda, or explaining the assessment process, serves several purposes:

- **Reducing participant anxiety.** Uncertainty about what will take place in any given situation can make people anxious. Participants who request WIC services are usually aware of the food package benefits. Clarifying the other services WIC provides, as well as the purpose of the assessment, helps ease participants' anxiety.
- **Creating a power-sharing dynamic.** Telling participants in advance what will be taking place shows respect and sets up a framework for open and honest communication. This collaborative approach helps the WIC visit stay on track and empowers both staff and participants to maintain focus. Asking permission to proceed can be part of setting the agenda and contributes to the power-sharing dynamic.
- **Increasing participant engagement (buy-in).** Being open about the intent of the assessment will help build interest and encourage participation in both assessment activities and the resulting nutrition services.

There are multiple opportunities to set the agenda in a WIC visit. It depends on the State agency or clinic's service model for when the agenda is set and by which WIC staff. Ideally, the WIC team is clear about the process—both what information is provided and who provides it. Setting the agenda is a shared responsibility that, when done effectively, makes information clear and gets the participant involved.

Collect Relevant Information

The second assessment step is to collect relevant information. The health determinants that affect the desired health outcome are explored with the participant. A consistent, organized approach helps CPAs collect relevant information. Collecting different types of information (e.g., anthropometric, biochemical, breastfeeding, clinical, dietary, and environmental) will help pinpoint protective factors and WIC nutrition risks for each determinant. Although the primary goal is to identify the

The Importance of Language

When a CPA sets the agenda, he/she can help reduce the participant's anxiety. By opening up the conversation with language such as, "I'll be asking some questions about your diet and health. This will help me focus on the information and services WIC provides to meet your needs," the CPA is letting the participant know what to expect. CPAs can also start the conversation with WIC's desired health outcome goal. For example, a CPA could say to a pregnant participant, "The mission of WIC is to support you in delivering a healthy baby and having good nutrition and health during your pregnancy."

information, the information also needs to be organized for meaning and relevance. How the CPA works with the participant to elicit, identify, and respond to information is key to making the participant's experience positive and helps the CPA customize the WIC nutrition services.

Sources of Relevant Information

A: Anthropometric (e.g., height, weight, head circumference)

B: Biochemical (e.g., hematocrit, hemoglobin, blood lead values[24])

B: Breastfeeding (e.g., breastfeeding history, healthcare provider recommendations, mother's breastfeeding goals)

C: Clinical (e.g., immunization record,[25] pre-existing or current medical conditions that may affect nutrition)

D: Dietary (e.g., food preferences, intolerances, dietary patterns, infant and child feeding practices)

E: Environmental (e.g., home environment, socioeconomic status, substance use)

Review of documented information from any prior assessments or other pertinent sources, such as referral information from a health care provider, is also necessary. This review helps the CPA begin the assessment with a better understanding of a participant's circumstances. This step can be critical in building rapport, showing respect, and conveying commitment to continuity of care. For example, it can be tedious and frustrating for a parent who has disclosed the child's serious medical diagnosis on several occasions to be asked again whether the child has any health conditions.

Before beginning the assessment, reviewing additional information sources may help the CPA understand the participant more fully. However, the availability of these sources depends on the agency or clinic's organizational structure and the participant's unique circumstances. Consider these potential sources:

- **The WIC team.** Other WIC staff who have interacted with this participant, whether at the same visit or previously, are a relevant source of information. The WIC team has the opportunity to function as a unit and share information internally, appropriately, and expeditiously.
- **Pre-surveys.** If the process involves collecting information from the participant in advance (e.g., via paper- or web-based questionnaires), reviewing this information will help identify areas where more clarification is needed and potential areas for subsequent nutrition services. Failure to review and use the information provided via pre-surveys can harm the relationship between staff and the participant: If the participant has spent time and energy completing a pre-survey,

[24] Upon enrollment of a child, the parent or caretaker must be asked if the child has had a blood lead screening test. If the child has not had a test, the parent or caretaker must be referred to programs where he or she can obtain such a test. See WIC Final Policy Memorandum 2001-1 at: **https://partnerweb.usda.gov/sites/sfp/WIC-FMNP-SFMNP/policymemodocs/2001-1-LeadScreening.pdf**

[25] It is WIC policy to assure that children served by WIC are screened for immunization status and, if needed, referred for immunizations. See WIC Policy Memorandum #2001-7 at: **https://partnerweb.usda.gov/sites/sfp/WIC-FMNP-SFMNP/policymemodocs/2001-7-ImmunizationScreeningandReferralinWIC.pdf**

it is important that staff review this information in advance and be prepared to build on it during the assessment.

- **Anthropometric or biochemical information.** Reviewing past anthropometric and biochemical information is important because it can identify changes to health status quickly. Growth charts and pregnancy weight gain graphs are valuable as assessment tools and may be used as counseling tools during the nutrition services component of a WIC visit.

Ideally, State agencies will establish expectations, support performance, and create a consistent method of information sharing and documentation from one WIC appointment to another. Similarly, local agencies will identify and support best practices for information sharing among staff to eliminate duplication of effort and foster teamwork, ensuring that WIC staff have easy and consistent access to key information.

When collecting additional relevant information, it is important to determine what information is best gathered at the family level. WIC services are highly individualized, but it is impractical and ineffective to isolate the individual from the family. It is important to consider what information is best identified at

Additional Information—Dietary Risk Assessment

Dietary risk assessment is a critical element of the nutrition assessment because it focuses attention on food and diet as central to health. The WIC dietary assessment is qualitative, not quantitative. WIC staff are encouraged to ask questions about food behaviors and preferences rather than questions about specific nutrients, ounces or servings. The dietary risk assessment is required to:

- Screen applicants for inappropriate nutrition practices.
- Determine specific concerns of the participant or caregiver related to eating/feeding practices.
- Ascertain participant acceptability and use of WIC foods.
- Obtain information that might explain other identified risk criteria.
- Allow a tailored intervention, including anticipatory guidance for each participant.

the family level and what additional clarification is needed specific to each participant. This process has a particularly strong impact on efficiency in assessments for several family members. A family-level assessment can also reduce caregivers' frustration by minimizing the number of times the same questions are asked about each sibling. Nevertheless, while providing services at the family level is desirable, it is also important to maintain documentation at the individual level. The tools used in assessment, such as the MIS, become key to the success of WIC staff. Additional guidance related to the MIS is provided in **Section 5. Technology and Assessment Tools**.

Throughout the process of gathering information, it is essential that staff listen for the participant's needs, interests, strengths, motivation, and potential knowledge gaps. These indicators will determine subsequent nutrition services.

Clarify and Synthesize Information

Synthesis is the critical thinking component of assessment, where the CPA decides whether additional information is needed or whether it is time to move on to nutrition services. In this step, WIC staff organize, evaluate, and prioritize information by integrating facts and informed opinions. By using counseling techniques (e.g., active listening, observation, questions) and critical thinking, WIC staff engage in this circular approach, moving from identifying information to synthesis and back until they are satisfied that they have done a thorough assessment.

In the process of synthesis, the CPA strives to get satisfactory answers to the following questions in order to identify nutrition risk(s) and protective factors:

- Do I hear needs, interest, or motivation?
- Do I hear **resistance** or defensiveness?
- Do I have a sense of health status within each assessment category?
- Do I know enough to confidently assign the correct risk code(s) based on WIC definitions/cutoff values?
- Can I confidently tailor this participant's food package?
- Do I have a sense of how receptive the participant will be to nutrition services?

Tips From the Field— Integrating Assessment Information

Using critical thinking and taking a holistic approach to assessment allows the CPA to see the "big picture" for each participant. Several pieces of information, assessment data, or nutrition risks may be interrelated and affected by one health determinant or behavior. For example, excessive milk intake, low iron, and overweight could all be related to late weaning from the bottle. By assessing the participant's motivations and existing knowledge, the CPA will be able to customize guided goal setting and information sharing.

Transition From Assessment Data to Customized Nutrition Services

A skillfully completed assessment with an adequate synthesis of information will smoothly transition to nutrition services. Additionally, a CPA will be able to use the assessment data to customize nutrition services to meet the participant's needs. Completing the assessment before moving on to nutrition services ensures:

- **Prioritized counseling.** Nutrition messages are limited so that the participant is not overwhelmed.
- **Accuracy of information sharing.** Any tips or suggestions are appropriate and actionable.
- **Individualized services.** Messages, referrals, and food packages are appropriate.
- **Efficient use of time.** Appointment time is spent focused on the most important issues.

Completing the assessment before moving on to nutrition services does not mean WIC staff cannot respond to a participant's needs, questions, or concerns during the assessment. Deciding when and how to respond requires critical thinking from the CPA.

For additional guidance on customizing nutrition counseling discussions for participants, consult the **WIC Nutrition Education Guidance** and **Section 4. Using Nutrition Assessment Data to Guide Nutrition Services.**

/Definition/

Critical thinking

***Critical thinking** is the disciplined process of organizing and synthesizing information to evaluate and prioritize it effectively. Critical thinking involves combining facts, informed opinions, active listening, and observations.*

Document the Assessment

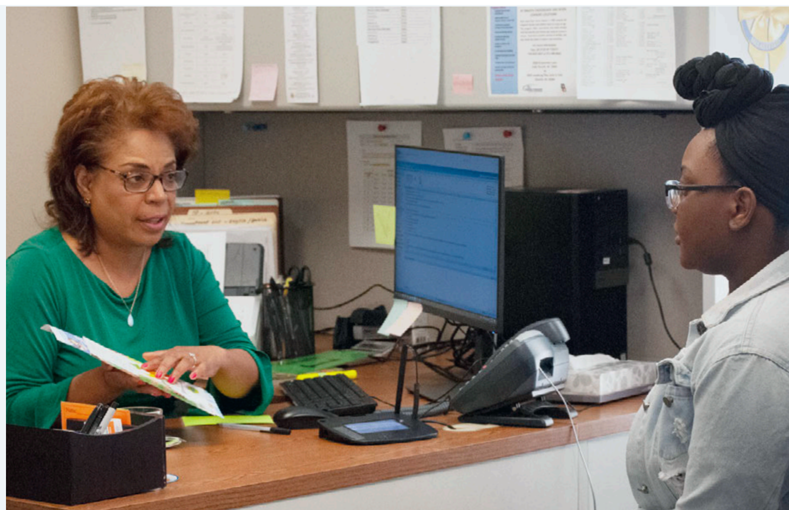
Documenting the assessment is a programmatic requirement[26] that supports continuity of care over time. Documentation is also reviewed during management evaluations and other program monitoring activities to evaluate the quality of WIC services provided. Since documentation related to assessment is just one component of WIC data collection/retention, agencies should establish methods to allow for successful assessment documentation within the broader WIC services continuum. FNS provides guidance on documentation in the WIC Nutrition Services Standards, Standard 14.[27] State agencies can support local staff by establishing policies and practices that balance adequate documentation while preventing excessive data collection that can reduce time available for nutrition services.

[26] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.7(e)(1) Certification of Participants. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=7a2c252817410a1e102dbbaab0898e9e&mc=true&n=pt7.4.246&r).#se7.4.246_17**

[27] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

Tips From the Field—Responding to Participant Questions During the WIC Nutrition Assessment

Completing a thorough assessment before providing nutrition services is a best practice for many reasons, but this does not mean that CPAs cannot respond to a participant's questions and concerns during assessment. One question that can help guide decisions about how to respond appropriately to questions and concerns is, "Do I have the information I need to answer this person's question?" If not, a CPA can respond by assuring the participant that he or she will come back to the question or concern after gathering additional information. There may be other instances when responding to a question or concern during the assessment is appropriate.



CPAs should use their critical thinking skills to determine what is best for each participant in each situation.

When creating policies around the types of information to be collected and documented, State agencies should consider:

- **Utility.** The collection of data that is not required or acted upon should be minimized or eliminated.
- **Ease of access.** CPAs should know where to find past assessment information quickly and consistently.
- **Referral data.** CPAs should know if the State agency and/or local agency has a Memorandum of Understanding for data sharing with other health care providers.

Consistent documentation processes make communication with other WIC staff easier and allow for continuity of care over time, helping to streamline workflow and allowing the CPA to start discussions after only a minimal review of the previous nutrition assessment. See **Section 5. Technology and Assessment Tools** for additional guidance about MIS documentation.

High-quality documentation helps staff deliver meaningful nutrition services and ensures continuity of care for WIC participants. All risks identified through the assessment process must be documented along with other information necessary to support ongoing care. For more on documentation requirements, consult **WIC Policy Memorandum #2008-4, WIC Nutrition Services Documentation**, and the *WIC Nutrition Services Standards,* Standards 6 and 14.[28]

[28] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

Conduct Follow-Up Assessment

The process of assessment is ongoing, with documentation from previous assessment(s) creating the foundation for subsequent WIC visits. At the follow-up visit, the CPA assesses any change from previous visits and collects additional information needed to help the participant achieve small positive behavioral changes over time. Depending on the situation, the CPA may prioritize what information to include in the follow-up assessment before moving forward. For example, it may be necessary to update some of the original assessment data, such as rechecking weight or hemoglobin/hematocrit values. In many cases, the follow-up will include checking on the status of a prior referral or assessing progress toward goals. This review will allow the CPA to work with the participant to either set new goals or address any challenges. Since there are many types of WIC visits, the WIC State agency will determine policies about when and how CPAs conduct follow-up assessments.

The Importance of Language

The words used to document an assessment are often different from those used to communicate with a participant. It is important to make careful distinctions between the language used for WIC administration and that used with participants. For example, while a CPA might document a participant as "high risk," telling the participants that they are high risk may be inappropri-ate and disruptive.

Tips From the Field—Don't Start From Scratch

Many State agencies have a WIC MIS that make it possible to see or import information from previous certifications, allowing CPAs to start from an informed standpoint and reducing the time needed for the assessment process. Although some information will change and need to be updated, other information, such as chronic medical conditions, may not change.

Local agencies should use past assessment information at follow-up appointments. This information is helpful for monitoring growth or health status, checking in on nutrition goals or creating new goals, and closing the loop on referrals.

Table 3 shows an example of the CPA's role at each step in the VENA approach to the WIC nutrition assessment process for a child determined to be overweight.

Table 3. Nutrition/Health Determinant Example: Overweight Child

WIC Nutrition Assessment Step	Competent Professional Authority's (CPA's) Role
Setting the agenda	The CPA introduces him/herself and gives the parent/caretaker a brief description of what they will be doing together. The CPA discusses the desired health outcome for a child (see **Table 1**).
Collecting relevant information	Collects health and nutrition status information; potential barriers to healthy outcomes; strengths, knowledge and capabilities; values, cultural practices, and environmental factors; interests and current nutrition knowledge; and motivations.
Clarifying and synthesizing information	Using springboard questions and probing questions, active listening, and observation, the CPA assesses for motivations, existing knowledge, and potential knowledge gaps. Is the parent/caregiver concerned about the child's weight? Are feeding practices appropriate? Does the parent/caregiver have options for providing physical activity for the child? Are the measurements accurate? The CPA identifies nutrition risks and needs (e.g., high intake of sugary beverages and snacks, overweight, lack of resources for physical activity). The CPA identifies protective factors (e.g., offering a variety of fruits and vegetables, expressing interest in improving diet).
Using assessment data to guide nutrition services	The CPA customizes information sharing and guided goal setting. For example, if the parent/caregiver wants to increase the child's activity, the CPA can share information about local area activities for children. If the parent/caregiver is concerned about how many sugary drinks the child consumes, the CPA can help set a goal for reducing sugary drinks and offer suggestions for alternatives.
Documenting the assessment	The CPA enters information in the participant's record, including data collected during the assessment that is required for eligibility (e.g., nutrition risk codes) and for follow-up care in future appointments (e.g., referrals made, goals set).
Conducting the follow-up assessment	At the next assessment, the CPA rechecks the child's weight and height and follows up on any referrals provided or assesses progress toward the goal set at the previous visit. The CPA affirms progress and/or helps the parent/caretaker identify ways to overcome barriers.

Section 4. Using Assessment Data to Guide Nutrition Services

Outcomes of the VENA approach to the WIC nutrition assessment process include customized nutrition education and breastfeeding counseling, a tailored food package, and targeted referrals if needed. CPAs use critical thinking to integrate each participant's unique set of circumstances, medical conditions, nutrition practices, and breastfeeding goals into a cohesive plan for nutrition services. Based on the participant's needs identified during the WIC nutrition assessment process, the CPA provides referrals and tailors the food package as necessary. For example, if a food allergy to egg is identified, the CPA will tailor the participant's food package to remove the eggs. Likewise, if a lack of a medical home is identified, the CPA will provide the participant with a referral to local area health care facilities.

/Definition/

WIC nutrition assessment

***WIC nutrition assessment** is the process of collecting and synthesizing relevant information in order to:*

- *Assess an applicant's nutrition and breastfeeding status, risks, capacities, strengths, needs, and/or concerns.*
- *Identify and assign WIC nutrition risk criteria.*
- *Customize counseling strategies (e.g., nutrition/ breastfeeding education, guided goal setting,* **affirmations***) that address a participant's needs and concerns.*
- *Tailor the food package to address nutrition needs and breastfeeding status and preferences, including those based on the participant's culture.*
- *Make appropriate referrals.*[29,30]

The Importance of Language

When exploring nutrition risks identified through the assessment, CPAs decide on the most effective communication strategies to meet each participant's needs. WIC State agencies may determine how the information is communicated to participants, provided that it is reflective of the VENA approach. That is, the information is provided to participants as part of a positive, participant-centered assessment process.[31] Although the term "risk" is used for documentation, using the term with participants may cause undue anxiety and negative emotions and undermine the VENA approach. Instead, the CPA can discuss the risk from an optimistic perspective, as something that can be resolved or improved in the future through behavior changes. The CPA can also normalize the risk by saying something like, "A lot of parents worry about their child drinking too much juice. Does that concern you?"

During the WIC nutrition assessment process, the CPA explores the protective factors unique to a participant and reinforces positive behaviors, motivations, and nutrition knowledge. CPAs personalize each conversation to best help the participant move closer to adopting nutrition and health behaviors for positive outcomes. For some participants, this might mean evoking and responding to hopes (e.g., "I don't want him on the bottle too long; I worry about his teeth") and using guided goal setting to help participants take small

[29] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

[30] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

[31] For more information on explaining the purpose of the assessment process for participants, consult **WIC Policy Memorandum #2008-1, WIC Program Explanation for Participants**.

behavioral action steps. For others, it may mean affirming or building on existing plans or positive behaviors. The CPA works with the participant to mutually determine where to focus the nutrition education conversation—using the nutrition risk and needs identified in the assessment as the menu of topics to choose from for discussion. Topics not covered at the certification appointment may be covered in later visits.

VENA both allows for and informs personalized discussions. State agencies can strengthen this approach by designing policies that help CPAs use their best judgment. In addition to fostering professional judgment or critical thinking, training and mentoring help staff feel more comfortable about the adequacy of their assessment practices and documentation and nutrition services. For more information on staff skills and training, see **Section 6. Staff Competencies and Training**.

Behavior Change Theories

The VENA approach emphasizes healthy behavior change and positive health outcomes. Behavior change theories and models provide the rationale for effective assessment and counseling approaches. Examples of behavior change theories include the **social-ecological model (SEM)** and the **transtheoretical model (TTM)**, also called Stages of Change.

The SEM provides a framework to show how an individual's food and physical activity choices are influenced by many factors. Individual demographics (e.g., age, ethnicity, income) and personal factors such as knowledge, skills, and preferences play a role, as does where individuals work, play, shop, learn, and pray. Organizations, businesses, and Government policies and systems shape an individual's access to healthy food and/or opportunities to be physically active. Social and cultural norms and values influence choices and, ultimately, health.

Through VENA, the CPA can apply the SEM in order to consider the multiple levels of individual and social influences and protective factors that can support participant behavior change to achieve positive health outcomes. Evidence suggests that changing behavior requires the support and engagement of various sectors of society. For example, a women's decision to breastfeed is highly influenced by her social network, and to be successful she needs institutional support, such as hospital practices that enable and encourage breastfeeding and workplace policies that provide accommodation for nursing mothers.

The TTM is based on the assumption that people do not change behaviors quickly but gradually, in incremental stages.[32] There are five stages of change that progressively move toward sustaining a long-term behavior change (i.e., maintenance stage). The model assesses a participant's willingness to make a behavior change in a specified amount of time (e.g., "In 3 months, I want to start walking every night after work") and linking it with a stage of change (e.g., the preparation stage). By understanding which stage of change the participant is in, the CPA can provide the appropriate strategies that will help the participant move into the next stage of change until ultimately reaching behavior maintenance.

[32] Prochaska JO, Redding CA, Evers K. The transtheoretical model and stages of change. In Glanz K, Rimer BK, Lewis FM, eds. Health Behavior and Health Education: Theory, Research, and Practice. 3rd ed. San Francisco (CA): Jossey-Bass, Inc.; 2002:99-120.

Table 4 shows the transtheoretical model's stages and their corresponding time frame.

There are also counseling methods that can help a CPA apply the VENA approach to the WIC nutrition assessment. **Table 5** shows several counseling methods based on behavior change theories that have proven to be successful for identifying a participant's strengths and motivations for change, even when time for intervention is limited.[33,34]

Note: Please see **WIC Works Resources System** for staff training resources for some of the behavior change theories described below.

Table 4. Transtheoretical Model and Stages of Change

Stage	Time Frame for Intended Behavior Change
Precontemplation	Do not intend to start healthy behavior within the next 6 months
Contemplation	Intend to start healthy behavior within next 6 months
Preparation	Intend to start healthy behavior within next 30 days
Action	Currently performing healthy behavior for less than 6 months
Maintenance	Currently performing healthy behavior for more than 6 months

Table 5. Counseling Methods to Identify Strengths and Motivations for Behavior Change

Stage	Time Frame for Intended Behavior Change
Motivational interviewing	Designed to explore and enhance an individual's internal motivation to change by resolving ambivalence, eliciting the importance for change, and increasing confidence to make change.
Appreciative inquiry	Focuses on building confidence by drawing out positive feelings related to what went well in the past, what is going well in the present, or what the family wants for the future.
Emotion-based counseling	Taps into how an individual feels about a given topic. It recognizes that while information and facts are important, emotions are more frequently the driver behind change.
Three-step counseling	Designed to promote positive practices by asking open-ended questions to reveal barriers or concerns, affirming and normalizing feelings, and sharing targeted information.

[33] Spahn JM, Reeves RS, Keim KS, et al. State of the evidence regarding behavior change theories and strategies in nutrition counseling to facilitate health and food behavior change. J Am Diet Assoc 2010;110(6):879-891. doi:10.1016/j.jada.2010.03.021

[34] Resnicow K, Davis R, Rollnick S. Motivational interviewing for pediatric obesity: conceptual issues and evidence review. J Am Diet Assoc 2006;106(12):2024-2033. doi:10.1016/j.jada.2006.09.015

Promoting Positive Behaviors

In most behavior change strategies, the concept of a person's inner motivation for change plays a central role.[35] One underlying assumption is that an individual's success in making behavior change is highly dependent on the person's internal beliefs and motivations regarding change. Unless a participant has internal motivation, providing information alone is unlikely to get the participant to change the behavior. Through VENA, CPAs have a powerful role in inspiring and building motivation for adopting positive nutrition- and health-related behaviors. Most participants have specific hopes or goals for themselves and their families, often centered on nutrition and overall health. By drawing out and building on these inner motivators, CPAs can help participants increase their chances for success. Often this involves the CPA helping participants connect goals regarding nutrition and health to small achievable action steps or identifying and building on existing positive behaviors and practices.

Sometimes the CPA might identify a nutrition risk and other barrier and, through probing, determine that the participant is not motivated to change or that information does not need to be shared. For example, a parent may share that she is aware of the recommendation for bottle weaning but that she prefers to wait until the child is older. Before urging her to wean earlier, the CPA can ask probing questions to identify the parent's reasons for delayed weaning. This framing is more likely to get the parent to talk about her beliefs and concerns around bottle use and weaning and may lead to an opportunity for change.

Additionally, compelling someone to make positive changes when the person is not ready can actually increase the participant's resistance to change and call forth **resistance talk**.[36] Knowing commonly used resistance talk statements can help CPAs identify resistance talk. CPAs can facilitate the transition from resistance talk to behavior change intention by expressing understanding, suggesting alternative ways to think about the issue, and performing guided goal setting.[37] It is important for the CPAs to facilitate these discussions with respect for the participant's autonomy.

/Definition/

Resistance

***Resistance** is a process of avoiding or diminishing sharing about oneself because the individual feels uncomfortable or anxious. **Resistance talk** is verbal evidence that participants are not ready to change and feel they need to defend against change. The more participants put forth arguments against change, the less likely it is that they will change their behavior. Resistance talk could mean participants are being pushed to make a change they are not ready for.*

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[35] Rollnick S, Miller WR, Butler CC. Motivational Interviewing in Healthcare. New York (NY): Guilford Publications; 2007.

[36] Kellogg M. Counseling Tips for Nutrition Therapists Practice Workbook (Vol. 1 and 2). Philadelphia (PA): Kg Press; 2006, 2009.

[37] Contento IR. Step 5: translating behavioral theory into educational strategies: a focus on enhancing motivation for change. Nutrition Education: Linking Research, Theory, and Practice. 2nd ed. Burlington (MA): Jones & Bartlett Learning; 2011:254-255.

Building Health Outcome–Based Goals

The VENA approach, using health outcomes as a focal point, allows discussions to be positive and proactive. Rather than talking about a nutrition deficiency as a problem to be solved in isolation, the conversation is more broad, addressing underlying determinants of health and emphasizing the behaviors that will influence participants' health over the lifespan. For example, a normal growth pattern and a healthy weight for a child are not behaviors but rather outcomes influenced by several behaviors, such as parents' following good infant feeding practices and the child's eating a variety of healthy foods and engaging in physical activity. It is important to connect the overall WIC health outcome (i.e., achieve a normal growth pattern) to specific goals for the participant (i.e., child achieving a healthy weight). Goals are achieved not by internal motivation alone but rather through a combination of observing the identified behavior change (e.g., the parent observes the child's eating pattern) and applying nutrition and health knowledge (e.g., what the parent learned from the CPA about appropriate infant feeding practices). The CPA can guide the participant through the goal-setting process and break each goal into small achievable action steps.

Tips From the Field—Less Is More

The nutrition assessment may identify several areas where behavior change could improve a participant's nutrition and health outcome. However, addressing too many areas at once can be overwhelming to the participant and make taking action harder. CPAs can use the VENA approach to prioritize topic areas. Because there are multiple opportunities for nutrition education over the course of a certification, CPAs can focus on small targets and behaviors over time rather than trying to address all determinants during one visit.

Focus Goals on Small Achievable Action Steps

The CPA guides the participant toward improved health outcomes through incremental behavior change by breaking goals into small achievable action steps. By demonstrating how a goal can be achieved through small action steps, it will help the participant gain confidence in their ability to perform the action steps and achieve the goal. With each successful step taken and goal achieved, participants will gain more confidence and often greater motivation, empowering them to maintain healthy behavior.

Table 6 shows examples of participant goals and action steps based on several nutrition/health objectives.

The Importance of Language

In many programs, WIC staff strive to establish goals with participants that are specific, measurable, achievable, relevant, and time-bound (SMART). However, different terms such as "next steps" or "small changes" may be better understood by participants. If a participant uses the term "goal," it is completely appropriate for the CPA to use that word as well. As with all word choices, CPAs select the most effective language based on real-time interactions and what will be most effective with the individual participant.

Behavior change is complex, but the VENA approach can help CPAs conduct the WIC nutrition assessment in a way that will identify a participant's determinants of health and internal motivations. Together, the CPA and participant can create small, achievable goals that can be taken to achieve a positive health outcome.

Table 6. Examples of Participant Action Steps

Nutrition/Health Objective	Example of a Participant Goal	Example of Action Step
Consume a variety of foods to meet energy and nutrient requirements and remain free from foodborne illness.	• Bring a homemade lunch and healthy snacks, including fruits and/or vegetables, to work instead of eating fast food.	• Prepare lunch and snacks the night before work.
Receive ongoing health care, as appropriate.	• Find a medical and dental home for child.	• Make an appointment with a health care provider. • Contact one of the pediatric dentists on the WIC referral list.
Achieve appropriate weight for life stage.	• Increase physical activity. • Decrease sugar intake.	• Take a walk four times per week. • Limit juice offered to a child to 4 ounces or less per day.
Remain free from nutrition-related illness or complications.	• Manage hyperemesis gravidarum to reduce nausea.	• Put crackers or dry cereal by bed to eat before getting up in the morning.
Avoid alcohol, tobacco, and drugs.	• Reduce the number of cigarettes smoked per day.	• Contact a smoking cessation helpline for additional information and support.
Breastfeed successfully for as long as desired.	• Exclusively breastfeed infant for 6 months.	• Create a plan for breastfeeding support after delivery. • Attend breastfeeding class next month.
Receive proper environmental and family support to thrive.	• Feel like healthy behaviors are supported by family members.	• Enroll in a free parenting class at a local health center. • Ask a partner to read the breastfeeding handout.

Section 5: Technology and Assessment Tools

Technology can enhance aspects of the VENA approach. For example, technology enables consistent data collection and rapid data analysis (e.g., by plotting growth graphs or identifying nutrition risks). It can support staff with an assessment framework and access to reports on participant characteristics (e.g., nutrition risks, demographics), and it offers opportunities for remote engagement with participants (e.g., videoconferencing).

In addition, State and local agencies may emphasize the collection and use of referral data from medical providers or other approved sources. Advances in technology and use of electronic medical records make it possible to use referral data across programs (e.g., WIC staff in an agency that provides health care may be able to access participants' medical records). For example, if a child was tested for hematocrit/hemoglobin at a recent medical appointment, using this information streamlines the assessment process and means there is more time to provide nutrition services. WIC agencies may explore data sharing agreements to permit access to referral data. Although establishing those agreements can take some time and effort up front, the return on investment typically makes it worth the effort.

However, despite its many advantages, technology can also present challenges in providing services to participants. For example, it can hamper the interpersonal communication between participants and CPAs, make staff rely too much on the tool and not enough on their own critical thinking skills, encourage overzealous data collection, and shift the focus from supporting health outcomes to just completing the assessment process. It is important to carefully balance priorities when incorporating technology into the assessment process. This section will address considerations to ensure that the VENA approach is maintained when technology is used during a WIC nutrition assessment.

**Tips From the Field—
Don't Start From Scratch**

When designing assessment questions, State agencies may collect tools and questions from other State agencies and tailor questions to be appropriate for their own populations. State-developed VENA training tools and webinars can be found on the **WIC Works Resource System**.

Designing Assessment Questions

WIC State agencies establish policies and practices to support a consistent VENA approach, including determining what dietary information to collect and what types of assessment tools and questionnaires to use, that will lead to a quality WIC service.

As information technology evolves and the needs and demographics of participants change, State agencies continue to improve assessment methodologies and instruments. There is no one tool or assessment process that will meet the needs of all State agencies, so there is a great deal of variation in tools and practices used. Although the assessment instruments/methods may vary, suggestions for designing processes include the following:

- Incorporate open-ended questions. Open-ended questions require more thought and more detailed answers. They allow the participant to share a range of responses and can help the CPA collect information about behaviors, values, and motivations.

- **Consider question order.** This affects the assessment conversation. One recommendation is to save highly personal or sensitive questions until later in the assessment, when more trust is established. Starting with some open-ended springboard questions (e.g., "What are some of your child's favorite foods?") sends the participant an early message that their engagement and participation in the process are valued. (For additional examples of springboard questions, see **Appendix 5. Sample Springboard Assessment Questions and Probing Questions for Nutrition/Health Determinants**.)
- **Encourage additional probing questions.** Although questions about behaviors will be more qualitative, it is sometimes necessary to ask follow-up questions to identify risk factors. Probing questions are also useful in determining whether a participant is motivated to address barriers or whether information sharing is appropriate.
- **Add questions to draw out internal motivation and values.** Questions specifically designed to evoke a participant's inner motivation, hopes, or concerns around health and nutrition will help the CPA personalize the conversation. For example, when working with a pregnant participant, the CPA could ask, "For you, what are the top three reasons you have decided to breastfeed?" or "How do you feel on the days when you manage to have a healthy breakfast instead of stopping for fast food?"
- **Allow flexibility in phrasing.** How CPAs phrase questions should depend on several considerations, such as the participant's age, literacy level, or knowledge of issues related to nutrition and health. CPAs should also practice multicultural awareness when phrasing questions.

Tips From the Field—Testing Participant-Facing Assessment Tools

An important step in finalizing any assessment tool that a participant will complete is to test it with a group of participants who reflect the population's diversity. Testing can determine whether wording is appropriate, questions are clear, time required to respond is not burdensome, and the tool is effective in collecting the intended information.

Tips From the Field—Evoking Interests, Motivations, or Challenges

In addition to collecting data about health status and behaviors, CPAs can collect information on a participant's interests and motivations and any barriers they face. All of this information can help customize the conversation to the participant's needs. Using open-ended questions that allow the participant to enter a response or choose topics of interest is a good way to engage the participant.

The Index of Allowable Risk Criteria gives CPAs a well-informed position to identify the nutrition risks and needs of the participant. For example, there are many WIC nutrition risks and needs associated with nutritionally related medical conditions; if a participant has such a condition, it is important for the CPA to consider it when customizing nutrition counseling. It is also important that the CPA document the condition to ensure continuity of care, providing information for the next CPA who works with the participant. However, it is not necessary or productive for the CPA to ask about each medical condition individually, expending valuable time that is better spent providing tailored nutrition services. Instead, CPAs can use global "springboard" questions to ask about medical conditions or identify other needs. The CPA can also use "probing" questions to further pinpoint deterrents.

Tips From the Field—Springboard Questions

To make the assessment as efficient as possible, CPAs often use open-ended springboard questions. These questions will help the CPA determine whether additional questions are necessary to probe for protective factors or needs within each determinant. For example, a CPA may say to a pregnant participant, "Tell me about any concerns or problems you are having with this pregnancy." The participant's response might share information that will help the CPA identify and document relevant risk factors. This approach is more effective than asking about each potential medical or health condition individually and allows the CPA to target additional probing questions. (For additional examples of health determinant–based springboard questions, see **Appendix 5. Sample Springboard Assessment Questions and Probing Questions for Nutrition/Health Determinants**.)

Tips From the Field—Maintain Focus on the Participant

Although the MIS is critical to participant services, CPAs should remember to maintain focus on the participant, not on the computer. Focusing on the participant helps build rapport and maintains the CPA–participant relationship. The CPA can stay focused on the participant by:

- Reviewing key historical information in the MIS before welcoming the participant into the office.
- Making eye contact throughout the appointment.
- Setting up the office so it is not dominated by the computer.
- Starting the assessment-related conversation with the participant, then turning to the computer to enter data, rather than doing both simultaneously.
- Asking permission to turn away from the participant to enter data as needed.

Management Information Systems

The FNS **Functional Requirements Document for a Model WIC Information System** describes data and functions associated with nutrition assessment, including maintaining participant nutrition and health characteristics, calculating **body mass index (BMI)** and producing growth charts, capturing and documenting blood test results, and determining nutrition risk factors.[38] A well-designed WIC MIS can support a quality WIC nutrition assessment. **Table 7** below lists some MIS functions to consider when a MIS is being designed or updated.

Table 7. MIS Functions/Components and Considerations

MIS Functions/Components	Considerations
Policy alignment	• Do the structure and function of the management information system (MIS) line up with the process and style Competent Professional Authorities (CPAs) use to complete the assessment and provide services?
Data collection	• What are the data used for? • Does the benefit outweigh the cost of collecting the data? • Is it clear which questions are mandatory and which are optional? • Are data maintained and easy to retrieve (e.g., prepopulated) for future certifications/appointments when appropriate?
Risk assignment	• Does the MIS support auto-assignment of risk factors? • Is it clear to staff which risks are auto-assigned and which are manually assigned? • Is it clear how an auto-assigned risk is generated?
Assessment questions	• How many assessment questions need to be included in the MIS? • Are the questions provided as examples or scripted? • What probing questions can be asked following a springboard question? • Is the wording of assessment questions aligned with best practice expectations (e.g., open-ended questions when appropriate, nonleading questions, questions to evoke needs and motivations)?
Notes	• Does the MIS make individualized documentation possible? • Are notes available in a central location within the MIS? • Is documentation for past visits easily accessible during subsequent visits?
Length of assessment	• How many screens and clicks are needed to complete a certification? • How long does it take a staff member to navigate the system to complete a certification or provide follow-up services?

[38] U.S. Department of Agriculture, Food and Nutrition Service. Functional Requirements Document for a Model WIC Information System. September 2008. Available from: **https://fns-prod.azureedge.net/sites/default/files/apd/FReD-v2.0-Final.pdf**

Other Technology to Collect Assessment Data

As technology advances, more WIC agencies are introducing innovative strategies for collecting assessment data before the one-on-one sessions. Collecting some data ahead of time can allow for a more personalized discussion. Instead of spending time collecting the data, CPAs can focus instead on building on the data and asking additional questions to target support and information sharing.

WIC agencies are using different types of technologies and tools, including tablets, cellphones, downloadable apps, and online questionnaires, to collect assessment data. Examples include having a participant complete initial questions on a tablet in the waiting room or asking the participant to complete questions before the visit, using their own cellphone, tablet, or computer. Important considerations when using technology to collect assessment data before the appointment include the following:

- **Workflow.** To use the data effectively to inform the assessment process, the CPA must have time to review the data ahead of the session. Doing this before the face-to-face discussion demonstrates respect to the participant and allows the CPA to follow up on any information as necessary.
- **Choice of questions.** Some assessment questions may be appropriate to ask before the visit, while others may be most effective if asked during the one-on-one meeting. For example, the CPA should ask commonly misunderstood questions during the visit rather than providing them to the participant beforehand. Regular updates to any pre-assessment questionnaires are also critical. Input from local agency staff is valuable in identifying commonly misunderstood questions and determining whether they should be reworded or simply deleted.
- **Integrating or storing information.** When considering tools for collecting assessment data, it is important to consider what data need to be stored and whether the technology can be integrated into the MIS. Regardless of how the data are collected and stored, it is important to prevent duplication of effort by WIC staff and ensure confidentiality of any personal health information.

Providing WIC Services Remotely

Providing remote WIC services helps both the Program and participants, with benefits such as expanding scheduling options, requiring less time for appointments, eliminating transportation barriers, and reducing congestion in clinic waiting areas. Before initiating remote services, State agencies must develop detailed policies and procedures for FNS review and approval.[39] Technology also offers more types of encounters, such as remote consultations with a registered dietitian or breastfeeding consultant and flexibility for the location where participants can receive services (e.g., at home or in a workplace). Remote access can also allow staff fluent in a particular language to provide direct service in participants, eliminating the need to work through an interpreter service. These options offer convenience and flexibility for participants. Reducing barriers to accessing WIC services will make it easier for participants to remain in and benefit from WIC.

WIC staff will require relevant training and support to provide WIC services remotely. For example, new workflow patterns or practices to accommodate the addition of remote options may be needed.

[39] Services can be provided remotely only when all regulatory requirements related to certification and physical presence exceptions are met. Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.7(o) Certification of Participants. August 2019. Available from: **https://www.ecfr.gov/cgi-binretrieveECFR?gp=&SID=7a2c252817410a1e102dbbaab0898e9e&mc=true&n=pt7.4.246&r).#se7.4.246_17**

Involving the local staff in planning will help ensure their buy-in and that the resulting strategy meets the needs of both the agency and participants. Participants too may need training on how to access and use the new technology. Pilot-testing remote services with a small group of participants or staff allows an opportunity to find and address issues in the processes before launching them to a wider audience.

Technology can be effective for remote appointments, but it is important to acknowledge its limitations; it may not be appropriate for every participant. For example, some participants may not have Internet access, and others may lack videoconferencing options on their phone or computer or may find costs for data usage prohibitive. Some participants may simply prefer a face-to-face encounter. Other participants may choose to attend some appointments in person and others remotely. When conducting an appointment remotely, consider the following strategies to make the interaction effective.

Avoid Distractions

Reduce distractions both for the CPA and the participant. Tell the participant in advance that being in a private, quiet place during the appointment is ideal. Provide the CPA with a similar environment.

Prepare in Advance

Ensure that information such as measurements, materials, or resources (e.g., handouts, websites, apps) will be available during the discussion.

Compensate for Lack of Body Language

For audio-only assessments, account for the lack of nonverbal communication. Body language is a rich source of information that is not available via telephone, so tone and word choice become even more important. Techniques that CPAs can use to compensate for lack of visual contact include the following:

- Smile at the beginning of the call; the participant will sense the smile by the tone of your voice.
- Set the agenda for your time together.
- Use follow-up questions, **reflective listening**, and summaries.
- Listen even more carefully for motivation language.

Tips From the Field—Collecting Anthropometric and Hematologic Data

Agencies must consider how to collect anthropometric or hematologic data before remote appointments. Referral data from medical providers or access to electronic medical records is helpful. Another option is to arrange brief walk-in visits for measurements and blood tests in the WIC clinic at a convenient time before the remote appointment.

Section 6. Staff Competencies and Training

Hiring and training qualified staff are essential in providing quality WIC services. State agencies may put VENA into action with well-trained professional or paraprofessional staff. Regardless of staff members' education or experience before working with WIC, State and local agencies must emphasize development of the essential knowledge base and work skills. Training, followed by ongoing staff development activities, ensures that WIC personnel maintain and refine their skills and have opportunities to develop new ones. For more information, please see the WIC Nutrition Services Standards, Standard 5.[40]

Competency Areas for WIC Nutrition Assessment

Competencies are desired outcomes for knowledge, skills, and behavior. When learners demonstrate a **competency**, they are demonstrating their ability to do something. In the VENA approach, competencies address a variety of knowledge and skill areas and are specific to the environment where the CPA works. Developing or selecting appropriate competencies should be based on factors such as job responsibilities and the CPA's educational preparation and experience. In developing staff competencies, it is important to consider the individuals' inherent talents and abilities, as well as their learned skills.

Because the tasks involved in VENA are fairly consistent among WIC agencies, the following six competencies to perform those tasks have been identified:

- **Principles of life cycle nutrition.** Understanding normal nutritional needs during pregnancy, lactation, the postpartum period, infancy, and early childhood.
- **The VENA approach.** Understanding the steps in the VENA approach to nutrition assessment, to include all the requirements related to blood work, anthropometric measurements, documentation, follow-up visits, and so on.
- **Data collection techniques.** Understanding the importance of precise and valid data, as well as how to collect anthropometric and hematological data.
- **Communication.** Knowing how to communicate effectively with participants and foster open exchanges.
- **Multicultural intelligence/awareness**. Understanding how sociocultural issues (race, ethnicity, religion, group affiliation, socioeconomic status, and worldview) affect nutrition and health practices and nutrition-related health problems.
- **Critical thinking.** Knowing how to analyze and synthesize information to draw appropriate conclusions.

[40] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

- For more information about the knowledge required and performance expected for each competency, see **Appendix 4. Essential Staff Competency for WIC Nutrition Assessment**

Building Competencies Through Training

Training approaches that focus on the outcome rather than the process of learning are ideal. Because many competency-based approaches incorporate independent learning, CPAs progress at their own rates. Training activities are planned to accommodate differences in learning styles and ensure that CPAs acquire the skills, understanding, and attitudes needed to function in their specific work roles. Because the conditions and requirements for performing most roles continuously evolve, it is important to review and update competencies regularly. State agencies may develop different training programs based on staffing patterns and service delivery models.

Tips From the Field—Ways to Build and Maintain WIC Nutrition Assessment Competencies

- Conduct regular in-service training to maintain focus on quality services.
- Identify and address individual employees' training needs.
- Provide opportunities for staff to attend local, State, and national nutrition training events and conferences focusing on maternal and child nutrition.
- Use training opportunities to discuss participant case studies and reinforce WIC nutrition assessment skills.
- Discuss successes and challenges during team meetings or huddles.
- Include role-playing or simulations in training events.
- Observe staff conducting WIC nutrition assessments and provide constructive feedback.

Tips From the Field—Encourage Self-Assessment

Having staff assess their own skills can help identify ongoing training needs. Self-assessment activities might include the following:

- Conducting a short interview with each staff member to ask about areas where the member is confident and where the member feels she or he need more training.
- Asking staff to rate themselves on various skills, using a scale where 1 equals "needs significant practice" and 5 equals "excellent."
- Conducting a short survey with staff that includes asking open-ended questions about their strengths, areas needing improvement, and what support would be most helpful in developing skills.

Trends or themes across staff members' responses can indicate areas where they require more training or mentoring.

Identifying Training Needs

Staff training needs can be identified in several ways. First, comparing essential competencies and performance expectations with the content of training programs for new staff can reveal gaps or areas for enhancement. Second, observation and mentoring provide excellent opportunities to evaluate individual staff members' performance with WIC nutrition assessments and further build their competence through constructive feedback. Third, ensuring that staff understand what is expected of them is essential to ensuring high-quality performance.

Planning Training to Build Competencies

CPAs must be able to do more than list or describe facts, data, or other information. Competencies combine higher-level cognitive skills and critical thinking to determine a course of action. Training begins with verifying that a foundation of knowledge exists or providing opportunities to establish

such a foundation. Trainees can then move on to synthesizing facts through problem-based learning and evaluating their performance through simulations. As training continues, opportunities for independent learning and performance in the work setting are incorporated until the trainee is proficient at job-related tasks. A well-designed training program includes various techniques to reach training outcomes in all areas: knowledge, skills, attitudes, and values. **Table 8** shows appropriate techniques for desired learning outcomes.

Tips From the Field—Use Mentors to Enhance Competency

Mentoring in WIC is a form of ongoing staff development that builds relationships between colleagues, supports staff skill enhancement, and identifies programmatic challenges to address. A mentor is a trusted, highly skilled individual who places the mentees' best interests foremost in each mentoring session. A mentor does not have to play a specific WIC staff role but may be a CPA, registered dietitian, site supervisor, State agency consultant, or something else. The mentor's approach, competence, and character are more important than their role. The most effective mentors:

- Approach mentoring as an ongoing process, modeling the style/technique expected of WIC staff in interactions with participants and recognizing that the time spent in mentoring offers exponential gains to the program.
- Can discuss program initiatives and policies broadly and specifically. Competent mentors have real-world WIC experience and understand the program's vision.
- Embody the core values of WIC in their interactions with colleagues, building trust, demonstrating respect, seeking first to understand, listening more, affirming specifically, managing expectations, being sincere, and providing honest feedback.

Table 8. Matching Training Techniques to the Desired Learning Outcome

Desired Outcome	Appropriate Techniques
Knowledge	Lecture, symposium, seminar, or other classroom-based situation; video, debate, dialogue, interview, recording, book-based discussion, reading, and web-based learning.
Skills	Role-playing, games, participative exercises, simulations, nonverbal hands-on exercises, skill practice exercises, drills, and coaching.
Attitudes	Experience-sharing discussion, group-centered discussion, role-playing, case studies, games, and rewarding appropriate behavior.
Values	Lecture, debate, dialogue, video, symposium or seminar, dramatization, guided discussion, experience-sharing discussion, role-playing, and games.

Section 7. Continuous Quality Improvement

The VENA approach to a WIC nutrition assessment has evolved as State and local agencies learn more about what drives behaviors and effective strategies to support the adoption of healthy nutrition practices among participants. The commitment of staff at the federal, regional, State, and local level to continuously improve the quality of the participant experience and the impact of WIC on health outcomes helps make this evolution possible. Initiatives to improve program quality also influence retention, helping to ensure that eligible participants remain in WIC and benefit from services. “Continuous quality improvement” is a term for all ongoing efforts to advance WIC service delivery, including WIC nutrition assessment.

There are several ways to promote continuous quality improvement in WIC. State and local agencies determine how to improve and enhance their services through prospective and retrospective reviews. Such reviews could be participant surveys and direct observation.

Direct observation can take place during a variety of activities, including formal evaluations, informal technical assistance, or staff coaching. Ongoing training, staff development, and other targeted program enhancement initiatives are also important quality improvement strategies. For more information, please see the *WIC Nutrition Services Standards*, Standard 16.[41]

Using Direct Observation to Evaluate VENA Implementation

Direct observation is an important part of evaluating the overall quality of assessment practices and the extent to which the VENA approach is operationalized, as well as for identifying opportunities for improvement. Although review of documentation in participant records is a useful indicator of *what* took place during a WIC visit, observation provides a more complete picture of not only what takes place during the WIC nutrition assessment but also how the assessment is conducted. While VENA is a framework for a systematic assessment process, the ways in which the assessment is carried out will vary. CPAs use a variety of soft skills during the assessment, such as body language, friendly greetings, and active listening, which directly affect the effectiveness of the assessment. Additionally, CPAs adapt the assessment and their use of soft skills for each participant based on what they believe will be most effective. Because of this individualized approach, CPAs’ use of soft skills can only be assessed through watching the staff–participant interactions.

CPAs face many decision points during an assessment, and they actively employ critical thinking to guide conversations with participants (e.g., evaluating the information they are receiving, determining areas of interest, identifying when more detail is needed). Because there is not one “right way” to complete an assessment, observation is also a useful tool in validating the CPAs decisions and/or supporting additional skill development. A brief conversation between the observer and CPA immediately following the WIC assessment can be instrumental in quality improvement. Similarly, observers can look for trends among CPAs to identify where a targeted training would be helpful.

Observers must be well trained in the VENA approach as well as in the soft skills used in assessment. This knowledge helps observers effectively model the desired skills in their communications with CPAs. By using these soft skills, the observer will reinforce to CPAs that

[41] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

staff at all organizational levels believe these are effective. The skill set of the observer can be developed through periodic training, with opportunities to practice the skills being evaluated.

When State and local agencies have more than one person conducting observations, consistency among observers is critical. Because VENA and subsequent nutrition services are highly individualized, they are also subjective and do not fit neatly into a checklist of "meets expectations" or "does not meet expectations." State agencies can help establish consistency among observers through strategies such as:

- Providing clear direction on core programmatic objectives and vision (e.g., nutrition assessment is a core process in the larger continuum of WIC services that ideally culminates in supporting positive health outcomes).
- Meetings among observers to discuss the intent of the VENA approach, related federal guidance, and implications for service delivery.
- Opportunities for multiple observers to watch the same interaction (i.e., in-person or video-recorded session) and compare notes.
- Periodically reviewing findings across agencies, both positive and negative, to identify possible inconsistencies.

Some State agencies have promoted consistency among observers and assisted local agencies by developing evaluation criteria or quality indicators to explain how to characterize "meets expectations" or "does not meet expectations" in practice. This helps observers and local staff better understand expectations for participant interactions. In some cases, State evaluation tools allow for different levels of competency to accommodate variations in staff proficiency, experience, and/or training. These added levels of competence allow for and encourage growth among WIC staff and facilitate the identification of training needs for individual staff and agencies as a whole. For examples of observation tools developed by State agencies, refer to **Appendix 6. Examples of Observation Tools Used to Evaluate VENA Practices**.

Resources

The **WIC Works Resource System** (WIC Works) is an online education, training, and resource center for State and local WIC staff that offers a variety of resources from FNS, WIC State and local agencies, other federal agencies, and non-Governmental entities.

Quality Indicators for Direct Observation of VENA Practices

When creating evaluation criteria or quality indicators, State agencies incorporate as much flexibility as possible to reflect how CPAs individualize services. CPAs do not use all skills or strategies during each appointment; rather, they prioritize their approach depending on the needs of the participant. One way to allow for flexibility and encourage CPAs to individualize services is to limit the number of indicators to be evaluated. Key indicators include those that capture the overall intents of the process, allowing the CPA the freedom to personalize the appointment while still meeting quality expectations. Having fewer criteria will also make it easier to achieve consistency across observers.

As State agencies determine how they will evaluate strength-based assessment and counseling practices, potential quality indicators to consider include the following:

- CPAs employ critical thinking skills to gather, analyze, and prioritize assessment information.
- CPAs individualize the assessment and nutrition services conversation to the unique circumstances of the participant.
- CPAs identify and affirm participants' strengths and positive behaviors.
- CPAs use open-ended questions to engage the participant in the assessment and nutrition services conversation.
- CPAs document relevant information, nutrition risks assigned, and nutrition interventions.
- State agencies can support quality improvement by making observation tools available to local agencies in advance. Sharing these promotes transparency and builds trust and clarity around expectations for both State agency staff and local staff. In addition, the tools can be used by local agency managers or staff mentors to observe services in their WIC sites and provide coaching to help staff build skills. Inviting local input when designing the tools will help ensure the process reflects service delivery principles important to local agencies and that the tools will be used for ongoing monitoring within the local agency.

Continuous Quality Improvement Strategies

Conversations between observers and WIC staff members can be very effective in affirming skills observed and offering ideas for strengthening the interactions with participants or for conducting the assessment process. A well-trained observer will be able to identify both strengths and opportunities for enhancement, and they will be skilled in providing feedback in style that is consistent with VENA approach. Observing the WIC nutrition assessment process across multiple WIC staff, either within the same agency or across multiple agencies, is useful for identifying overall strengths, challenges, and opportunities for improvement. The information gleaned during direct observations may indicate a need for additional training using existing curricula or developing new training resources on new topics or using different modes of learning. Alternatively, the information may highlight the need for revisions or clarification to a State or local policy or process. This could involve a straightforward update and communication about the change or it may require a longer-term initiative, such as modifications to the WIC MIS. In addition, comparing observation findings across multiple observers may highlight a need to refine current observation tools or to provide additional training efforts. For more information on staff training, refer to **Section 6. Staff Competencies and Training**.

Appendix 1. Glossary of Terms

Affirmation—A statement that acknowledges an individual's positive qualities (strengths, efforts, or personal characteristics) and encourages continued application of those qualities. Affirmations strengthen relationships, encourage positive behaviors, and build confidence in one's ability to change.

Autonomy—An individual's ability and right to make decisions concerning their lives. Although the WIC staff supports behavior change, ultimately it is up to the individual to decide whether to change. Recognizing and respecting a participant's autonomy supports behavior change by empowering participants and reducing the chance of resistance.

Body mass index (BMI)—A measure of body fat based on height and weight. The calculation involves dividing weight in kilograms by height in meters squared or dividing weight in pounds times 703 by height in inches squared (kg/m2 or 703 × lbs./in2).

Competency—An individual's demonstrated knowledge, skills, or abilities performed to a specific standard. Competencies are observable behavioral acts demonstrated in a job context and are influenced by an organization's culture and work environment.

Competent Professional Authority (CPA)—An individual on the staff of a local agency authorized to conduct the nutrition assessment, determine nutrition risk, and prescribe supplemental foods. Federal WIC program regulations define the CPA as a physician, nutritionist, registered nurse, dietitian, or medically trained State or local health official, or person designated by physicians or medically trained State or local health officials.[42]

Continuity of care—The process of ensuring quality care over time. The participant and the WIC staff collaborate to identify and support the achievement of small steps toward health goals over time. Continuity of care is supported by appropriate documentation and processes to allow for access to a participant's history and seamless sharing of information between staff members.

Critical thinking—The disciplined process of organizing and blending information to evaluate and prioritize it effectively. Critical thinking involves integrating facts, informed opinions, active listening, and observations.

Emotion-based counseling—A counseling approach that recognizes that emotions drive behaviors and that discussing a participant's motivations and emotions around change before providing facts and information is most effective in helping to bring about lasting behavior change.

Guided goal setting—The process of helping participants set goals. The WIC staff and the participant work together to identify potential goals through the assessment process and develop small progressive action steps toward positive health outcomes. Guided goal setting is based on the premise that participants who set realistic, achievable goals for themselves are more likely to make changes than those who do not set goals.

Health determinants—A range of behavioral, biological, socioeconomic, and environmental factors whose interactions affect people's health status. Health determinants that promote a positive health outcome may be viewed as protective factors, while determinants that may hinder positive outcomes can be considered potential barriers, e.g., WIC nutrition risks.

[42] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

Health Outcome–Based Approach—An approach to the WIC nutrition assessment where a desirable health outcome (e.g., delivery of a healthy full-term baby) serves as a focal point to collect relevant information. The elements of this approach include (1) a desired health outcome, (2) nutrition/health objectives (e.g., consume a healthy diet) and (3) health determinants (see definition). This approach also allows participants to gain a greater appreciation of how to attain good health and recognize their own need(s) and/or needs of an infant/child for health improvement.

Index of Allowable Risk Criteria—A list of permitted nutrition risk criteria for use in determining WIC eligibility and providing nutrition services (nutrition education, food packages, referrals, and breastfeeding support). The nutrition risk explanations are a source of technical assistance to State and local agency WIC staff, providing an evidence-based definition and justification for risk assignment, as well as nutrition education messages, for each criterion.[43]

Management information system (MIS)—A computerized information-processing system designed to support data collection and synthesis and service delivery.

Motivation—A person's reason(s) for acting or behaving in a particular way, or the general desire to do something.

Motivational interviewing—An approach to assessment and counseling designed to explore and enhance an individual's internal motivation to change by resolving ambivalence, eliciting the importance for change, and increasing confidence to make a change.

Multicultural intelligence/awareness—The capability to relate and work effectively with people from different cultural backgrounds. Multicultural intelligence includes an understanding of how sociocultural aspects (race, ethnicity, religion, group affiliation, socioeconomic status, and worldview) affect nutrition and health practices.

Nutrition risk—Attributes that hinder positive health outcomes, including (a) detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements; (b) other documented nutritionally related medical conditions; (c) dietary deficiencies that impair or endanger health; (d) conditions that directly affect the nutritional health of a person, including alcoholism or drug abuse; or (e) conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, including, but not limited to, homelessness and migrancy.[44]

Nutrition services—A comprehensive term for activities that result from the assessment process. WIC nutrition services encompass customized nutrition counseling, referrals for additional programs or services, assignment of a tailored food package, and breastfeeding promotion and support. Customized nutrition counseling could include nutrition education, guided goal setting, sharing relevant information, and/or reinforcing positive behaviors.

Open-ended questions—Questions that require more than a simple one-word answer, often used to gain a broader situational understanding. In contrast, closed-ended questions can be answered simply (e.g., yes or no) and are often used to gather specific information.

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[43] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

[44] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

Participant—For the purposes of this document, the word refers to a WIC participant, an applicant, or a parent/caregiver.[45]

Participant-centered approach—A systems approach designed to focus on topics and issues that are relevant to the participant. This approach puts the participant's needs and the goal of healthy behaviors at the core of WIC service delivery and focuses on a person's capacities, strengths, and developmental needs, not solely on the problems, risk, or negative behaviors. In contrast to the traditional didactic WIC assessment and education model, participant-centered services encourage staff to engage the participant/caretaker in dialogue, information exchange, listening, and feedback, in order to translate the assessment into action and customize the nutrition services provided.[46]

Plain language—Communication used so your audience can understand the first time they read or hear it.[47]

Reflective listening—A statement that conveys understanding. This can include paraphrasing someone's statement to confirm its meaning or reflecting more than what was said directly, such as emotions or intent. Reflective listening is effective in a variety of scenarios and helps clarify understanding, encourages greater exploration, and builds relationships.

Resistance—A process of avoiding or diminishing sharing about oneself because the individual feels uncomfortable or anxious.

Resistance talk—Evidence of a person's defense against change, often in the form of arguments against change. The more participants argue against change, the less likely it is that they will change their behavior.

Self-efficacy—Participants' beliefs about their ability to succeed in reaching specific goals. Efforts to support participants' beliefs about their own strengths and abilities will affect how likely they are to achieve goals.

Social-ecological model (SEM)—An approach that addresses several social ecologies or levels of influence on behavior at once. These levels are labeled intrapersonal factors, interpersonal processes and primary groups, institutional factors, community factors, and public policy and legislation.[48]

Three-step counseling—A strategy designed to promote positive behaviors by asking open-ended questions to identify barriers or concerns, affirming and normalizing feelings, and sharing targeted information.

Transtheoretical model (TTM, stages of change)—Proposes that self-change in behavior is a process that occurs through five stages and that individuals use a variety of psychological and behavioral processes in making changes.[49]

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[45] See the following citation for regulatory definition: Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

[46] U.S. Department of Agriculture, Food and Nutrition Service, Supplemental Food Program Division. WIC Nutrition Services Standards. 2013. Available from: **https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf**

[47] U.S. Plain Language Action and Information Network. Available from: **https://www.plainlanguage.gov/**

[48] Contento IR. Foundation in theory and research: promoting environmental support in action. Nutrition Education: Linking Research, Theory, and Practice. 2nd ed. Burlington (MA): Jones & Bartlett Learning; 2011: 121–122.

[49] Contento IR. Foundation in theory and research: facilitating the ability to take action. Nutrition Education: Linking Research, Theory, and Practice. 2nd ed. Burlington (MA): Jones & Bartlett Learning; 2011: 108-112.

VENA Approach—a participant-centered, health outcome–based approach to WIC nutrition assessment. The VENA approach incorporates a WIC nutrition assessment process with policies, staff competencies, a Management Information System (MIS), and quality improvement strategies that together enhance the delivery of WIC nutrition services. The words "VENA" and "the VENA approach" are used interchangeably.

VENA Guidance—Comprehensive nutrition assessment guidance to assist WIC State agencies in operationalizing the VENA Approach to WIC nutrition assessment.

WIC nutrition assessment—The process of collecting and synthesizing relevant information in order to assess an applicant's nutrition and breastfeeding status, risks, capacities, strengths, needs, and/or concerns; identify and assign WIC nutrition risk criteria; customize counseling strategies (e.g., nutrition/breastfeeding education, guided goal setting, affirmations) that address a participant's needs and concerns; tailor the food package to address nutrition needs and breastfeeding status and preferences, including those based on the participant's culture; and make appropriate referrals.[50,51]

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[50] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.11 Nutrition Education. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=7a2c252817410a1e102dbbaab0898e9e&mc=true&n=pt7.4.246&r**

[51] Electronic Code of Federal Regulations. Title 7. Agriculture. Part 246. Special Supplemental Nutrition Program for Women, Infants, and Children. Section 246.2 Definitions. August 2019. Available from: **https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=ede49f3ec92e9131f2fb220fedbe8ccd&mc=true&n=pt7.4.246&r=PART&ty=HTML#se7.4.246_12**

Appendix 2. Health Outcome–Based Assessment by Category

Health outcomes are dependent upon health determinants, a set of factors influenced by individual behaviors, past and current health conditions, and the family and social environment. Protective factors for each determinant are things that will increase the likelihood of achieving the desired health outcome, while identified WIC nutrition risks may reduce the possibility of a positive outcome. Each health determinant can be explored with the participant by collecting and synthesizing relevant information. For example, data on weight, height, pre-pregnancy weight, and weeks of gestation are collected and evaluated to assess whether the pregnant woman is achieving a recommended weight gain. During the exploration of each objective, CPAs work to identify WIC nutrition risks and protective factors and how they relate to the nutrition/health objective. The CPAs work with participants to identify relevant goals and action steps (see **Table 6**). This systematic process of exploring each health determinant can be adapted for State and local processes and contribute to positive outcomes for participants.[52]

Below is a framework for a health outcome–based VENA for each participant category. The tables describe the desired health outcomes, a list of health objectives for each participant category, and examples of potential WIC nutrition risks and protective factors. The tables also include examples of what actions the CPA can take to properly identify a participant's WIC nutrition risks and protective factors.

It should be noted that the examples of potential WIC nutrition risks, protective factors, and CPA's role are not exhaustive. For a complete listing of WIC nutrition risks for each health objective (crosswalk), please see **Appendix 3. Crosswalk of Health Objectives and WIC Nutrition Risks**. For a complete list of the most up-to-date WIC risk criteria that include evidence-based definitions and justifications for risk assignment, as well as applicable nutrition education messages, please visit the **WIC Nutrition Risk PartnerWeb**.

[52] The order of health determinants below does not imply priority or importance. Each State agency establishes policies and procedures about nutrition assessment tasks, including how tasks are organized and when each is completed.

Table A2-1. Health Outcome–Based WIC Nutrition Assessment for a Pregnant Woman

Desired health outcome: Deliver a healthy full-term infant while maintaining the mother's optimal health status				
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Nutrition/Health Determinants: Examples of Potential WIC Nutrition Risks/ Needs*	Nutrition/Health Determinants: Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role†
Consume a variety of foods to meet energy and nutrient requirements, and remain free from foodborne illnesses	Dietary Intake/ Nutrition Practices	• Consumes a diet very low in calories and/ or essential nutrients • Compulsively ingests nonfood items • Inadequate vitamin/mineral supplementation	• Eats a variety of fruits and vegetables, lean proteins, and whole grains • Takes prenatal vitamins or multivitamins with adequate folic acid • Practices food safety behaviors	• Assess current nutrition practices • Assess current and potential impact on nutritional intake and nutritional needs • Assess factors that may affect meal pattern • Identify misconceptions about ideal nutrition practices • Assess potential for foodborne illnesses
Receive ongoing health care, including early prenatal care	Health/Dental Care	• Lack of adequate prenatal Care • Lack of medical or dental home	• Established a medical home • Enrolled in a health insurance plan • Receives regular oral health care	• Assess barriers to obtaining care • Ask about dental status and treatment already in progress • Assess level of access to follow-up medical care
Achieve a recommended maternal weight gain	Weight/ Height Status (Anthropometric)	• Underweight • Overweight • Low maternal weight gain • High maternal weight gain • Lack of physical activity	• Eats a variety of foods to meet	• Assess possible contributors to weight gain/loss (e.g., knowledge and attitudes regarding weight gain, physical activity level, appetite, stress)
Remain free from nutrition-related illness or complications	Clinical/Health/ Medical	• Low hematocrit/ low hemoglobin • Nutrition deficiency diseases • Diabetes Mellitus	• Eats high iron foods • Takes prenatal vitamins/minerals as prescribed by health care provider • Monitors and manages blood glucose levels	• Assess factors that may affect hemoglobin/ hematocrit levels • Assess whether it is likely to be a nutritional or physiological anemia • Assess/reinforce compliance with treatment plan from health care provider

Table A2-1. Health Outcome–Based WIC Nutrition Assessment for a Pregnant Woman *(continued)*

<table>
<tr><th colspan="5">Desired health outcome: Deliver a healthy full-term infant while maintaining the mother's optimal health status</th></tr>
<tr><th rowspan="2">Nutrition/ Health Objective</th><th rowspan="2">Nutrition/ Health Determinant Category</th><th colspan="2">Nutrition/Health Determinants</th><th rowspan="2">Competent Professional Authority's (CPA's) Role†</th></tr>
<tr><th>Examples of Potential WIC Nutrition Risks/ Needs*</th><th>Examples of Protective Factors*</th></tr>
<tr><td>Avoid alcohol, tobacco, drugs, and other harmful substances</td><td>Substance Use</td><td>• Alcohol and substance use
• Nicotine and tobacco use</td><td>• Does not smoke
• Avoids alcohol, drugs, and other harmful substances</td><td>• Assess understanding of the potential dangers to herself and her pregnancy
• Assess attitude toward treatment/cessation programs
• Assess awareness of available help and readiness to access/ accept it</td></tr>
<tr><td>Make an informed decision about breastfeeding</td><td>Infant Feeding Decisions</td><td>• Experienced breastfeeding complications previously
• Lack of breastfeeding support</td><td>• Is knowledgeable about different feeding options
• Has an existing support network for breastfeeding</td><td>• Assess interest for more information/participation in breastfeeding peer counseling and other breastfeeding support resources
• Assess contraindications to breastfeeding</td></tr>
<tr><td>Receive proper environmental and family support to thrive</td><td>Social Support/ Home Environment</td><td>• Homelessness
• Recipient of abuse</td><td>• Has access to adequate food preparation and food storage resources
• Has access to safe and adequate water
• Lives in a supportive and safe environment</td><td>• Assess food preparation and food storage equipment
• Assess home environment and support systems
• Identify referral opportunities</td></tr>
</table>

* The nutrition/health determinants listed are examples of some of the potential determinants that a CPA could identify during a WIC nutrition assessment. They do not represent an exhaustive list of WIC nutrition risks or protective factors.

† The roles listed are examples of actions that a CPA will perform during a WIC nutrition assessment. They do not represent an exhaustive list of all the actions a CPA will take to complete a WIC nutrition assessment.

Table A2-2. Health Outcome–Based WIC Nutrition Assessment for a Breastfeeding Woman

Desired health outcome: Achieve optimal health during the childbearing years and reduce the risk of chronic diseases				
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Nutrition/Health Determinants		Competent Professional Authority's (CPA's) Role†
		Examples of Potential WIC Nutrition Risks/ Needs*	Examples of Protective Factors*	
Consume a variety of foods to meet energy and nutrient requirements, and remain free from foodborne illnesses	Dietary Intake/ Nutrition Practices	• Consumes a diet very low in calories and/ or essential nutrients • Compulsively ingests nonfood items • Ingests foods that could be contaminated with pathogenic microorganisms	• Eats a variety of fruits and vegetables, lean proteins, and whole grains • Limits calories from added sugars and saturated fats and reduces sodium intake • Practices food safety behaviors • Takes vitamins/ minerals as prescribed by health care provider	• Assess current nutrition practices • Assess current and potential impact on nutritional intake and nutritional needs • Assess factors that may affect meal pattern • Identify misconceptions about ideal nutrition practices • Assess potential for foodborne illnesses
Receive ongoing health care, including early postpartum care	Weight/ Height Status (Anthropometric)	• Overweight • Underweight • Low maternal weight gain • High maternal weight gain • Lack of physical activity	• Eats a variety of foods to meet energy requirements • Engages in physical activity	• Assess possible contributors to weight gain/loss (e.g., knowledge and attitudes regarding weight gain, physical activity level, appetite, stress)
Achieve a desirable postpartum weight or body mass index (BMI)	Weight/ Height Status (Anthropometric)	• Overweight • Underweight • Low maternal weight gain • High maternal weight gain • Lack of physical activity	• Eats a variety of foods to meet energy requirements • Engages in physical activity	• Assess possible contributors to weight gain/loss (e.g., knowledge and attitudes regarding weight gain, physical activity level, appetite, stress)
Remain free from nutrition-related illness or complications	Clinical/Health/ Medical	• History of gestational diabetes • Elevated blood lead levels • Lactose Intolerance	• Takes vitamins/ minerals as prescribed by health care provider • Is knowledgeable about high iron foods	• Ask about potential sources of lead exposure • Assess special diet and medications prescribed to manage or treat condition

Table A2-2. Health Outcome–Based WIC Nutrition Assessment for a Breastfeeding Woman *(continued)*

Desired health outcome: Achieve optimal health during the childbearing years and reduce the risk of chronic diseases				
		Nutrition/Health Determinants		
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Examples of Potential WIC Nutrition Risks/ Needs*	Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role†
Avoid alcohol, tobacco, drugs, and other harmful substances	Substance Use	• Alcohol and substance use • Nicotine and tobacco use	• Does not smoke • Avoids alcohol, drugs, and other harmful substances	• Assess understanding of the potential dangers to herself and her infant • Assess attitude toward treatment/cessation programs • Assess awareness of available help and readiness to access/ accept it
Breastfeed infant successfully	Infant Feeding Decisions	• Breastfeeding complications or potential complications • Lack of breastfeeding support	• Breastfeeds enough to ensure adequate milk supply • Eats a variety of foods to meet energy requirements • Has an existing support network for breastfeeding	• Evaluate awareness of breastfeeding recommendations • Assess effectiveness of mother's management strategies • Assess adherence to medical providers' recommendations • Assess support system
Receive proper environmental and family support to thrive	Social Support/ Home Environment	• Homelessness • Recipient of abuse • Limited ability to prepare food	• Has access to adequate food preparation and food storage resources • Has access to safe and adequate water • Lives in a supportive and safe environment	• Assess possible contributors to weight gain/loss (e.g., knowledge and attitudes regarding weight gain, physical activity level, appetite, stress)

* The nutrition/health determinants listed are examples of some of the potential determinants that a CPA could identify during a WIC nutrition assessment. They do not represent an exhaustive list of WIC nutrition risks or protective factors.

† The roles listed are examples of actions that a CPA will perform during a WIC nutrition assessment. They do not represent an exhaustive list of all the actions a CPA will take to complete a WIC nutrition assessment.

Table A2-3. Health Outcome–Based WIC Nutrition Assessment for a Non-Breastfeeding Postpartum Woman

Desired health outcome: Achieve optimal health during the childbearing years and reduce the risk of chronic diseases				
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Nutrition/Health Determinants: Examples of Potential WIC Nutrition Risks/ Needs*	Nutrition/Health Determinants: Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role†
Consume a variety of foods to meet energy and nutrient requirements, and remain free from foodborne illnesses	Dietary Intake/ Nutrition Practices	• Consumes a diet very low in calories and/ or essential nutrients • Consumes sugary beverages in excess • Ingests foods that could be contaminated with pathogenic microorganisms	• Eats a variety of fruits and vegetables, lean proteins, and whole grains • Limits calories from added sugars and saturated fats and reduces sodium intake • Practices food safety behaviors	• Assess current nutrition practices • Assess current and potential impact on nutritional intake and nutritional needs • Assess factors that may affect meal pattern • Identify misconceptions about ideal nutrition practices • Assess potential for foodborne illnesses
Receive ongoing health care, including early postpartum care	Health/Dental Care	• Lack of adequate postpartum care • Lack of medical or dental home	• Attends postpartum visits to a health care provider • Enrolled in a health insurance plan • Receives regular oral health care	• Assess barriers to obtaining care • Ask about dental status and treatment already in progress • Assess level of access to follow-up medical care
Achieve a desirable postpartum weight or body mass index (BMI)	Weight/ Height Status (Anthropometric)	• Overweight • Underweight • Low maternal weight gain • High maternal weight gain • Lack of physical activity	• Eats a variety of foods to meet energy requirements • Engage in physical activity	• Assess possible contributors to weight gain/loss (e.g., knowledge and attitudes regarding weight gain, physical activity level, appetite, stress)
Remain free from nutrition-related illness or complications	Clinical/Health/ Medical	• History of gestational diabetes • Elevated blood lead levels • Gastrointestinal disorder • Food allergy	• Adheres to diet recommendations provided by health care provider • Reads food labels carefully to manage food allergy	• Ask about potential sources of lead exposure • Assess special diet and medications prescribed to manage or treat condition • Assess knowledge/ compliance with diet recommendations for medical condition

Table A2-3. Health Outcome–Based WIC Nutrition Assessment for a Non-Breastfeeding Postpartum Woman *(continued)*

Desired health outcome: Achieve optimal health during the childbearing years and reduce the risk of chronic diseases				
		Nutrition/Health Determinants		
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Examples of Potential WIC Nutrition Risks/ Needs*	Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role†
Avoid alcohol, tobacco, drugs, and other harmful substances	Substance Use	• Alcohol and substance use • Nicotine and tobacco use	• Does not smoke • Avoids drugs other harmful substances • Limits alcohol to recommended levels	• Assess understanding of the potential dangers to herself and her infant • Assess attitude toward treatment/cessation programs • Assess awareness of available help and readiness to access/ accept it
Receiving proper environmental and family support to thrive	Social Support/ Home Environment	• Homelessness • Recipient of abuse	• Has access to adequate food preparation and food storage resources • Has access to safe and adequate water • Lives in a supportive and safe environment	• Assess food preparation and food storage equipment • Assess home environment • Identify referral opportunities

* The nutrition/health determinants listed are examples of some of the potential determinants that a CPA could identify during a WIC nutrition assessment. They do not represent an exhaustive list of WIC nutrition risks or protective factors.

† The roles listed are examples of actions that a CPA will perform during a WIC nutrition assessment. They do not represent an exhaustive list of all the actions a CPA will take to complete a WIC nutrition assessment.

Table A2-4. Health Outcome–Based WIC Nutrition Assessment for an Infant

Desired health outcome: Achieve optimal growth and development in a nurturing environment and develop a foundation for healthy eating patterns				
		Nutrition/Health Determinants		
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Examples of Potential WIC Nutrition Risks/ Needs*	Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role†
Consume human milk and/or iron-fortified infant formula and other foods as developmentally appropriate, and remain free from foodborne illnesses	Dietary Intake/ Nutrition Practices	• Developmental delays or feeding barriers that affect intake • Routinely feeding inappropriately diluted formula • Routinely offering complementary foods or other substances that are inappropriate in type or timing • Parent or caregivers routinely using feeding practices that disregard the developmental needs or stage of the infant • Parent or caregivers routinely using nursing bottles or cups inappropriately	• Consumes adequate breast milk and/or iron-fortified infant formula to meet energy and nutrient requirements • Consumes complimentary foods as developmentally appropriate • Establishes feeding patterns appropriate for their age • Uses nursing bottles and/or cups appropriately • Achieves self-feeding milestones • Caregiver practices infant feeding recommendations and is responsive to infant feeding cues	• Assess current and potential impact on nutritional intake, nutritional needs, and feeding • Assess potential for breastfeeding problems • Assess cultural, medical, and other influences on feeding practices • Assess developmental skills related to feeding • Assess potential for foodborne illness • Assess caregivers' ability to mix formula appropriately and follow feeding recommendation from baby's health care provider
Receive ongoing health care, including screenings and immunizations	Health/Dental Care	• Inappropriate preventive health care, including screening and immunizations • Lack of medical or dental home	• Attends recommended well-child visits and receives appropriate immunizations	• Assess barriers to obtaining care • Assess level of access to follow-up medical care

Table A2-4. Health Outcome–Based WIC Nutrition Assessment for an Infant *(continued)*

Desired health outcome: Achieve optimal growth and development in a nurturing environment and develop a foundation for healthy eating patterns				
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Nutrition/Health Determinants		Competent Professional Authority's (CPA's) Role†
		Examples of Potential WIC Nutrition Risks/ Needs*	Examples of Protective Factors*	
Achieve a normal growth pattern	Weight/ Height Status (Anthropometric)	• Underweight • High weight for length • Short stature/ length • Low birth weight	• Consumes sufficient calories to meet energy and nutrient requirements	• Determine possible contributors that may affect growth • Assess caregivers' knowledge and attitudes regarding development of good eating habits, satiety cues, and nutrition
Remain free from nutrition-related illness or complications	Clinical/Health/ Medical	• Inborn error of metabolism • Failure to thrive • Preterm or early term delivery	• Attends medical appointments for nutrition-related illness • Caregiver understands and complies with treatment plan	• Assess understanding of and compliance with treatment plan • Assess current and potential impact on nutritional intake, nutritional needs, and feeding • Assess level of access to follow-up medical care
Receive proper environmental and family support to thrive	Social Support/ Home Environment	• Homelessness • Migrancy • Exposure to environmental smoke • A primary caregiver with limited ability to make feeding decisions and/or prepare food	• Lives in an environment that is free of lead or secondhand smoke • Lives in a safe environment and establishes a trusting relationship with the caregivers	• Assess food preparation and food storage equipment • Assess home environment

* The nutrition/health determinants listed are examples of some of the potential determinants that a CPA could identify during a WIC nutrition assessment. They do not represent an exhaustive list of WIC nutrition risks or protective factors.

† The roles listed are examples of actions that a CPA will perform during a WIC nutrition assessment. They do not represent an exhaustive list of all the actions a CPA will take to complete a WIC nutrition assessment.

Table A2-5. Health Outcome–Based WIC Nutrition Assessment for a Child 12–60 Months of Age

Desired health outcome: Achieve optimal growth and development in a nurturing environment and begin to acquire dietary and lifestyle habits associated with a lifetime of good health				
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Nutrition/Health Determinants: Examples of Potential WIC Nutrition Risks/ Needs*	Nutrition/Health Determinants: Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role††
Consume a variety of foods to meet energy and nutrient requirements, achieve developmental milestones for self-feeding and remain free from foodborne illnesses	Dietary Intake/ Nutrition Practices	• Consumes an inappropriate beverage as the primary milk source • High intake of sugar-containing beverages • Intake of potentially contaminated foods • Routine inappropriate use of nursing bottles, cups, or pacifiers • Inappropriate feeding practices for the child's developmental stage/needs	• Eats fruits and vegetables, lean proteins, and whole grains • Limits calories from added sugars and saturated fats and limits sodium intake • Consumes adequate calories daily • Weaned from the bottle at an appropriate age • Achieves self-feeding milestones • Caregiver aware of child feeding recommendations	• Assess current and potential impact on nutritional intake, nutritional needs, and feeding • Assess cultural, medical, and other influences on feeding practices • Assess developmental skills related to feeding • Assess potential for foodborne illness • Assess caregivers' knowledge and attitudes regarding development of good eating habits, satiety cues, and nutrition
Receive ongoing health care, including screenings and immunizations	Health/Dental Care	• Inappropriate preventive health care, including screening and immunizations • Lack of medical or dental home	• Attends regular appointments for oral care after the age of 1 • Attends regular well-child visits that include blood lead screening and immunizations	• Assess barriers to obtaining care • Ask about dental status and treatment already in progress • Assess level of access to follow-up medical care
Achieve a normal growth pattern	Weight/ Height Status (Anthropometric)	• Underweight • Overweight • Low stature	• Consumes sufficient calories to meet energy and nutrient requirements • Is given opportunities for active play	• Determine possible contributors that may affect growth • Assess caregivers' knowledge and attitudes regarding development of good eating habits, satiety cues, and nutrition

Table A2-5. Health Outcome–Based WIC Nutrition Assessment for a Child 12–60 Months of Age *(continued)*

Desired health outcome: Achieve optimal growth and development in a nurturing environment and begin to acquire dietary and lifestyle habits associated with a lifetime of good health				
Nutrition/ Health Objective	Nutrition/ Health Determinant Category	Nutrition/Health Determinants: Examples of Potential WIC Nutrition Risks/ Needs*	Nutrition/Health Determinants: Examples of Protective Factors*	Competent Professional Authority's (CPA's) Role†
Remain free from nutrition-related illness or complications	Clinical/Health/ Medical	• Low hematocrit/ low hemoglobin • Elevated lead levels • Recent surgery or trauma	• Attends medical or dental visits for nutrition-related illness • Caregiver understands and complies with treatment plan	• Assess understanding of and compliance with treatment plan • Assess current and potential impact on nutritional intake, nutritional needs, and feeding • Assess level of access to follow-up medical care
Receive proper environmental and family support to thrive	Social Support/ Home Environment	• Homelessness • Recipient of abuse • Exposure to environmental smoke	• Lives in an environment that is free of lead or secondhand smoke • Lives in a safe environment and establishes a trusting relationship with the caregiver	• Assess food preparation and food storage equipment • Assess home environment

* The nutrition/health determinants listed are examples of some of the potential determinants that a CPA could identify during a WIC nutrition assessment. They do not represent an exhaustive list of WIC nutrition risks or protective factors.

† The roles listed are examples of actions that a CPA will perform during a WIC nutrition assessment. They do not represent an exhaustive list of all the actions a CPA will take to complete a WIC nutrition assessment.

Appendix 3. Crosswalk of Health Objectives and WIC Nutrition Risks

The purpose of this appendix is to list the WIC nutrition risks that correspond to the health objectives within the framework of a health outcome–based assessment.

Table A3-1. Crosswalk for a Pregnant Woman

Consume a diet to meet energy and nutrient requirements and remain free from foodborne illnesses

- Failure to Meet Dietary Guidelines for Americans
- Inappropriate Nutrition Practices for Women:
  - Consuming dietary supplements with potentially harmful consequences
  - Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery
  - Compulsively ingesting non-food items (pica)
  - Inadequate vitamin/mineral supplementation recognized as essential by national public health policy
  - Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms

Receive ongoing preventative health care including prenatal care

- Lack of Adequate Prenatal Care

Achieve a recommended maternal weight gain

- Underweight (Women)
- Overweight (Women)
- Low Maternal Weight Gain
- High Maternal Weight Gain

Remain free from nutrition-related illness or complications

- Low Hemoglobin/Low Hematocrit
- Elevated Blood Lead Levels
- Hyperemesis Gravidarum
- Gestational Diabetes
- History of Gestational Diabetes
- History of Preeclampsia
- History of Preterm or Early Term Delivery
- History of Low Birth Weight
- History of Spontaneous Abortion, Fetal or Neonatal Loss
- Pregnancy at a Young Age
- Short Interpregnancy Interval
- Multi-fetal Gestation
- Fetal Growth Restriction
- History of Birth of a Large for Gestational Age Infant
- Pregnant Woman Currently Breastfeeding
- History of Birth with Nutrition-Related Congenital or Birth Defect
- Nutrition Deficiency Diseases
- Gastrointestinal Disorders
- Thyroid Disorders
- Hypertension and Prehypertension
- Renal Disease
- Cancer
- Central Nervous System Disorders
- Genetic and Congenital Disorders
- Inborn Errors of Metabolism
- Infectious Diseases (Acute and Chronic)
- Food Allergies
- Celiac Disease
- Lactose Intolerance
- Hypoglycemia
- Drug Nutrient Interactions
- Eating Disorders
- Recent Major Surgery, Physical Trauma, Burns
- Other Medical Conditions
- Depression
- Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat
- Oral Health Conditions
- Fetal Alcohol Spectrum Disorder

Table A3-1. Crosswalk for a Pregnant Woman *(continued)*

Avoid alcohol, tobacco, and drugs, and other harmful substances
• Nicotine and Tobacco Use • Alcohol and Substance Use
Make an informed decision about breastfeeding
• Breastfeeding Mother of Infant at Nutritional Risk
Achieve a recommended maternal weight gain
• Presumptive Eligibility for Pregnant Women • Homelessness • Migrancy • Recipient of Abuse • Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food • Foster Care • Environmental Tobacco Smoke Exposure

Table A3-2. Crosswalk for a Breastfeeding Woman

Consume a diet to meet energy and nutrient requirements and remain free from foodborne illnesses

- Failure to Meet Dietary Guidelines for Americans
- Inappropriate Nutrition Practices for Women:
  - Consuming dietary supplements with potentially harmful consequences
  - Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery
  - Compulsively ingesting non-food items (pica)
  - Inadequate vitamin/mineral supplementation recognized as essential by national public health policy

Achieve a desirable postpartum weight or body mass index (BMI)

- Underweight (Women)
- Overweight (Women)
- High Maternal Weight Gain

Remain free from nutrition-related illness or complications

- Low Hemoglobin/Low Hematocrit
- Elevated Blood Lead Levels
- History of Gestational Diabetes
- History of Preeclampsia
- History of Preterm or Early Term Delivery
- History of Low Birth Weight
- History of Spontaneous Abortion, Fetal or Neonatal Loss
- Pregnancy at a Young Age
- Short Interpregnancy Interval
- Multi-fetal Gestation
- History of Birth of a Large for Gestational Age Infant
- History of Birth with Nutrition-Related Congenital or Birth Defect
- Nutrition Deficiency Diseases
- Gastrointestinal Disorders
- Diabetes Mellitus
- Thyroid Disorders
- Hypertension and Prehypertension
- Renal Disease
- Cancer
- Central Nervous System Disorders
- Genetic and Congenital Disorders
- Inborn Errors of Metabolism
- Infectious Diseases (Acute and Chronic)
- Food Allergies
- Celiac Disease
- Lactose Intolerance
- Hypoglycemia
- Drug Nutrient Interactions
- Eating Disorders
- Recent Major Surgery, Physical Trauma, Burns
- Other Medical Conditions
- Depression
- Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat
- Pre-Diabetes
- Oral Health Conditions
- Fetal Alcohol Spectrum Disorder

Avoid alcohol, tobacco, and drugs, and other harmful substances

- Nicotine and Tobacco Use
- Alcohol and Substance Use

Table A3-2. Crosswalk for a Breastfeeding Woman *(continued)*

Breastfeeds her infant(s) successfully
• Breastfeeding Mother of Infant at Nutritional Risk • Breastfeeding Complications or Potential Complications (Women)
Receive proper environmental and family support to thrive
• Possibility of Regression • Homelessness • Migrancy • Recipient of Abuse • Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food • Foster Care • Environmental Tobacco Smoke Exposure

Table A3-3. Crosswalk for a Non-Breastfeeding Postpartum Woman

Consume a diet to meet energy and nutrient requirements and remain free from foodborne illnesses

- Failure to Meet Dietary Guidelines for Americans
- Inappropriate Nutrition Practices for Women:
  - Consuming dietary supplements with potentially harmful consequences
  - Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery
  - Compulsively ingesting non-food items (pica)
  - Inadequate vitamin/mineral supplementation recognized as essential by national public health policy

Achieve a desirable postpartum weight or body mass index (BMI)

- Underweight (Women)
- Overweight (Women)
- High Maternal Weight Gain

Remain free from nutrition-related illness or complications

- Low Hemoglobin/Low Hematocrit
- Elevated Blood Lead Levels
- History of Gestational Diabetes
- History of Preeclampsia
- History of Preterm or Early Term Delivery
- History of Low Birth Weight
- History of Spontaneous Abortion, Fetal or Neonatal Loss
- Pregnancy at a Young Age
- Short Interpregnancy Interval
- Multi-fetal Gestation
- History of Birth of a Large for Gestational Age Infant
- History of Birth with Nutrition-Related Congenital or Birth Defect
- Nutrition Deficiency Diseases
- Gastrointestinal Disorders
- Diabetes Mellitus
- Thyroid Disorders
- Hypertension and Prehypertension
- Renal Disease
- Cancer
- Central Nervous System Disorders
- Genetic and Congenital Disorders
- Inborn Errors of Metabolism
- Infectious Diseases (Acute and Chronic)
- Food Allergies
- Celiac Disease
- Lactose Intolerance
- Hypoglycemia
- Drug Nutrient Interactions
- Eating Disorders
- Recent Major Surgery, Physical Trauma, Burns
- Other Medical Conditions
- Depression
- Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat
- Pre-Diabetes
- Oral Health Conditions
- Fetal Alcohol Spectrum Disorder

Avoid alcohol, tobacco, and drugs, and other harmful substances

- Nicotine and Tobacco Use
- Alcohol and Substance Use

Table A3-3. Crosswalk for a Non-Breastfeeding Postpartum Woman *(continued)*

Receive proper environmental and family support to thrive
• Possibility of Regression • Homelessness • Migrancy • Recipient of Abuse • Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food • Foster Care • Environmental Tobacco Smoke Exposure

Table A3-4. Crosswalk for an Infant

Consume human milk and/or iron-fortified infant formula and other foods as developmentally appropriate, and remain free from foodborne illnesses

- Inappropriate Nutrition Practices for Infants:
  - Routinely using a substitute(s) for breast milk or for Food and Drug Administration-approved iron-fortified formula as the primary nutrient source during the first year of life
  - Routinely using nursing bottles or cups improperly
  - Routinely offering complementary foods or other substances that are inappropriate in type or timing
  - Routinely using feeding practices that disregard the developmental needs or stage of the infant
  - Feeding foods to an infant that could be contaminated with harmful microorganisms or toxins
  - Routinely feeding inappropriately diluted formula
  - Routinely limiting the frequency of nursing of the exclusively breastfed infant when breast milk is the sole source of nutrients
  - Routinely feeding a diet very low in calories and/or essential nutrients
  - Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breastmilk or formula
  - Feeding dietary supplements with potentially harmful consequences
  - Routinely not providing dietary supplements recognized as essential by national public health policy when an infant's diet alone cannot meet nutrient requirements
- Dietary Risk Associated with Complementary Feeding Practices
- Breastfeeding Complications or Potential Complications (Infant)
- Breastfeeding Infant of a Woman at Nutritional Risk

Achieve a normal growth pattern

- Underweight or At Risk of Underweight (Infants and Children)
- Overweight or At Risk of Overweight (Infants and Children)
- High Weight-for-Length (Infants and Children <24 Months of Age)
- Short Stature or At Risk of Short Stature (Infants and Children)
- Slowed/Faltering Growth Pattern

Remain free from nutrition-related illness or complications

- Low Hemoglobin/Low Hematocrit
- Elevated Blood Lead Levels
- Failure to Thrive
- Low Birth Weight and Very Low Birth Weight
- Preterm or Early Term Delivery
- Small for Gestational Age
- Low Head Circumference (Infants and Children <24 Months of Age)
- Large for Gestational Age
- Nutrition Deficiency Diseases
- Gastrointestinal Disorders
- Diabetes Mellitus
- Thyroid Disorders
- Hypertension and Prehypertension
- Renal Disease
- Cancer
- Central Nervous System Disorders
- Genetic and Congenital Disorders
- Inborn Errors of Metabolism
- Infectious Diseases (Acute and Chronic)
- Food Allergies
- Celiac Disease
- Lactose Intolerance
- Hypoglycemia
- Drug Nutrient Interactions
- Recent Major Surgery, Physical Trauma, Burns
- Other Medical Conditions
- Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat
- Oral Health Conditions
- Fetal Alcohol Spectrum Disorders
- Neonatal Abstinence Syndrome
- Infant up to 6 Months Old of WIC Mother of or a Woman Who Would Have Been Eligible During Pregnancy

Table A3-4. Crosswalk for an Infant *(continued)*

Receive proper environmental and family support to thrive
• Possibility of Regression • Homelessness • Migrancy • Recipient of Abuse • Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food • Foster Care • Environmental Tobacco Smoke Exposure

Table A3-5. Crosswalk for a Child 12-60 Months of Age

Consume a variety of foods to meet energy and nutrient requirements as developmentally appropriate, and remain free from foodborne illnesses

- Failure to Meet Dietary Guidelines for Americans (only for children after 24 months)
- Inappropriate Nutrition Practices for Children:
  - Routinely feeding inappropriate beverages as the primary milk source
  - Routinely feeding a child any sugar-containing fluids
  - Routinely using nursing bottles, cups, or pacifiers improperly
  - Routinely using feeding practices that disregard the development needs or stage of the child
  - Feeding foods to a child that could be contaminated with harmful microorganisms
  - Routinely feeding a diet very low in calories and/or essential nutrients
  - Feeding dietary supplements with potentially harmful consequences
  - Routinely not providing dietary supplements recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements
  - Routine ingestion of non-food items (pica)
- Dietary Risk Associated with Complementary Feeding Practices

Achieve a normal growth pattern

- Underweight or At Risk of Underweight (Infants and Children)
- Obese (Children 2-5 years of Age)
- Overweight or At Risk of Overweight (Infants and Children)
- High Weight-for-Length (Infants and Children <24 Months of Age)
- Short Stature or At Risk of Short Stature (Infants and Children)
- Low Birth Weight and Very Low Birth Weight (Children <24 Months of Age)
- Preterm or Early Term Delivery (Children <24 Months of Age)

Remain free from nutrition-related illness or complications

- Low Hemoglobin/Low Hematocrit
- Elevated Blood Lead Levels
- Failure to Thrive
- Small for Gestational Age
- Low Head Circumference (Infants and Children <24 Months of Age)
- Nutrition Deficiency Diseases
- Gastrointestinal Disorders
- Diabetes Mellitus
- Thyroid Disorders
- Hypertension and Prehypertension
- Renal Disease
- Cancer
- Central Nervous System Disorders
- Genetic and Congenital Disorders
- Inborn Errors of Metabolism
- Infectious Diseases (Acute and Chronic)
- Food Allergies
- Celiac Disease
- Lactose Intolerance
- Hypoglycemia
- Drug Nutrient Interactions
- Recent Major Surgery, Physical Trauma, Burns
- Other Medical Conditions
- Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat
- Oral Health Conditions
- Fetal Alcohol Spectrum Disorders

Table A3-5. Crosswalk for a Child 12-60 Months of Age *(continued)*

Receive proper environmental and family support to thrive
• Possibility of Regression • Homelessness • Migrancy • Recipient of Abuse • Woman or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food • Foster Care • Environmental Tobacco Smoke Exposure

Appendix 4. Essential Staff Competency for WIC Nutrition Assessment

The following tables represent samples of knowledge required and performance expected for each competency. These tables can help guide State agencies in developing VENA staff training.

Competency Statement: Understanding of normal nutritional needs for pregnancy, lactation, the postpartum period, infancy, and early childhood.

Table A4-1. Competency Area 1—Principles of Life Cycle Nutrition

Competency Statement: Understanding of normal nutritional needs for pregnancy, lactation, the postpartum period, infancy, and early childhood.

Knowledge Required	Performance Expected
Nutrition requirements and dietary recommendations for the women, infants, and children WIC serves.	• Analyzing health and nutrition information based on life cycle stage. • Evaluating the impact of the parent/feeding dynamics on nutritional status, growth, and development.
Federal nutrition policy guidance and what it means for women, infants, and children.	• Interpreting and comparing dietary practices of participants with federal policy guidance. • Differentiating between protective and harmful nutrition practices.
Relevant, evidence-based recommendations published by reputable sources.	• Comparing participant dietary practices with evidence-based recommendations.
Basic physical and practical elements of breast milk production (lactation) and breastfeeding and evidence-based techniques for managing lactation, including potential difficulties.	• Applying knowledge of the human body in assessing breastfeeding problems. • Completing breastfeeding assessments at critical points in the early postpartum period according to State agency policies.

Table A4-2. Competency Area 2—The VENA Approach to WIC Nutrition Assessment

Competency Statement: Understanding of the WIC nutrition assessment process.

Knowledge Required	Performance Expected
Purpose and process of a WIC nutrition assessment.	• Providing individualized nutrition assessment. • Obtaining and synthesizing relevant assessment information. • Using nutrition assessment information to identify WIC nutrition risk and provide subsequent nutrition services. • Using systematic processes according to State agency policies.
WIC nutrition risk criteria.	• Applying risk definitions correctly and using appropriate cutoff values when assigning nutrition risks.
Process for documenting WIC nutrition assessment results.	• Documenting relevant information appropriately according to State agency policy. • Using information documented during previous appointments to provide follow-up and continuity of care.

Table A4-3. Competency Area 3—Anthropometric and Hematological Data Collection Techniques

Competency Statement: Understanding of the importance of precise and valid data as well as the methodology for collecting anthropometric and hematological data.

Knowledge Required	Performance Expected
Relevance of anthropometric data to health and nutrition status.	• Demonstrating appropriate anthropometric measurement techniques. • Reading and recording measurements accurately. • Interpreting growth data and prenatal weight gain correctly.
Relationship of hematological parameters to health and nutrition status.	• Demonstrating appropriate techniques for performing a hemoglobin or hematocrit assessment according to State agency policies. • Evaluating blood work results according to State agency policy.

Table A4-4. Competency Area 4—Communication

Competency Statement: Knowledge of how to communicate effectively with participants and foster open communication.

Knowledge Required	Performance Expected
The principles of effective communication for collecting WIC nutrition assessment information.	• Using appropriate techniques to establish a relationship and begin a conversation. • Practicing active listening. • Collecting information without bias or prejudicing a participant's response. • Avoiding jargon unfamiliar to the participant. • Adapting word choice, rate of speech, and communication mannerisms to be more like those of the participant. • Confirming accuracy of understanding by paraphrasing or reflecting what was heard. • Comparing participant's verbal responses to nonverbal indicators to assess participant's attitude and feelings. • Using open-ended and closed-ended questions appropriately. • Ensuring adequacy of understanding before providing nutrition services. • Selecting self-administered information-gathering tools that are appropriate according to State agency policy.

Table A4-5. Competency Area 5—Multicultural Intelligence/Awareness

Competency Statement: Understanding of how sociocultural issues (race, ethnicity, religion, group affiliation, socioeconomic status, and worldview) affect nutrition and health practices and nutrition-related health problems.

Knowledge Required	Performance Expected
Cultural groups in the target population.	• Respecting different belief systems. • Assessing cultural practices for protective or potential harm to the participant's health or nutrition status.
Cultural eating patterns.	• Asking about cultural foods and recognizing their nutrient contributions in assessment of eating patterns. • Evaluating food
Culturally based communication differences.	• Using culturally appropriate communication styles to collect WIC nutrition assessment information. • Using interpretation and/or translation services appropriately.

Table A4-6. Competency Area 6—Critical Thinking

Competency Statement: Knowledge of how to synthesize and analyze information to draw appropriate conclusions.

Knowledge Required	Performance Expected
Principles of critical thinking.	• Collecting adequate relevant information before drawing a conclusion and guiding further nutrition services. • Clarifying information and verifying accuracy of understanding as needed. • Recognizing protective and harmful behavioral factors. • Recognizing irrelevant information and disregarding it. • Considering the participant's perspectives and opinions about nutrition and health behaviors. • Identifying causal relationships between behaviors and health. • Verifying the accuracy of inconsistent or unusual measurements and referral data. • Prioritizing nutrition services based on synthesis of assessment information and participant's interests, needs, and desires.

Appendix 5. Sample Springboard Assessment Questions and Probing Questions for Nutrition/Health Objectives

The following tables are examples of springboard assessment questions a CPA might ask a participant in order to elucidate all the nutrition/health objectives related to the participant's health outcome. This is not an exhaustive list of springboard assessment questions or probing questions.

Table A5-1. Health Outcome–Based Springboard Questions for a Pregnant Woman

Desired health outcome: Delivery of a healthy full-term infant while maintaining the mother's optimal health status		
Nutrition/Health Objectives	**Examples of Springboard Assessment Question**	**Examples of Probing Questions**
Consuming a variety of foods to meet energy and nutrient requirements and remain free from foodborne illnesses	Tell me what you eat in a typical day.	• Are there any foods you avoid or dislike? • How many meals and snacks do you eat in a day? • What are some foods you eat that are related to your culture? • Do you have safe water and refrigeration at home?
Receiving ongoing health care, including prenatal care.	Are you going to all of your prenatal appointments?	• Are you having trouble getting a doctor's appointment?
Achieving the recommended weight gain.	How do you feel about your weight gain during this pregnancy?	• How much weight did your doctor tell you to gain? • How much did you gain with your last pregnancy? • How often do you go on walks or work out?
Remain free from nutrition-related illness or complications.	Tell me about any concerns or problems you are having with this pregnancy. Do you have any medical conditions?	• Do you take any medications? • Are you on a special diet? • Do you receive treatments for any medical condition?
Avoid alcohol, tobacco, and drugs.	Is there anything you feel you should do less of in order to have a healthy pregnancy?	• Do you use nicotine products? • Do you drink alcohol? • Does anyone living with you use nicotine products?

Table A5-1. Health Outcome–Based Springboard Questions for a Pregnant Woman *(continued)*

Desired health outcome: Delivery of a healthy full-term infant while maintaining the mother's optimal health status		
Nutrition/Health Objectives	**Examples of Springboard Assessment Question**	**Examples of Probing Questions**
Make an informed decision about breastfeeding.	What have you heard about breastfeeding?	• Would you like to know more about breastfeeding? • Tell me about previous experience with breastfeeding? • What are your mom/partner/friends telling you about how to feed your baby?
Receive proper environmental and family support to thrive.	Tell me about who is available to help you during your pregnancy and with the new baby.	• Do you feel supported by your partner/parent/relative? • Do they have experience with a newborn?

Table A5-2. Health Outcome–Based Springboard Questions for a Breastfeeding Woman

Desired health outcome: Achieving optimal health during the childbearing years and reducing the risk of chronic diseases		
Nutrition/Health Objectives	**Examples of Springboard Assessment Question**	**Examples of Probing Questions**
Consume a variety of foods to meet energy and nutrient requirements and remain free from foodborne illnesses.	Tell me about the foods you typically eat over the course of a week.	• Do you feel like you're eating enough? • Do you drink/eat raw or unpasteurized milk/dairy products? • Has your diet affected your milk supply? • Do you drink plenty of fluids?
Receive ongoing health care, including early postpartum care.	Have you been attending or have you scheduled your postpartum check-up?	• Have you had any trouble getting an appointment?
Achieve a desirable postpartum weight or body mass index (BMI).	How do you feel about your weight?	• How often do you go on walks or work out? • Are you losing weight according to your doctor's recommendation? • What do you think is your ideal weight?
Remain free from nutrition-related illness or complications.	Do you see a doctor for a medical condition?	• Do you use nicotine products? • Do you drink alcohol? • Does anyone living with you use nicotine products?
Avoid alcohol, tobacco, and drugs.	Is there anything you feel you should do less of in order to have a healthy pregnancy?	• Do you use nicotine products? • Do you drink alcohol? • Does anyone living with you use nicotine products?
Breastfeed her infant(s) successfully.	How's breastfeeding going?	• What questions or concerns do you have about breastfeeding? • What do your partner and family members say about
Receive proper environmental and family support to thrive.	Tell me about who is helping you with breastfeeding or caring for your baby.	• How do you feel your partner has been able to support your breastfeeding efforts? • If you have returned to work*, is there a clean and safe place for you to pump and store your milk?

* These sample questions use "if you have returned to work." In practice, it is more participant-centered to ask the postpartum woman participant whether she has returned to work and then use probing questions to further investigate her feelings and circumstances.

Table A5-3. Health Outcome–Based Springboard Questions for a Non-Breastfeeding Postpartum Woman

Desired health outcome: Achieving optimal health during the childbearing years and reducing the risk of chronic diseases		
Nutrition/Health Objectives	**Examples of Springboard Assessment Question**	**Examples of Probing Questions**
Consume a variety of foods to meet energy and nutrient requirements and remain free from foodborne illnesses.	What are some of your favorite foods?	• Do you eat foods from all of the food groups? • Do you like to cook/prepare family meals?
Receive ongoing health care, including early postpartum care.	What did your doctor tell you during your postpartum visit?	• Do you understand what your doctor told you? • Did your doctor prescribe you any medications?
Achieve a desirable postpartum weight or body mass index (BMI).	How do you feel about your weight currently?	• Do you feel like you are losing weight at an appropriate rate? • Has your doctor said anything about losing weight after a baby?
Remaining free from nutrition-related illness or complications.	Have you been diagnosed with any medical condition/disease?	• Do you feel like you are properly managing your medical complications*?
Avoid alcohol, tobacco, drugs, and other harmful substances.	What, if any, concerns do you have about alcohol, tobacco, or drugs for yourself or others around you and the baby?	• Is there anyone at home who is using nicotine products? • Are you aware of what is in secondhand smoke?
Receive proper environmental and family support to thrive.	Who is available if you need help?	• If you have returned to work†, do you feel like your work environment is supportive? • Do you feel supported by those at home?

* These sample questions use "medical complications." In practice, it is more participant-centered to use the participant's medical history and say the medical complication by name (e.g., diabetes, hypertension).

† These sample questions use "if you have returned to work." In practice, it is more participant-centered to ask the postpartum woman participant whether she has returned to work and then use probing questions to further investigate her feelings and circumstances.

Table A5-4. Health Outcome–Based Springboard Questions for an Infant

Desired health outcome: Achieving optimal health during the childbearing years and reducing the risk of chronic diseases		
Nutrition/Health Objectives	**Examples of Springboard Assessment Question**	**Examples of Probing Questions**
Consume human milk and/or iron-fortified infant formula and other foods as developmentally appropriate and remain free from foodborne illnesses.	How does your baby* act when he or she is hungry?	• What is your baby eating? • How often is your baby nursing/ drinking a bottle? • If formula fed, how do you mix formula? • What are your thoughts about when to give your baby solids? • Has your doctor prescribed vitamins/minerals for your baby?
Receive ongoing health care, including screenings and immunizations.	What has your baby's doctor told you during the well-baby check-ups?	• Is your baby up to date on his/her immunizations? • Are you able to make all of your baby's doctor's appointments?
Achieve a normal growth pattern.	How do you feel about your baby's weight and growth?	• Do you feel that your baby is getting enough to eat? • What does the doctor say about your baby's growth
Remaining free from nutrition-related illness or complications.	Does your baby have any medical conditions?	• Does your baby have any medical conditions that make it hard for him/her to eat? • Is your baby on any medications? • Is your baby able to perform the appropriate milestone†?
Receiving proper environmental and family support to thrive.	Who helps you care for your baby?	• Tell me about where your baby sleeps. • Does anyone at home smoke?

* These sample questions use "your baby." In practice, it is more participant-centered to use the infant's name when speaking with the parent/caregiver.

† This sample question uses "appropriate milestone." In practice, the CPA would know the age of the baby and the corresponding milestone to inquire about. For example, if the participant is 9 months old, it would be appropriate to ask whether the baby is picking up cereal O's with its thumb and index finger.

Table A5-5. Health Outcome–Based Springboard Questions for a Child 12–60 Months of Age

Desired health outcome: Achieving optimal growth and development in a nurturing environment and beginning to form dietary and lifestyle habits associated with a lifetime of good health		
Nutrition/Health Objectives	**Examples of Springboard Assessment Question**	**Examples of Probing Questions**
Consume a variety of foods to meet energy and nutrient requirements, achieve developmental milestones for self-feeding and remain free from foodborne illnesses	Tell me about feeding times with your child.*	• Do you feel that your child eats a variety of food? • Is there anything that your child refuses to eat? • Describe mealtime at your house. • How often does your family eat out?
Receive ongoing preventive health care, including screenings and immunizations.	What has your child's doctor told you?	• Are you able to make all of your child's doctor's appointments? • Has your child been screened for blood lead? • Is your child on any medications?
Achieve a normal growth pattern.	How do you feel about your child's growth?	• What does your child's doctor say about his/her growth? • What kind of play activities does your child enjoy?
Remain free from nutrition-related illness or complications.	Does your child have any medical conditions?	• Does your child see a doctor for anything other than a well-child visit? • Is your child on any special diet? • Does your child have any cavities or fillings?
Achieve developmental milestones.	Tell me something your child has recently learned to do on his/her own.	• Is your child able to perform the appropriate milestone†? • How does your child tell you he/she is full?
Receive proper environmental and family support to thrive.	Who helps you care for your child?	• Does your child have a safe place to play? • When you're not home, who is feeding your child?

* These sample questions use "your child." In practice, it is more participant-centered to use the child's name when speaking with the parent/caregiver.

† This sample question uses "appropriate milestone." In practice, the CPA would know the age of the baby and the corresponding milestone to inquire about. For example, if the baby were 9 months old, it would be appropriate to ask if he/she is picking up cereal O's with the thumb and index finger.

Appendix 6. Examples of Observation Tools Used to Evaluate VENA Practices

The following tables represent examples of observation tools used by State agencies to evaluate VENA practices. There are strengths and weaknesses to each of the samples, and State agencies are encouraged to adapt or create tools that best match their Program operations, quality improvement, and integrity needs.

Table A6-1. Assessing Skills with Frequency Used Rating and Examples to Provide Feedback

On a scale of 1 to 5, indicate the extent to which the WIC staff member applied each skill.
(1 = not at all, 2 = slightly, 3 = moderately, 4 = to a good extent, 5 = to a great extent)

Skill	Score
Opened the session in an engaging way and informed the participant what to expect from the visit. *Write examples below for giving feedback:*	
Listened with presence and gave undivided attention to the participant. *Write examples below for giving feedback:*	
Used reflective listening to repeat what the participant has said as a way to confirm understanding and build a positive rapport. *Write examples below for giving feedback:*	
Asked mostly open-ended questions rather than closed-ended questions. *Write examples below for giving feedback:*	
Probed with questions to clarify information and gain a better understanding of the participant's needs. *Write examples below for giving feedback:*	

Table A6-1. Assessing Skills with Frequency Used Rating and Examples to Provide Feedback *(continued)*

Skill	Score
Allowed silence in session to give participant time to think and respond. *Write examples below for giving feedback:*	
Affirmed the participant by saying things that are positive or complimentary, focusing on strengths, abilities, or efforts. *Write examples below for giving feedback:*	
Tailored the session to the participant's questions and experiences. *Write examples below for giving feedback:*	
Focused on the participant and not the computer or other forms. *Write examples below for giving feedback:*	
Recognized and supported the participant's culture and living situation and how that may affect dietary and health decisions. *Write examples below for giving feedback:*	

Source: FNS Western Region

Table A6-2. Assessing Skills to Determine Competency and Mentoring Needed

Area/Action	Needs to Be Mentored in Specific Identified Skills	Demonstrates Competence
Invest in the Interaction Welcome the participant and build rapport by opening the conversation in a warm, inviting, genuine tone.	• Greets participant by name • Introduces self • Sets the agenda • Reviews previous notes at an inappropriate time • Uses participant-centered practices	• Reviews previous notes before calling client • Greets client by name • Staff introduces self • Sets the agenda in the spirit of participant-centered services • Affirms client
Assessment Uses critical thinking skills to gather, analyze, evaluate, and prioritize the assessment to appropriately assign WIC codes.	• Assessment is incomplete • Uses ABCDE (anthropometric, biochemical, breastfeeding, clinical, dietary, and environmental), misses key areas in a section • Introduces "Getting to the Heart of the Matter" tool, but does not connect it to the assessment • Asks the client relevant closed-ended questions • Actively listens to client • Asks probing questions • Interrupts complete assessment process to identify WIC codes	• Uses ABCDE completely; introduces "Getting to the Heart of the Matter" tool appropriately • Introduces "Getting to the Heart of the Matter" tool at start and connects it to the assessment • Asks the client relevant open-ended questions • Asks probing questions to get complete information • Reflects what client is saying • Identifies WIC codes after assessment is complete
Nutrition Counseling and Education Offers appropriate, relevant, and accurate counseling and advice	• Offers different topics to discuss based on assessment and client's interest at appropriate times • Offers anticipatory guidance • Offers education in a didactic manner	• Offers different topics to discuss based on assessment and client's interest at appropriate times • Offers anticipatory guidance • Tailors discussion around client's assessed needs and interests • Uses OARS (open-ended questions, affirmations, reflections, summaries) • Asks permission • Uses consensus • Explores and offers ideas • Explores client's feelings
Support Health Outcomes Encourage success by closing the conversation.	• Asks client about next steps • Briefly summarizes discussion	• Asks and discusses with client next steps • Summarizes discussion in more detail • Affirms client • Sets up topics for next appointment for follow-up

Source: Arizona WIC Program

Table A6-3. Checklist of Skills Used During Appointment

Question	Yes	No	Not applicable (NA)
Are client concerns, knowledge, readiness for change explored?	+	-	NA
Was the client actively involved in the encounter?	+	-	NA
Are nutrition education topics discussed based on client concerns?	+	-	NA
Is the previous nutrition education topic reviewed? Is this documented?	+	-	NA
Was the encounter friendly, supportive, accommodating, respectful, welcoming?	+	-	NA
Was the encounter positive and based on health outcomes not deficiencies?	+	-	NA

Source: Michigan WIC Program

Table A6-4. Assessing Skills Using Examples

Skill to Listen and Watch for:	Observations: Specific examples you heard or observed
Engages the participant • Introductions • Sets agenda	
Focuses the appointment • Completes assessment • Listens first—before sharing • Open-ended questions • Affirmations • Reflections • Summaries • Tracks potential topics for counseling • Prioritizes topics to explore	
Evokes change talk • Allows time for participant to talk • Reflects change talk • Explore—offer—explore • Asks permission to share information with participant • Provides nutrition-focused counseling • Rolls with resistance • Uses brain science strategies	
Plans with the participant • Works with the participant to develop an actionable next step/plan • Summarizes the next step for the participant • Documents the plan • Shares hope for a positive health outcome	

Source: Oregon WIC Program

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"Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages; Final Rule." Federal Register 79:42 (March 4, 2014) p. 12274-12300.

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Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages; Final Rule

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

7 CFR Part 246

[FNS–2006–0037]

RIN 0584–AD77

Special Supplemental Nutrition Program for Women, Infants and Children (WIC): Revisions in the WIC Food Packages

AGENCY: Food and Nutrition Service (FNS), USDA.

ACTION: Final rule.

SUMMARY: This final rule considers public comments submitted in response to the interim rule revising the WIC food packages published on December 6, 2007. The interim rule implemented the first comprehensive revisions to the WIC food packages since 1980. The interim rule revised regulations governing the WIC food packages to align them more closely with updated nutrition science and the infant feeding practice guidelines of the American Academy of Pediatrics, promote and support more effectively the establishment of successful long-term breastfeeding, provide WIC participants with a wider variety of food, and provide WIC State agencies with greater flexibility in prescribing food packages to accommodate participants with cultural food preferences. This rule makes adjustments that improve clarity of the provisions set forth in the interim rule.

DATES: *Effective Date:* This rule is effective May 5, 2014.

Implementation Dates:

- State agencies must implement the provision in Table 2 at 7 CFR 246.10(e)(10) increasing the cash-value voucher for children to $8 per month no later than June 2, 2014.
- The provision found at 7 CFR 246.12(f)(4) requiring split tender for cash-value vouchers shall be implemented no earlier than October 1, 2014 and no later than April 1, 2015.
- Footnote 11 of Table 2 at 7 CFR 246.10(e)(10) shall be implemented on the later of October 1, 2014, or the date on which the State agency exercises their option to issue authorized soy-based beverage or tofu to children who receive Food Package IV.
- The provisions in Footnote 10 of Table 2 at 7 CFR 246.10(e)(10) and Footnote 12 of Table 3 at 7 CFR 246.10(e)(11) authorizing yogurt for children and women in Food Packages III–VII may be implemented no earlier than April 1, 2015.

FOR FURTHER INFORMATION CONTACT: Anne Bartholomew, Chief, Nutrition Services Branch, Supplemental Food Programs Division, Food and Nutrition Service, USDA, 3101 Park Center Drive, Room 522, Alexandria, Virginia 22302, (703) 305–2746 OR *ANNE.BARTHOLOMEW@FNS.USDA.GOV.*

SUPPLEMENTARY INFORMATION:

I. Overview

This final rule addresses public comments submitted in response to the interim rule revising the WIC food packages published on December 6, 2007 (72 FR 68966), and makes adjustments that improve clarity of the provisions set forth in the interim rule.

II. Background

An interim rule revising the WIC food packages was published in the **Federal Register** on December 6, 2007 (72 FR 68966). The interim rule implemented the first comprehensive revisions to the WIC food packages since 1980 and largely reflected recommendations made by the National Academies' Institute of Medicine (IOM) in its Report ''WIC Food Packages: Time for a Change'' (''Report'').[1] The interim rule aligned the food packages more closely with updated nutrition science, promoted and supported more effectively the establishment of successful long-term breastfeeding, provided WIC participants with a wider variety of food, and provided WIC State agencies with greater flexibility in prescribing food packages to accommodate participants with cultural food preferences. WIC State agencies were required to implement the changes by October 1, 2009.

III. General Summary of Comments Received on the Interim Rule To Revise the WIC Food Packages

The interim rule revising the WIC food packages provided an extensive public comment period to obtain comments on the impact of the changes experienced during implementation of the new food packages. The interim rule comment period ended February 1, 2010.

A total of 7,764 comment letters were received on the interim rule; of those, 111 were form letters. A total of 6,664 of the letters were from program participants, and included comments submitted in Spanish, Chinese, and other languages, in addition to English. The remaining comment letters were submitted from a variety of sources, including WIC State and local agencies and Indian Tribal Organizations, the National WIC Association (NWA), professional organizations and associations, advocacy groups, healthcare professionals (including universities), members of Congress, the food industry, vendors, farmers, and private citizens.

In general, commenters expressed broad support for the changes and reported relatively smooth implementation of the new WIC food packages. Commenters also voiced concerns about various aspects of the interim rule and made recommendations for clarifying or improving specific provisions of the interim rule. Overall, participants expressed overwhelming support for the revised WIC food packages, especially the addition of whole grains and fruits and vegetables. However, many participants who were enrolled in WIC during the transition from the previous food packages to the revised food packages expressed displeasure with changes to fat-reduced milks and less cheese.

FNS considered all timely comments without regard to whether they were provided by a single commenter or repeated by many. Importance was given to the substance or content of the comment, rather than the number of times a comment was submitted.

WIC State agencies are to be commended for the staff and vendor training that led to successful implementation of the new WIC food packages, as well as nutrition education provided to participants on the benefits of the new foods in the WIC food packages. Successful implementation of the new WIC food packages was further enhanced by the efforts of WIC's partners in the advocacy, retail, and medical communities.

IV. Discussion of the Final Rule Provisions

The following is a discussion of the major provisions set forth in this final rule, a brief summary of the comments received on the interim rule that addressed these issues, and FNS' rationale for either modifying or retaining provisions in this final rule. Provisions not addressed in the preamble to this final rule did not receive significant or substantial public comments and remain unchanged.

The preamble to this final rule articulates the basis and purpose behind significant changes from the December 6, 2007 interim rule. The reasons supporting provisions of the interim

[1] Institute of Medicine, National Academy of Sciences. ''WIC Food Packages: Time for a Change,'' 2005. Available at Internet site: *http://www.fns.usda.gov/wic-food-packages-time-change.*

regulations were carefully examined in light of the comments received to determine the continued applicability of the justifications. Unless otherwise stated, or unless inconsistent with this final rule or this preamble, the rationales contained in the preamble to the proposed and interim regulations should be regarded as the basis for this final rule. Therefore, a thorough understanding of the rationales for the interim regulations may require reference to the preamble of the August 7, 2006 proposed rule (71 FR 44784) and the December 6, 2007 interim rule (72 FR 68966).

A. Definitions

The following definitions have been added or modified in the final rule.

Farmers' market. As described in a subsequent section of this preamble, this final rule adds the definition of ''farmers' markets'' at 7 CFR 246.2.

Full nutrition benefit. As described in a subsequent section of this preamble, this final rule adds the definition of ''full nutrition benefit'' at 7 CFR 246.2.

WIC-eligible medical foods. Based on review and discussion with the Food and Drug Administration (FDA), this final rule changes the name of the food category ''WIC-eligible medical food'' to ''WIC-eligible nutritionals,'' but does not substantively change this food category. This nomenclature modification better describes the group of special WIC-eligible nutritional products the WIC Program provides to participants with qualifying conditions, and alleviates confusion associated with the use of the term ''medical food,'' which is defined by regulations governing FDA and differs from the WIC use of this term. The FNS definition for ''WIC-eligible medical food'' and the FDA definition for ''medical food'' are both comprehensive and detailed. Although the definition of ''WIC-eligible medical food'' closely aligns with the FDA definition for ''medical food,'' there are slight differences, such that some, but not all ''WIC-eligible medical foods'' meet FDA's definition of ''medical food.'' In an effort to alleviate confusion, and distinguish between the two product categories and definitions, FNS is modifying the name of the food category from ''WIC-eligible medical food'' to ''WIC-eligible nutritionals.'' Other than the name change, the definition for this food category put forth in the interim rule remains unchanged in this final rule.

B. General Provisions That Affect All WIC Food Packages

1. Nutrition Tailoring

Prior to the interim rule, FNS policy allowed both categorical and individual nutrition tailoring of WIC food packages. Categorical nutrition tailoring is the process of modifying the WIC food packages for participant groups or subgroups with similar supplemental nutrition needs, based on scientific nutrition rationale, public health concerns, cultural eating patterns, and State established policies. The interim rule prohibits categorical nutrition tailoring, but continues to allow individual nutrition tailoring based on the Competent Professional Authority's (CPA) assessment of a participant's supplemental nutrition needs.

A total of 33 commenters (of these, 8 were form letters) opposed the provision that prohibits categorical tailoring, stating that State agencies need the flexibility to propose modifications to food packages that respond to rapid changes in food industry, science, dietary recommendations, demographics, and other factors. Commenters asked that State agencies be able to request approval for categorical tailoring to meet nutritional needs and preferences.

As stated in the preamble to the interim rule, the IOM conducted a full, independent and rigorous scientific review of the nutritional needs of WIC participants prior to recommending the quantities and types of WIC foods to address those needs in its Report. In addition, Section 232 of Public Law 111–296 amended Section 17(f)(11)(C) of the Child Nutrition Act of 1966, as amended (42 U.S.C. 1786), by requiring the Secretary to conduct, as often as necessary, but not less than every 10 years, a scientific review of supplemental foods available under the program and to amend the foods, as needed, to reflect nutrition science, public health concerns, and cultural eating patterns. As such, future reviews of the WIC food packages by FNS will be conducted as needed and used to determine the need for modification of current WIC food packages. FNS believes that this is the appropriate process for changes to the WIC food packages and that State agencies will best be able to meet the nutritional needs of each WIC participant through nutrition assessment and *individual* tailoring of the food package. Therefore, the provision to disallow State agency proposals to categorically tailor WIC food packages is retained in this final rule at 7 CFR 246.10(c).

2. Cultural Food Package Proposals

The interim rule allows State agencies to submit to FNS a plan for substitution of food(s) to allow for different cultural eating patterns. The interim rule includes criteria for submitting plans for substitutions and the criteria FNS will use to evaluate such plans. A total of 26 commenters (8 form letters) asked FNS to change the criterion that ''any proposed substitute food must be nutritionally equivalent or superior to the food it is intended to replace'' to be less restrictive and easier to satisfy.

The increased variety and choice in the supplemental foods in the interim rule, as recommended by the IOM, provide State agencies expanded flexibility in prescribing culturally appropriate packages for diverse groups. Further, the interim rule allows State agencies flexibility to meet unanticipated cultural needs of participants by submitting plans for substitutions. The criteria are not meant to preclude justifiable cultural substitution proposals submitted by WIC State agencies, but are intended to ensure that WIC food substitutions maintain the nutritional integrity of the WIC foods they replace. FNS will continue to make determinations on proposed plans for cultural substitutions based on existing evaluation criteria as appropriate. Therefore, the criteria for submitting State agency plans for substitutions for different cultural eating patterns and the criteria FNS will use to evaluate such plans are retained at 7 CFR 246.10(i).

The interim rule increased the variety and number of substitutions available for several WIC foods. This final rule further increases the number of substitutions and options available, i.e., yogurt, canned jack mackerel, and whole wheat macaroni (pasta) products. These additions are within the context of the IOM recommendations. FNS believes that these changes already provide substantial flexibility for prescribing food packages and that further modifications of the current WIC food packages are best determined through future scientific reviews of the WIC food packages. FNS will, therefore, not accept WIC State agency plans for substitutions of WIC foods for reasons other than to accommodate cultural eating patterns as provided for in 7 CFR 246.10(i).

3. Medical Documentation and Supervision Requirements

a. Milk and Milk Alternatives

Under the interim rule, medical documentation by a health care professional licensed to write medical

prescriptions is required for the issuance of certain milk alternatives for children and women. A total of 180 comment letters (53 of these form letters) opposed this requirement, primarily the documentation for children to receive soy-based beverage. Commenters stated that the provision is unnecessary, costly and burdensome for participants and physicians, creates barriers to services, and undermines FNS' efforts to provide foods that meet the cultural needs of participants. The NWA and the American Dietetic Association (now known as the Academy of Nutrition and Dietetics) stressed that WIC dietitians and nutritionists are trained health professionals capable of doing a complete nutrition assessment, selecting WIC foods, and providing appropriate education to participants and caregivers, in consultation with the health care provider when warranted.

Based on the experiences cited by WIC State and local agencies related to medical documentation throughout implementation of the new food packages, FNS will no longer require a health care professional licensed to write medical prescriptions to provide documentation for children to receive soy-based beverage and tofu as milk substitutes. Also, FNS will no longer require documentation from a health care professional licensed to write medical prescriptions for women to receive tofu in excess of the maximum substitution allowance. Instead, consistent with IOM recommendations for documentation from a ''WIC recognized medical authority,'' FNS will allow the CPA to determine and document the need for tofu and soy-based beverage as substitutes for milk for children, as established by State agency policy. Such determination must be based on individual nutritional assessment, as required under the interim rule and retained in this final rule at 7 CFR 246.10(b)(2)(ii)(C), and consultation with the participant's health care provider, as appropriate. Such determination can be made for situations that include, but are not limited to, milk allergy, lactose intolerance, and vegan diets. As previously discussed, the interim rule revised regulations governing the WIC food packages to, among other things, accommodate participants with cultural food preferences. Since cultural practices may affect nutrient intake, FNS will allow soy for cultural practices that prevent participants from including in their diets cow's milk and lactose-free or lactose-reduced fortified dairy products in amounts that meet their nutritional needs.

FNS will allow the CPA, as established by State agency policy, to determine the need for tofu in quantities that exceed the maximum substitution rates. Such determination can be made for situations that include, but are not limited to, milk allergy, lactose intolerance, and vegan diets.

FNS believes that allowing the CPA to make determinations for milk substitutes is consistent with IOM recommendations for documentation from a ''WIC recognized medical authority.'' Although FNS is no longer requiring documentation from a health care professional licensed to write medical prescriptions, it is incumbent upon WIC State agencies to ensure that participants and caregivers receive education that stresses the importance of milk over milk substitutes, and that appropriate policies and procedures are in place for appropriate issuance of milk substitutes. Parents and caregivers should be made aware that children's diets may be nutritionally inadequate when milk is replaced by other foods, and provided appropriate nutrition education. The value of milk for WIC participants, particularly in the development of bone mass for children, should be emphasized. Lactose-free or lactose-reduced fortified dairy products should be offered before non-dairy milk alternatives to those participants with lactose intolerance that cannot drink milk. Also, if milk is replaced by milk alternatives that are not vitamin D fortified, vitamin D intakes may be inadequate. Thus, replacements for milk are to be approached with caution even if they are rich in calcium.

Therefore, Table 2 of 7 CFR 246.10(e)(10) of this final rule requires that issuance of tofu and soy-based beverage as substitutes for milk for children be based on an individual nutritional assessment by the CPA, in consultation with the participant's health care provider as appropriate. Table 2 of 7 CFR 246.10(e)(10) allows the CPA, as established by State agency policy, to determine the need for women to receive tofu in excess of the maximum substitution allowance.

b. Technical Requirements for Medical Documentation

Under the interim rule, technical requirements for medical documentation were established. A total of 51 comments opposed the provision requiring health care providers to prescribe the supplemental foods and quantities appropriate for a participant's qualifying condition in Food Package III (for participants with qualifying conditions). Commenters believe that medical documentation, especially for authorization of supplemental foods in Food Package III, is burdensome to State agencies, participants and the medical community. Commenters stated that this provision has little value since the foods could otherwise be purchased by the participants at grocery stores. Commenters also stated that the WIC nutritionist or registered dietitian is capable of determining appropriate amounts and types of supplemental foods to issue to participants based on a nutrition assessment of the participant.

Due to the nature of the health conditions of participants who are issued supplemental foods in Food Package III, close medical supervision is essential for each participant's dietary management. FNS considers it appropriate that the responsibility for this close medical supervision remain with the participant's health care provider. Medical documentation requirements for specific supplemental foods that do not usually require a prescription were established to ensure that the participant's healthcare professional has determined that the supplemental foods are not medically contraindicated by the participant's condition. Therefore, FNS retains the technical requirements for medical documentation for supplemental foods in Food Package III as written in the interim rule. However, FNS recognizes that WIC registered dietitians and/or qualified nutritionists play an important role in the continuum of care of medically fragile WIC participants. Therefore, FNS would support State agency policy that allows health care providers to refer to the WIC registered dietitian and/or qualified nutritionist for identifying appropriate supplemental foods (excluding WIC formula) and their prescribed amounts, as well as the length of time the supplemental foods are required by the participant. This arrangement would be supported only in situations where the health care provider has indicated on the medical documentation form that the provider acknowledges referral to the WIC registered dietitian and/or qualified nutritionist for such determinations. This gives the health care provider medical oversight while allowing the WIC registered dietitian and/or qualified nutritionist to determine the appropriate issuance of WIC foods to participants with qualifying conditions in Food Package III.

4. Sodium Content of WIC Foods

In its Report, the IOM found that intakes of sodium were excessive in the

diets of WIC participants. The IOM reported that more than 90 percent of WIC children 2 through 4 years and of pregnant, lactating, and non-breastfeeding postpartum women had usual sodium intakes above the Tolerable Upper Intake Level (UL). More than 60 percent of WIC children age 1 year had usual sodium intakes above the UL. As such, the IOM recommended, and the interim rule reflected, reductions in the overall sodium level of WIC food packages. The majority of WIC foods under the interim rule may not contain added salt (sodium).

However, options for some WIC foods, i.e., cheese, vegetable juice, canned vegetables, canned beans, peanut butter, and canned fish include both regular and lower sodium varieties. In an effort to support participants in reducing sodium intake, FNS provided technical assistance to State agencies encouraging them to offer only lower sodium varieties of these foods when these options exist.

FNS encourages WIC State agencies that offer canned vegetables to allow only lower sodium canned vegetables and lower-sodium versions of other WIC-eligible foods, i.e., breads, as they become more widely available in the marketplace. FNS encourages food manufacturers to reduce excess sodium in processed foods and to make a wider variety of these foods available to help WIC achieve its goal to safeguard the health of children and women.

5. Organic Foods

The interim rule authorizes organic forms of foods that meet minimum nutrition requirements described in Table 4 of 7 CFR 246.10(e)(12). However, WIC State agencies are responsible for determining the specific brands and types of foods to authorize on their State WIC food lists. Some State agencies allow organic foods on their foods lists, but this will vary by State. The decision may be influenced by a number of factors such as cost, product distribution within a State, and WIC participant acceptance.

FNS received 52 comments asking that State agencies be required to offer organic foods in the WIC food packages. Many of these comments were from one State where the WIC State agency had recently removed organic milk from its list of authorized WIC foods. This final rule continues to provide State agencies the option to offer organic forms of WIC-eligible foods through the regular WIC food instrument, e.g., milk, eggs, peanut butter, and encourages State agencies to make available authorized foods that are acceptable and will be consumed by participants, including organic varieties. This final rule clarifies in Table 4 of 7 CFR 246.10(e)(12) that State agencies are required to allow organic forms of fruits and vegetables purchased with the cash-value voucher.

C. Supplemental Foods and Food Packages

Note: The order of some of the topics in this section is modified from the interim rule for the purposes of discussion.

1. Fruits and Vegetables in Food Packages III Through VII

a. Dollar Amount of Cash-Value Voucher

In order to maintain cost neutrality, the interim rule published December 2007 (72 FR 68966) only provided fully breastfeeding women with the IOM recommended amount of $10.00 per month fruit and vegetable cash-value vouchers; all other women participants were provided $8.00 per month, and children were provided $6.00. An amendment to the interim rule was published in the **Federal Register** on December 31, 2009 (74 FR 69243) to provide all WIC women participants with $10.00 per month fruit and vegetable cash-value vouchers, consistent with IOM's recommendations.

A total of 448 commenters (76 form letters) asked FNS to increase the fruit and vegetable cash-value voucher to the IOM recommended level from $6 to $8 for children. The Department has responded to commenters' requests under this final rule by increasing the cash-value voucher for children to $8 per month. This increase will allow State agencies to further efforts to increase fruit and vegetable consumption by children.

A total of 162 commenters (36 form letters) asked FNS to further increase the fruit and vegetable voucher for fully breastfeeding women from $10 to $12 to provide incentive for women to choose to fully breastfeed, and to meet the intent of the IOM to provide an enhancement to the food packages for fully breastfeeding women. While FNS understands the benefit of increasing the value of the food package for fully breastfeeding women, it is not possible under this rulemaking to go beyond the dollar value for the cash-value voucher for the fully breastfeeding package due to cost. Therefore, the cash-value voucher remains at $10 for all women, including fully breastfeeding women, in this final rule. The base year for calculation of the value of the fruit and vegetable voucher and the base value to be used are updated in 7 CFR 246.16(j)(2).

b. Clarification of Authorized Fruits and Vegetables

To improve the consumption of fresh fruits and vegetables and to appeal to participants of different cultural backgrounds, the interim rule authorized a wide variety of choices within the authorized fruit and vegetable options. The interim rule reflects the IOM recommendation to provide a cash-value fruit and vegetable benefit to participants with few restrictions. The following is a discussion of clarifications and revisions to the interim rule pertaining to authorized fruits and vegetables. Technical corrections in this final rule clarify that both fresh fruits and fresh vegetables must be authorized by State agencies. This final rule further clarifies that 21 CFR 101.95 defines the term ''fresh'' when referring to eligible fresh fruits and vegetables.

Technical corrections in this final rule clarify that the cash-value voucher may be redeemed for any eligible fruit and vegetable (refer to Table 4 of 7 CFR 246.10(e)(12) and its footnotes). Except as authorized by this final rule, State agencies may not selectively choose which fruits and vegetables are available to participants. For example, if a State agency chooses to offer dried fruits, it must authorize all WIC-eligible dried fruits, i.e., those without added sugars, fats, oils, or sodium, and may not allow only a single variety of dried fruits. This final rule clarifies that State agencies may, however, invoke their administrative option at 7 CFR 246.10(b)(1)(i) to establish criteria in addition to the minimum Federal requirements in Table 4 of 7 CFR 246.10(e)(12), which could include restricting packaging (such as plastic containers) and package sizes (such as single serving) of processed fruits and vegetables available for purchase with the cash-value voucher. In addition, State agencies may identify specific types of certain processed WIC-eligible fruits and vegetables (e.g., salsas, tomato sauces, stewed and diced tomatoes) on their food lists if they believe there is cause for significant vendor and participant confusion in identifying specific items within those categories that are WIC-eligible.

A technical correction has been made in Table 4 of 7 CFR 246.10(e)(12) to clarify that the following products are not allowed: Dried white potatoes, mixed vegetables containing white potatoes, noodles, nuts or sauce packets, and decorative flowers and blossoms. Canned tomato sauce and tomato paste without added sugar, fats, oils are authorized. Salsa and spaghetti sauce

without added sugar, fats, and oils are also authorized.

This final rule clarifies that the fruit or vegetable must be listed as the first ingredient in WIC-eligible processed fruits and vegetables. In addition, it clarifies that frozen fruits may not contain added fats, oils, salt (i.e., sodium) or added sugars.

For the reasons described in section IV.B.4 of this preamble, Table 4 of 7 CFR 246.10(e)(12) will be revised to allow State agencies the option to offer only lower sodium canned vegetables for purchase with the cash-value voucher.

c. White Potatoes

The interim rule excludes the purchase of white potatoes with the cash-value voucher. A total of 266 (of these, 213 were form letters) opposed the restriction of white potatoes. Commenters stated that white potatoes should be included in the WIC food packages because they are versatile, economical, contain key nutrients, and are preferred by participants. Thirty-two commenters (20 form letters) stated that the exclusion of white potatoes is difficult to administer.

The restriction of white potatoes, as recommended by the IOM, is based on data indicating that consumption of starchy vegetables meets or exceeds recommended amounts, and food intake data showing that white potatoes are the most widely used vegetable. Including white potatoes in the WIC food packages would not contribute towards meeting the nutritional needs of the WIC population and would not support the goal of expanding the types and varieties of fruits and vegetables available to program participants, as recommended by the IOM. Therefore, the provision to exclude white potatoes from the WIC food packages is retained in this final rule. The Department recognizes that white potatoes can be a healthful part of one's diet. However, WIC food packages are carefully designed to address the supplemental nutritional needs of a specific population. Although white potatoes are not offered in the WIC food package, nutrition education provided to WIC participants will continue to include white potatoes as a healthy source of nutrients and an important part of a healthful diet.

d. Dried Fruit and Dried Vegetables for Children

As recommended by the IOM, the interim rule disallows dried fruits and vegetables to be purchased with the cash-value voucher for children because of the risk of choking. FNS received a small number of comments asking that dried fruits be allowed for children, citing a lack of evidence that they pose choking hazards for all children. Recommendations made by IOM for the Child and Adult Care Food Program allow dried fruits for children as long as they do not pose a choking hazard.[2] Therefore, at the State agency's option, this final rule authorizes dried fruits and dried vegetables to be purchased with the cash-value voucher for children. Nutrition education regarding choking hazards, developmental readiness, proper food preparation, and oral health care should be provided to caregivers of young children.

e. Standards of Identity for Canned Fruits and Canned Vegetables

Two technical corrections have been in made in Table 4 of 7 CFR 246.10(e)(12) related to the standards of identity for canned fruits and canned vegetables. This final rule corrects the specifications for WIC-eligible canned fruits to reflect that only those WIC-eligible canned fruits that have a standard of identity, as listed at 21 CFR Part 145, must conform to the FDA standard of identity. Similarly, this final rule corrects the specifications for WIC-eligible canned vegetables to reflect that only those WIC-eligible canned vegetables that have a standard of identity, as listed at 21 CFR Part 155, must conform to the FDA standard of identity. The provision that WIC-eligible canned vegetables contain no added sugars, fats, and oils remains unchanged. This final rule clarifies that home-canned and home-preserved fruits and vegetables are not authorized.

f. Implementation of Fruit and Vegetable Options

(1) Paying the difference with the cash-value voucher. The interim rule authorized State agencies the option to allow participants to pay the difference if the fruit and vegetable purchase exceeds the value of the cash-value voucher, a transaction known as ''split tender.'' A total of 116 commenters (59 form letters) asked FNS to require all State agencies to allow split tender transactions to ensure that participants are able to maximize use of their cash-value voucher. Because it may be difficult for participants to accurately estimate the exact purchase price of the fruit and vegetable selections, particularly when fresh, canned, dried, or frozen items are combined in one purchase or when items are purchased in bulk, FNS agrees that all participants should be allowed to pay the difference when the purchase of allowable fruits and vegetables exceeds the value of the fruit/vegetable cash-value voucher. Therefore, this final rule adds a provision at 7 CFR 246.12(f)(4) to require State agencies to allow split tender transactions with the cash-value voucher.

(2) Minimum vendor stocking requirements. A technical oversight in the interim rule has been corrected at 7 CFR 246.12(g)(3)(i) by clarifying that authorized vendors must stock at least two *different* fruits and two *different* vegetables.

(3) Authorizing farmers' markets. The interim rule gave State agencies the option to allow farmers at farmers' markets to accept cash-value vouchers. FNS received 29 comments (mostly form letters) recommending that farmers' market organizations, rather than the individual farmer, be authorized to accept cash-value vouchers, as is permitted under the WIC Farmers' Market Nutrition Program (FMNP). Sixty-nine commenters (mostly form letters) additionally recommended that the WIC Program regulations be more closely aligned with the FMNP. Commenters stated that consistency between the two programs would make FMNP participation easier both for WIC participants and authorized farmers. Many of the comments suggested that State agencies be allowed to authorize farmers' markets in addition to the current provision (7 CFR 246.12(v)) that allows State agencies the flexibility to authorize farmers at farmers' markets or roadside stands. FNS finds merit in such a provision; this also would provide more consistency between WIC and FMNP.

Seventy-eight comments went on to suggest that the authorization of farmers' markets should be a Federal requirement, rather than a State agency option. FNS believes that State agencies are in the best position to determine what works for their individual benefit delivery systems, taking into consideration such factors as participant access, the availability of farmers, and the administrative burdens of monitoring and authorization. Therefore, the final rule amends 7 CFR 246.12 to allow WIC State agencies to authorize farmers or farmers' markets to accept WIC cash-value vouchers, but such authorization will remain as a State agency option. As a result of the addition of farmers' markets, conforming amendments have been

[2] Institute of Medicine, National Academy of Sciences. ''Child and Adult Care Food Program: Aligning Dietary Guidance for All,'' 2010. Available at Internet site: *http://www.fns.usda.gov/child-and-adult-care-food-program-aligning-dietary-guidance-all.*

made in 7 CFR 246.2, 246.4, 246.18, and 246.23.

A number of comments were received recommending that the Federal WIC regulations be modified to be consistent with the fruits and vegetables eligible for purchase under the FMNP. FNS makes every effort to ensure that both programs are aligned in most areas, to the extent possible. However, each program has different statutory objectives. Thus, FNS is convinced that it is critical for each program to maintain its separate identity. As stated previously, FNS found merit in allowing farmers' markets to redeem WIC cash-value vouchers, an example of aligning both programs. FNS finds no need to make any further operational changes in this area through this final rule. A technical amendment is added to 7 CFR 246.4(a)(14) to correct a cross-reference to 7 CFR 246.12 that addresses the State agency options regarding vendor sanctions.

2. Mature Legumes (Dry Beans, Peas and Lentils) and Peanut Butter

a. Clarification of Allowable Mature Legumes

Technical corrections have been made to the list of authorized mature legumes in Table 4 of 7 CFR 246.10(e)(12). Refried beans, without added sugars, fats, oils, vegetables or meat, have been added to the examples of allowable legumes in Table 4 of 7 CFR 246.10(e)(12). The specification in Table 4 also clarifies that mature legumes issued via the WIC food instrument may not contain added vegetables or fruits.

b. Issuance of Mature Legumes (Dry Beans and Peas)

The interim rule includes mature dry beans, peas, or lentils in dry-packaged or canned forms as a WIC food category. Items in this food category are issued via the regular WIC food instrument. FNS provided technical assistance to State agencies on the interim rule clarifying that beans and peas that do not qualify under this category may be purchased only with the cash-value voucher. A total of 23 commenters (8 of which were form letters) asked FNS to allow all mature varieties and forms of dry beans and peas to be purchased with both the cash-value voucher and the WIC food instrument to eliminate confusion on the part of participants and vendors.

The nutritional profile of mature dry legumes is different than that for immature varieties and FNS believes it is important to maintain this distinction. Mature legumes are excellent sources of plant protein, and also provide other nutrients such as iron and zinc. Mature dry beans and peas are similar to meats, poultry, and fish in their contribution of these nutrients. In WIC, they are offered as a separate food category from the fruit and vegetable category. Therefore, mature legumes in dry-packaged and canned forms, without added vegetables, fruits, meat, sugars, fats, or oils, are the only dry beans and peas authorized to be issued via the WIC food instrument.

c. Disallowed Ingredients in Peanut Butter

A technical oversight has been corrected in Table 4 of 7 CFR 246.10(e)(12) to disallow peanut butter with added marshmallows, honey, jelly, chocolate/or similar ingredients.

3. Fruit and Vegetable Juice

Technical corrections have been made in Table 4 of 7 CFR 246.10(e)(12) related to the standard of identities for canned fruit and vegetable juices. This final rule corrects the specifications for WIC-eligible canned fruit juice and vegetable juice to reflect that only those WIC-eligible juices that have a standard of identity, as listed at 21 CFR Part 146 and 21 CFR Part 156, must conform to these FDA standards of identity.

4. Milk and Milk Alternatives

a. Whole milk for participants greater than 2 years of age. Under the interim rule, and as recommended by the IOM, whole milk is not authorized for children greater than 2 years of age and women in Food Packages IV–VII. Under the interim rule, whole milk may be issued to medically fragile children older than 2 years of age and women only in Food Package III for participants with qualifying conditions. A total of 216 commenters, primarily local agency WIC staff, asked FNS to allow the CPA to prescribe whole milk for participants in any food package if necessary for participants who have medical or nutritional reasons for requiring additional calories.

FNS believes that WIC staff can assist participants in Food Packages IV–VII in meeting their nutritional needs through fat-reduced milks and other foods. Whole milk adds unnecessary saturated fat and cholesterol to the diets of participants. Nutrition education and individual tailoring of the food package within authorized parameters remain the most effective tools for WIC staff to use to help participants make appropriate choices based on their specific needs. Therefore, the provision to authorize whole milk for children greater than 2 years of age and women only in Food Package III is retained in this final rule in Table 3 of 7 CFR 246.10(e)(11).

b. Fat-Reduced Milks for Children 12 Months to 2 Years of Age in Food Package III and IV

Under the interim rule, children 12 months to 2 years of age may only be issued whole milk. A total of 332 commenters (34 form letters) want flexibility in this provision, citing American Academy of Pediatrics (AAP) policy,[3] recommending fat-reduced milks for children over the age of 1 for whom overweight or obesity is a concern.

In light of current AAP policy, FNS will allow, at State agency option, fat-reduced milks to be issued to 1-year-old children (12 months to 2 years of age) for whom overweight or obesity is a concern. Under Food Package IV, FNS will allow the CPA to make a determination for the need for fat-reduced milks for young children based on an individual nutritional assessment and consultation with the child's health care provider if necessary, as established by State agency policy. FNS will provide technical assistance for issuing fat-reduced milks to children 12 months to 2 years of age in Food Package IV. Due to the medically fragile qualifying conditions of children 12 months to 2 years of age, FNS will continue to require medical documentation for issuance of WIC-eligible formula and foods, including fat-reduced milks, under Food Package III.

c. Fat Content of Milk for Children Over 2 Years of Age and Women

Under the interim rule, children ≥ 24 months of age and women may be issued a variety of milk types (i.e., nonfat, lowfat (1%) and reduced fat (2%) milk). Seven commenters recommended the issuance of only nonfat or lowfat (1%) milk to children ≥ 24 months of age and women to be consistent with the Dietary Guidelines for Americans. FNS notes that State agencies already have policies to ensure that CPAs issue the appropriate milk to participants based on the assessed nutritional needs of individual participants. Since 1995 the Dietary Guidelines for Americans have recommended consumption of nonfat and lowfat milk and milk products. In technical assistance provided to State agencies on the interim rule, FNS supported and encouraged State agencies to issue only nonfat and lowfat

[3] *American Academy of Pediatrics. Policy Statement* Lipid Screening and Cardiovascular Health in Childhood, *Pediatrics Vol. 122 No. 1 July 2008, pp. 198–208.*

milk to children and women unless otherwise indicated by nutrition assessment. As such, FNS finds merit in adding a provision that nonfat and lowfat (1%) milks are the standard issuance for children ≥ 24 months of age and women in Food Packages IV–VII. Reduced fat (2%) milk is authorized only for participants with certain conditions, including but not limited to, underweight and maternal weight loss during pregnancy. The need for reduced fat (2%) milk for children ≥ 24 months of age (Food Package IV) and women (Food Packages V, VI, VII) will be determined as part of the careful nutrition assessment completed by the CPA, as established by State agency policy.

d. Fortification of Whole Milk

This final rule clarifies the minimum nutrient requirements for all milks listed in Table 4 of 7 CFR 246.10(e)(12). The table restates the milk specifications to make it clearer that vitamin A fortification is not required for whole milk.

e. Provision of Maximum Monthly Allowance of Milk

Under the interim rule, the maximum monthly allowance of milk must be provided to participants, as the WIC benefit to participants is the full authorized amount. The interim rule allows a substitution rate of 1 pound of cheese for 3 quarts of milk, leaving a quart of milk or milk substitute that must be provided to participants issued this option to fulfill the maximum allowance in the food package.

A total of 17 commenters (6 of these form letters) asked FNS to drop the ''dangling quart'' or allow State agencies to round the quantity of milk up when substituting cheese for milk because of limited availability and higher costs of milk in quart size containers. A total of 20 commenters (6 of these form letters) asked FNS to allow State agencies to issue 12 ounce cans of evaporated milk, which are the largest size available in the marketplace and which reconstitute to 24 fluid ounces, as the ''dangling quart.''

The IOM cited milk as an important source of calcium and vitamin D for WIC participants, and this food category should not be shortchanged. Therefore, the ''dangling quart'' may not be ignored. This final rule will continue to require that State agencies provide the maximum allowance of milk to participants if cheese is substituted for milk in order for participants to obtain their full milk benefit.

State agencies continue to have the option to make available other authorized milk substitutes to fulfill the maximum allowance. Because milk in quart sizes has become more widely available as States have implemented the interim rule, and this final rule allows the option of providing a quart of yogurt for children and women (as described in a subsequent section of this preamble), and allows issuance of a 12 ounce can of evaporated milk to substitute for the ''dangling quart,'' State agency concerns about difficulty providing the full milk benefit to participants who substitute cheese for milk should be alleviated. State agencies also have the option to prescribe half gallon containers of milk every other month for participants in lieu of the ''dangling quart.''

f. Cheese in Excess of Maximum Substitution Rates

Under the interim rule, cheese may be substituted for milk. The IOM set a substitution rate for cheese for milk, but put a cap on the amount that can be substituted to control total and saturated fat content of the food packages. Under the interim rule, FNS allowed, with medical documentation, additional amounts of cheese to be issued beyond the substitution rate to provide State agencies with flexibility to accommodate participants with lactose intolerance. This accommodation was made because, at the time, milk alternatives for participants with lactose intolerance were more limited. Few soy-based beverages that met FNS' nutritional standards were available, and the interim rule did not authorize yogurt, which had been recommended by IOM as a milk substitute. Since that time, more soy-based beverages that meet the nutritional standards established by FNS are available in the marketplace, and this final rule authorizes yogurt for children and women. As a result, State agencies have increased flexibility, in addition to offering lower lactose milks, to accommodate lactose intolerance with substitutes other than cheese, as recommended by the IOM. Therefore, this final rule will no longer allow cheese to be issued beyond established substitution rates, even with medical documentation, which is consistent with the recommendation of the IOM.

g. Yogurt

The IOM recommended adding yogurt to the WIC food packages as a partial milk substitute for children and women. However, under the interim rule, FNS determined that the addition of yogurt to the WIC food packages was cost prohibitive. The interim rule solicited comments from State agencies about the extent to which WIC participants would benefit from the addition of yogurt, and whether that addition could be achieved in a cost-effective manner.

A total of 304 comment letters (63 of these form letters) encouraged FNS to allow yogurt as a milk substitute, emphasizing that yogurt provides priority nutrients and is convenient, popular, and culturally acceptable to WIC participants. Commenters also cited a pilot study, conducted by the California WIC Program in conjunction with the National Dairy Council, which demonstrated the feasibility of providing yogurt in WIC food packages.[4] The pilot study results cited participant acceptance and ease of implementation.

FNS agrees that yogurt is a desirable milk alternative for participants who might not otherwise drink sufficient amounts of fluid milk due to lactose intolerance or other reasons. Therefore, this final rule authorizes yogurt as a substitute for milk for children and women in Food Packages III–VII, at the State agency's option.

(1) Maximum Monthly Allowance of Yogurt

At State agency option, 1 quart of yogurt may be substituted for 1 quart of milk for women and children in Food Packages III–VII. No more than 1 quart of yogurt is authorized per participant.

(2) Authorized Yogurts

As recommended by the IOM, yogurt must conform to the standard of identity for yogurt as listed in Table 4 of 7 CFR 246.10(e)(12) and may be plain or flavored with ≤ 40 grams of total sugar per 1 cup of yogurt. Only lowfat and nonfat yogurts are authorized for children over 2 years of age and women. Whole fat yogurt is authorized only for children less than two years of age. State agencies have the option to determine the container sizes of yogurt to authorize on their food lists.

h. Tofu

Under the interim rule, calcium-set tofu prepared only with calcium salts, (e.g., calcium sulfate), and without added fats, sugars, oils, or sodium, is authorized. A technical correction has been made in this final rule to clarify that tofu must be calcium-set, i.e., contain calcium salts, but may also contain other coagulants, i.e., magnesium chloride. This additional flexibility allows State agencies to meet the needs of WIC's culturally diverse participants. Tofu with only calcium

[4] Fung, EB, et al. Randomized, controlled trial to examine the impact of providing yogurt to women enrolled in WIC. J Nutr Educ Behav. 2010 May–Jun;42(3 Suppl):S22–9.

sulfate may not be readily available in the marketplace. Major tofu manufactures with national distribution make tofu with calcium sulfate alone or in addition to magnesium chloride as a coagulant. Magnesium chloride is not a flavoring or preservative, and should not be confused with sodium chloride, which is not permitted. The calcium content of various types of tofu, even those set only with calcium salts, varies. In choosing the brands and types of calcium-set tofu to include on food lists, State agencies should read the nutrition labels and choose tofu with the highest amount of calcium.

5. Breastfeeding Provisions

Under the interim rule, food packages for infants and women are designed to strengthen WIC's breastfeeding promotion and support efforts and provide additional incentives to assist mothers in making the decisions to initiate and continue to breastfeed. The provisions disallow routine issuance of infant formula to partially breastfeeding infants in the first month after birth to help mothers establish milk production and the breastfeeding relationship. Overall, commenters expressed support for the breastfeeding provisions, with 7 State agencies stating they have already seen increases in breastfeeding rates attributable to the interim rule provisions. State agencies stressed that adequate training of WIC staff and the provision of appropriate counseling and support to mothers is critical to the success of the new food packages for the breastfeeding mothers and their infants.

a. Exclusive Breastfeeding

This final rule clarifies the intent of the WIC Program that all women be supported to exclusively breastfeed their infants and to choose the fully breastfeeding food package without infant formula at 7 CFR 246.10(e). Breastfeeding women who do not exclusively breastfeed are to be supported to continue breastfeeding to the maximum extent possible through minimum supplementation with infant formula.

b. Clarification of Partially Breastfeeding Terminology

Commenters asked FNS to address terminology used to describe the mother-infant pair who ''partially'' breastfeed (both breastfeed and formula feed). Confusion exists because partially breastfeeding is used to describe a combination of any amounts of breastfeeding and formula feeding. However, under the interim rule, for the purposes of food package issuance, the partially breastfeeding food package is defined by a maximum quantity of formula that assumes the mother is substantially breastfeeding her infant. Confusion also exists because WIC's definition of a breastfeeding woman is the practice of feeding a mother's breast milk to her infant on the average of at least once a day. This definition determines the categorical eligibility of a participant as a breastfeeding woman, and did not change under the interim rule revising the WIC food packages. All women who meet this definition are counted as breastfeeding women for participation purposes, regardless of the food package they are issued or the amount of formula their infants receive.

Under the interim rule, three infant feeding variations are defined for the purposes of assigning food quantities and types in Food Packages I and II for infants: (1) Fully formula feeding, (2) fully breastfeeding (the infant does not receive formula from the WIC Program), and (3) partially breastfeeding (the infant is breastfed but also receives some infant formula from WIC up to the maximum allowance described for partially breastfed infants in Table 1 of 7 CFR 246.10(e)(9)). Breastfeeding assessment and the mother's plans for breastfeeding serve as the basis for determining food package issuance. Breastfed infants who are assessed to need more formula than is allowed under the food package for partially breastfed infants are assigned to the fully formula feeding package.

FNS agrees that terminology used to describe food packages for the mother-infant pair that both breastfeed and formula feed, regardless of amount from either source, needs clarification. Therefore, this final rule attempts to minimize confusion about food package issuance by parenthetically adding the descriptor ''mostly'' breastfeeding to the partially breastfeeding food package designation established under the interim rule.

c. Issuance of Formula to Breastfed Infants

There has been some confusion about the issuance of one can of powder infant formula in the first month to breastfed infants. For breastfeeding women who do not receive the fully breastfeeding package, WIC staff are expected to individually tailor the amount of infant formula based on the assessed needs of the breastfeeding infant and provide the minimal amount of formula that meets but does not exceed the infant's nutritional needs. This is consistent with long-standing FNS policy that dates back to the 1980s. State agencies should develop policies for handling breastfeeding mothers' formula requests that encourage substantial and continued breastfeeding. This is true whether the infant receives the fully formula feeding package (although the infant may be minimally breastfeeding) or the partially (mostly) breastfeeding food package. The full nutrition benefit should not be used as the standard for issuance unless the mother is not breastfeeding the infant at all.

The interim rule strengthened the WIC food packages to better enhance breastfeeding promotion and support. Food packages for partially (mostly) breastfed infants and women were created that provide additional foods for mothers as incentives, to better meet nutritional needs, and to provide less infant formula to partially breastfed infants than to infants who receive the fully formula fed package.

The food packages for partially (mostly) breastfed mothers and infants are designed to provide for the supplemental nutrition needs of the breastfeeding pair, provide minimal formula supplementation to help mothers maintain milk production, and provide incentives for continued breastfeeding by way of a larger variety and quantity of food than the full formula/postpartum packages. FNS emphasizes that the benefits of the partially breastfed food packages are lost if the breastfeeding mother-infant pair is issued the full formula/postpartum packages. Appropriate support and counseling should be provided to mothers to minimize the number of breastfeeding infants receiving the full formula packages.

This final rule clarifies at 7 CFR 246.10(b)(2)(ii)(C) that food package quantities are to be issued based on assessment of each participant's individual breastfeeding and nutritional needs.

d. Issuance of Formula to Breastfed Infants in the First Month After Birth

This final rule clarifies that the issuance of any formula to breastfed infants in the first month after birth is a State agency option. If a State agency chooses this option, it may issue one can of powder infant formula in the container size that provides closest to 104 reconstituted fluid ounces to partially breastfed infants on a case-by-case basis. Breastfed infants who are provided this option are considered partially (mostly) breastfed. Breastfed infants should not receive more than the one can option in order to maintain the mother's milk production. State agencies should not create food packages that standardize issuance of formula to partially (mostly) breastfed infants in the first month after birth.

e. Food Package VII for Fully Breastfeeding Women

Under the interim rule, Food Package VII is issued to three categories of WIC participants—fully breastfeeding women whose infants do not receive formula from the WIC Program; women pregnant with two or more fetuses, and women fully or partially (mostly) breastfeeding multiple infants. This final rule clarifies that Food Package VII is issued to partially (mostly) breastfeeding mothers who are breastfeeding multiples *from the same pregnancy.*

A total of 12 commenters (4 form letters) asked that partially breastfeeding women who are also pregnant be allowed to receive the more enhanced Food Package VII. FNS agrees with commenters that pregnant women who are also partially (mostly) breastfeeding singleton infants would benefit from the increased quantity and variety of foods in this food package. Therefore, this final rule authorizes pregnant women who are also partially (mostly) breastfeeding to receive Food Package VII.

Under the interim rule, women fully breastfeeding multiples receive 1.5 times the maximum allowance of foods authorized in Food Package VII to meet their nutritional needs. A total of 36 commenters (8 form letters) asked FNS to revise the food package quantities for women fully breastfeeding multiples to reflect a consistent amount each month and to specify amounts in quantities available in marketplace. In technical assistance provided to State agencies on the interim rule, FNS provided flexibility to allow States to choose how they will issue these quantities. Some States have elected to issue foods in this food package in amounts averaged over a 2-month timeframe to eliminate concern about providing quantities available in the marketplace. Others issue double the ''regular'' fully breastfeeding package one month and then issue the ''regular'' fully breastfeeding package the next month. FNS will allow State agencies to retain the flexibility to determine how best to issue food packages quantities for women fully breastfeeding multiples and therefore will not change the provision to specify a set amount that must be provided each month.

f. Human Milk Fortifier (HMF)

Fifteen commenters (4 form letters) asked that partially (mostly) breastfeeding women whose infants receive human milk fortifier (HMF) be considered fully breastfeeding.

Issuance of HMF as a WIC formula is allowed with medical documentation under the interim rule, as it was under previous WIC policy. A woman whose infant receives HMF is considered partially breastfeeding because her infant is receiving formula from WIC. HMF provides additional protein, minerals, and vitamins that, when added to breastmilk in the first postpartum month for premature infants, results in nutrient, mineral, and vitamin concentrations similar to those of the formulas developed for feeding preterm infants. HMF is given in the hospital, but most often is discontinued prior to discharge. There is a limit on how long HMF is necessary and the need and length of time an infant should remain on HMF should be determined and monitored by the health care provider.

Since HMF is to be used for only a very short time, the woman can be transitioned back to the fully breastfeeding package as soon as the infant is no longer receiving HMF from WIC. The final rule will retain the provision that Food Package VII is issued only to women whose infants do not receive formula from WIC, including HMF.

6. Whole Wheat Bread and Whole Grain Options

a. Authorized Breads

Under the interim rule, whole wheat breads, rolls and buns that meet the FDA standard of identity for whole wheat bread (21 CFR 136.180) are authorized. Some commenters asked FNS to allow baked products that do not meet the standard of identity for whole wheat bread, e.g., English muffins and bagels, if these products otherwise meet the whole wheat requirements. FNS has considered this request, but has determined that identifying the WIC-eligibility of whole wheat bread products that do not meet the standard of identity would be complex given the number of products in the marketplace. Therefore, the requirement that whole wheat breads meet the standard of identity for whole wheat bread is retained in this final rule in Table 4 of 7 CFR 246.10(e)(12).

b. Package Sizes of Whole Wheat/Whole Grain Bread

The interim rule established a maximum monthly allowance of two pounds of whole wheat bread or other whole grain options for children in Food Packages III and IV; and one pound of whole wheat bread or other whole grain options for women in Food Packages III, V and VII. Commenters asked that FNS authorize bread in the more commonly available 20 ounce package size.

Although the availability of bread in package sizes to meet the WIC maximum monthly amount of bread authorized in WIC food packages was of initial concern as State agencies planned to implement the new food packages and supply in the marketplace may have been limited, bread manufacturers have increasingly produced WIC-eligible breads in 16 ounce package sizes to respond to the changes in the WIC Program. As such, all State agencies have breads in appropriate size packages on their WIC food lists. A greater number of WIC-eligible breads in 16 ounce package sizes continue to be introduced by manufacturers, which will further increase the bread options available to participants. Therefore, FNS believes that this situation has been addressed and the maximum allowance for whole wheat and whole grain bread is unchanged in this final rule.

c. Expansion of Whole Grain Options

Under the interim rule, whole grains (brown rice, bulgur, oats, and whole grain barley), as well as tortillas, are authorized as substitutions for whole wheat and whole grain bread. A total of 310 commenters (22 of these form letters) asked FNS to consider expanding the list of whole grain foods available to participants. Suggestions included whole grain pasta, whole wheat English Muffins, and whole wheat bagels.

To make available additional whole grain foods to participants, this final rule will add whole wheat pasta to the list of whole wheat/whole grain bread alternatives. Whole wheat macaroni (pasta) products that meet the FDA standard of identity (21 CFR 139.138) and have no added sugars, fats, oils, or salt (i.e., sodium) are WIC-eligible. Other shapes and sizes that otherwise meet the FDA standard of identity for whole wheat macaroni (pasta) products are also authorized (e.g. whole wheat rotini, whole wheat penne).

d. Technical Corrections

In technical assistance provided to State agencies on the interim rule, FNS clarified that State agencies must offer whole wheat and/or whole grain bread. State agencies have the option to also authorize the other whole grain options listed in Table 4 of 7 CFR 246.10(e)(12). This final rule clarifies this provision. Also, consistent with technical assistance provided to State agencies on the interim rule, FNS clarifies in Table 4 of 7 CFR 246.10(e)(12) of this final

rule that corn tortillas made from ground masa flour (corn flour) using traditional processing methods are WIC-eligible. FNS recognizes that a small loss of corn kernel occurs during the traditional processing of tortillas, and therefore, such tortillas are not considered whole grain. FNS encourages State agencies to authorize corn tortillas that have whole corn listed as their primary ingredient. However, if the market availability of such corn tortillas is limited, FNS will allow State agencies to authorize corn tortillas made from ground masa flour using traditional processing methods, due to the high participant acceptance of corn tortillas, especially among Hispanic cultures. A technical clarification has been made in Table 4 of 7 CFR 246.10(e)(12) to the minimum requirements and specifications for whole wheat tortillas to address the types of flour authorized. This final rule continues to require that whole grain breads and cereals meet FDA labeling requirements for making a health claim as a ''whole grain food with moderate fat content.'' However, for simplicity and clarity, the final rule removes the specifics of the labeling requirements from Table 4 of 7 CFR 246.10(e)(12) and instead refers readers and manufacturers directly to the FDA health claim notification for further reference at *http://www.fda.gov/food/ingredientspackaginglabeling/labelingnutrition/ucm073634.htm*.

A technical clarification has been made in Table 4 of 7 CFR 246.10(e)(12) to the minimum requirements and specification for whole wheat bread to address consistency with the standard of identity for whole wheat bread. For additional clarity and to aid State agencies and participants in identifying WIC-eligible whole grain bread products, a statement has been added to the requirements noting whole grain breads must conform to the FDA standard of identity for bread, buns and rolls.

7. Breakfast Cereals

Under the interim rule, at least one half of all breakfast cereals on each State agency's authorized food list must meet the whole grain requirements as specified in Table 4 at 7 CFR 246.10(e)(12). This provision allows certain corn and rice-based cereals to be offered to participants who may have allergies to whole grain cereals. FNS is retaining this provision in this final rule, but encourages State agencies to issue whole grain cereals to participants to the maximum extent possible, reserving non-whole grain options for those participants with allergies or other medical reasons where whole grains are contraindicated. Participants should receive nutrition education on the benefits of whole grain in the diets to reduce the risk of coronary heart disease and type-2 diabetes, help with body weight maintenance, and increase intake of dietary fiber.

A technical correction has been made in this final rule in Table 4 of 7 CFR 246.10(e)(12) to clarify that there is no FDA standard of identity listed for breakfast cereals.

8. Infant Foods in Food Packages II and III

a. Fresh Bananas as Substitute for Jarred Infant Foods

Under the interim rule, State agencies have the option to offer fresh bananas as a substitute for up to 16 ounces of infant food fruit at a rate of one pound of bananas per eight ounces of infant food fruit via the regular WIC food instrument. To ensure participants receive the full food package benefit of this provision, and to simplify the transaction for vendors as well as participants, FNS will also allow State agencies the option to substitute fresh bananas at a rate of one banana per four ounces of jarred infant food fruit, up to a maximum of 16 ounces, in Food Packages II and III for infants 6 to 12 months of age. This is consistent with recommendations of the IOM.

b. Cash-Value Voucher in Lieu of Commercial Jarred Infant Foods

Under the interim rule, jarred infant foods (fruits, vegetables, and meat) are provided in Food Packages II and III for infants 6 months through 11 months of age. Although this provision overall has been well received, concerns initially made by commenters on the proposed rule persist regarding this provision. A total of 508 commenters on the interim rule asked FNS to include a State option to provide a cash-value voucher to older infants receiving Food Packages II and III in lieu of commercial jarred infant food fruits and vegetables. Commenters stated that foods for older infants should be developmentally appropriate as infants transition to toddler foods, and noted the lack of availability of jarred infant foods in appropriate textures for the older infant. Commenters also stated that the amount of jarred infant foods in the WIC food packages is excessive for some older infants who are progressing in their feeding skills and transitioning from infant foods to table foods consumed during family meals.

FNS remains committed to IOM's recommendation that commercial jarred infant foods be provided in the WIC food packages to ensure that infants receive and consume fruits and vegetables in developmentally appropriate textures and in a variety of flavors. The IOM also intended that commercial jarred infant foods be provided to ensure that these items are consumed by infants and not other participants or family members. Food safety and nutrient content were also considerations. FNS recognizes these considerations and continues to provide commercial jarred infant foods in this final rule.

FNS acknowledges the preference for alternative options for infants and agrees that the lack of developmentally appropriate infant foods available in the marketplace may make it difficult for State agencies to provide a range of textures appropriate for infants at different stages of development. This void in the market is particularly noted among infant food products for older infants, and may compromise the appropriate progression of an infant's feeding skills. The FNS Infant Nutrition and Feeding Guide [5] indicates that at around nine months of age, most infants are developmentally ready to consume foods of increased texture and consistency. Such consistency should progress from pureed to ground to fork-mashed and eventually to diced.

Therefore, in light of these considerations, under this final rule, FNS will allow infants 9 months through 11 months of age to receive a cash-value voucher for the purchase of fresh fruits and vegetables in lieu of a portion of the infant food fruits and vegetables provided in Food Packages II and III. For partially breastfed infants and fully formula fed infants, participants may opt to receive a $4 cash-value voucher plus 64 ounces of infant food fruits and vegetables; fully breastfed infants may receive an $8 cash-value voucher plus 128 ounces of infant food fruit and vegetables. The decision to issue cash-value vouchers in lieu of infant food fruits and vegetables is a State agency option. If a State agency chooses this option, it may not categorically issue cash-value vouchers to all infants of this age group. Instead, the cash-value voucher is to be provided to the participant only after a thorough assessment by the CPA, as established by State agency policy, and is optional for the participant, i.e., the mother may choose to receive either the maximum allowance of jarred foods or the combination of jarred foods and a fruit

[5] Food and Nutrition Service 2009. Infant Nutrition and Feeding: A Guide for Use in the WIC and CSF Programs. Available at Internet site: *http://www.nal.usda.gov/wicworks/Topics/FG/CompleteIFG.pdf.*

and vegetable cash-value voucher for her infant. State agencies must ensure that appropriate nutrition education is provided to the caregiver addressing safe food preparation, storage techniques, and feeding practices to make certain participants are meeting their nutritional needs in a safe and effective manner.

States continue to have the option to offer, via the regular WIC food instrument, fresh bananas as a substitute for infant food fruit in Food Packages II and III for infants six to twelve months of age as described in section IV.C.8.a of this preamble.

This final rule clarifies that a fruit or vegetable must be listed as the primary (first) ingredient in WIC-eligible jarred infant foods. Further, this final rule clarifies that combinations of single ingredients of fruits and/or vegetables (e.g., peas and carrots, apples and squash) are allowed in Food Package II and III for infants 6 to 12 months of age.

c. White Potatoes in Jarred Infant Foods

White potatoes are excluded from purchase with the cash-value voucher in the WIC food packages. However, this final rule clarifies that jarred infant foods that meet the minimum requirements and specifications for an infant food product and include white potatoes as an ingredient, but not the primary ingredient, are allowed in Food Packages II and III for infants 6 to 12 months of age.

d. Infant Cereal

Under the interim rule, infant cereal is provided in Food Packages II and III for infants 6 months to 12 months of age. A total of 223 commenters (16 form letters) asked FNS to allow State agencies the option to offer ''adult'' breakfast cereals, as appropriate, to older infants to encourage developmental feeding skills and support the transition from infant foods to appropriate table and finger foods. Commenters stated that participants report not purchasing infant cereal because older infants prefer cereals they can eat with their fingers.

The IOM recommended the provision of iron-fortified infant cereal for infants 6 to 12 months of age as a quality source of iron and zinc, nutrients needed by infants for optimal growth and development. Providing infant cereal for infants 6 months through 11 months of age is consistent with pediatric nutrition guidelines. The FNS Infant Nutrition and Feeding Guide [6] states that ready-to-eat, iron-fortified cereals designed for adults or older children are not recommended for infants because they: (1) often contain mixed grains; (2) tend to contain more sodium and sugar than infant cereals; and (3) typically contain less iron per infant-sized serving. Food safety is also of concern with the provision of adult cereals to infants as these products could cause choking if the infant is not developmentally ready to consume foods of this texture. For these reasons, the provision of iron-fortified infant cereal for infants 6 months of age through 12 months of age in Food Packages II and III remains unchanged in this final rule.

9. Canned Fish

The IOM recommended that a variety of canned fish that do not pose a mercury hazard be offered in Food Package VII. In addition to canned light tuna, canned salmon, and canned sardines, the interim rule authorized canned mackerel in Food Package VII for fully breastfeeding women. However, the two species of mackerel specified in the interim rule—N. Atlantic and Chub (Pacific)—are not readily available in canned form in the United States. FNS received 21 comments asking that canned Jack mackerel also be authorized in Food Package VII, citing its lower levels of mercury and acceptance by WIC participants.

To allow more variety and choice among canned fish options, this final rule authorizes Jack mackerel as a canned fish option in Food Package VII. King mackerel is not authorized in any form. FNS encourages State agencies to offer all authorized canned fish options, i.e., tuna, salmon, sardines, and Jack mackerel, to ensure variety and choice for participants. This final rule also clarifies that canned fish with added sauces and flavorings, e.g., tomato sauce, mustard, lemon, are authorized at the State agency's option.

10. Food Package III for Children and Women With Qualifying Conditions

a. Infant Foods In Lieu of the Cash-Value Voucher

Under the interim rule, children and women with qualifying conditions who require the use of a WIC formula (i.e., infant formula, exempt infant formula or WIC-eligible nutritional (formerly WIC-eligible medical food)) receive Food Package III. Among the supplemental foods provided to participants in this food package is a cash-value voucher to purchase fruits and vegetables. A total of 33 commenters requested the substitution of commercial jarred infant food fruit and vegetables in lieu of the cash-value voucher for participants over the age of one who have a qualifying medical condition, such as prematurity, developmental delays, and dysphasia (swallowing disorders). Commenters pointed out that these individuals would benefit from the use of this ready-to-feed form of pureed fruits and vegetables over the purchase of fresh fruits and vegetables.

Food Package III is reserved for medically fragile participants who have specific dietary needs that are dictated by their medical condition. FNS is committed to providing these individuals with WIC Formula (i.e., infant formula, exempt infant formula and WIC-eligible nutritionals) and supplemental foods that best meet their special dietary needs. Thus, FNS finds merit in the argument that some participants with certain qualifying conditions may require a pureed form of fruits and vegetables to meet their nutritional needs, and would benefit from the convenience of purchasing jarred infant food fruits and vegetables. As such, this final rule allows State agencies the flexibility to provide children and women in Food Package III the option of receiving commercial jarred infant food fruits and vegetables in lieu of the cash-value voucher. The quantity of commercial jarred infant food fruits and vegetables is based on the substitution ratio of 128 ounces of infant food fruits and vegetables for the $8 cash-value voucher for children and 160 ounces of infant food fruits and vegetables for the $10 cash-value voucher for women. The need for commercial jarred infant food fruits and vegetables in lieu of the cash-value voucher will be determined by medical documentation that meets the criteria established in 7 CFR 246.10(d). Some participants may prefer to purchase fruits and vegetables via the cash-value voucher and process/puree the fruits and vegetables themselves; this remains an option and is encouraged for those who would benefit from this method of modifying the consistency and texture of foods to improve nutritional intake.

Some commenters asked FNS to allow children in Food Package IV the option to receive commercial jarred infant foods in lieu of the cash-value voucher. However, FNS believes it appropriate that caregivers of children who do not have qualifying conditions making them eligible for Food Package III, and who need modifications in food consistency, receive nutrition education on choosing and preparing foods that meet the child's needs, e.g., pureeing fruits and

[6] Food and Nutrition Service 2009. Infant Nutrition and Feeding: A Guide for Use in the WIC and CSF Programs. Available at Internet site: *http://www.nal.usda.gov/wicworks/Topics/FG/CompleteIFG.pdf*

vegetables and/or choosing those with soft texture/consistency.

b. Allowance of Infant Formula in Food Package III for Infants

Food package III is reserved for participants who have one or more qualifying conditions that require an exempt infant formula or WIC-eligible nutritional (formerly WIC-eligible medical food) to supplement their nutrition needs, as determined by the participant's health care professional. Infants who have a qualifying condition and are successfully managed with an infant formula are issued Food Package I or II, as deemed appropriate for their age and feeding method.

Under the interim rule, infants who require a combination of infant formula and a WIC-eligible nutritional or exempt infant formula are not able to receive both products through a WIC food package. In addition, these infants at 6 months of age may not be developmentally ready to consume solid foods due to their medical condition and would benefit from an increased amount of formula in place of infant foods at that timeframe. FNS received 74 comments requesting that infants who are not developmentally ready to consume solid foods be allowed increased infant formula amounts in lieu of infant foods in Food Package II.

FNS agrees that there are a small percentage of infants who have a qualifying condition, such as prematurity, whose nutritional needs may be successfully managed with infant formula alone or a combination of infant formula and WIC-eligible nutritionals. These infants are considered medically fragile and would benefit from the close medical supervision provided under Food Package III. These infants may not be ready to consume infant foods at 6 months of age, as would otherwise generally healthy term infants, and they may benefit from receiving additional formula in lieu of infant foods at that time. Therefore, this final rule expands the type of formula authorized to infants with qualifying conditions in Food Package III to include infant formula. The issuance of infant formula in Food Package III would be strictly reserved for those infants who are medically fragile. Infants who do not have a qualifying condition and are otherwise generally healthy infants will continue to receive Food Packages I and II, as appropriate. In Food Package III, infants greater than 6 months of age may receive additional infant formula, exempt infant formula or WIC-eligible nutritionals (formerly WIC-eligible medical food) in lieu of infant foods at the same maximum monthly allowance as infants ages 4 through 5 months of age of the same feeding option. As with exempt infant formula and WIC-eligible nutritionals, infants receiving infant formula in Food Package III will need medical documentation that meets the criteria established in 7 CFR 246.10(d).

11. Liquid Concentrate Infant Formula Amounts and Full Nutrition Benefit

Table 1 in 7 CFR 246.10(e)(9) of the interim rule established the full nutrition benefit and the maximum monthly allowances of each physical form of infant formula, for each food package category and infant feeding variation. The interim rule also described the full nutrition benefit as the reconstituted fluid ounce amounts for liquid concentrate infant formula (based on a 13 ounce can) which formed the basis of substitution rates for other physical forms of infant formula (i.e., powder and ready-to-feed infant formula). Providing the full nutrition benefit amounts ensure that participants receive a comparable nutritional benefit no matter which physical form of infant formula they receive.

For decades, infant formula manufacturers consistently provided liquid concentrate and ready-to-feed infant formula in container sizes or packaging that evenly divide into the maximum monthly allowance, while powder infant formulas traditionally vary in package size across manufacturers. FNS has become aware of a shift in the marketplace, such that liquid concentrate and ready-to-feed infant formula container sizes (i.e., 13 and 32-fluid ounces) are no longer standard for all major infant formula manufacturers. Because the maximum monthly allowance amounts of liquid infant formula under the interim rule are evenly divisible by a 13 ounce standard for liquid concentrate (reconstituted) and a 32 ounce standard of ready-to-feed infant formula, there is little flexibility to accommodate changes in the package size while still providing the full nutrition benefit and not exceeding the maximum monthly allowance amount.

This final rule provides the technical correction of revised maximum monthly allowance amounts for liquid concentrate and ready-to-feed infant formula. The revision of maximum monthly allowance amounts for liquid infant formula (i.e., liquid concentrate and ready-to-feed) is consistent with the legislative authority granted to the Secretary of Agriculture in Section 733 of Public Law 111–80 and reiterated in Section 712 of Public Law 112–55, the Consolidated and Further Continuing Appropriations Act, 2012 that authorizes State Agencies to exceed the current maximum amount of liquid infant formula to ensure the full nutrition benefit be provided to participants. This will maintain competition in the infant formula market and address recent changes in package size availability of liquid concentrate and ready-to-feed infant formula.

Liquid concentrate infant formula will now have a separate maximum monthly allowance amount different from the full nutrition benefit to accommodate market changes in packaging. This provision does not change the full nutrition benefit amounts as established in the interim rule. The full nutrition benefit will now be defined as the minimum amount of reconstituted liquid concentrate infant formula as specified in Table 1 of 7 CFR 246.10(e)(9) of this rule for each food package category and infant feeding option (e.g., Food Package IA fully formula fed, IA–FF).

Infant formula issuance, whether using monthly issuance or rounding methodology, should be based on providing the amount of infant formula that most closely provides the full nutrition benefit to all infant participants as deemed appropriate based on breastfeeding assessment and infant food package and feeding method. At a minimum, State agencies must provide the full nutrition benefit to all non-breastfed infants. For breastfed infants, even those receiving the fully formula fed package, infant formula amounts should be tailored based on the assessed needs of the breastfed infant and provide the minimal amounts of formula that meets but does not exceed the infant's nutritional needs. This final rule adds the definition of full nutrition benefit at 7 CFR 246.2.

12. Infant Formula Requirements Technical Correction

A technical correction has been made to infant formula requirements in 7 CFR 246. 246.10(e)(1)(iii) to clarify the qualifying conditions for the types of supplemental foods (i.e., noncontract brand infant formula and any contract brand infant formula that does not meet the requirements in Table 4 of 7 CFR 246.10(e)(12)) that may be issued in this food package only with medical documentation.

Procedural Matters

Executive Order 12866 and Executive Order 13563

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

This final rule has been designated a ''significant regulatory action,'' under section 3(f) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

Regulatory Impact Analysis Summary

As required for all rules that have been designated as Significant by the Office of Management and Budget, a Regulatory Impact Analysis (RIA) was developed for this final rule. The RIA for this rule was published as part of docket number FNS–2006–0037 on *www.regulations.gov*. A summary of the analysis follows:

Need for Action. This final rule considers public comments submitted in response to the interim rule revising the WIC food packages published in December 2007 (72 FR 68966). The interim rule implemented the first comprehensive revisions to the WIC food packages since 1980. The interim rule revised regulations governing the WIC food packages to align them more closely with updated nutrition science and the infant feeding practice guidelines of the American Academy of Pediatrics, promote and support more effectively the establishment of successful long-term breastfeeding, provide WIC participants with a wider variety of food, and provide WIC State agencies with greater flexibility in prescribing food packages to accommodate participants with cultural food preferences.

This final rule addresses public comments received on the interim rule and makes adjustments that improve clarity of the provisions set forth in the interim rule.

Benefits. The revised food packages were developed to better reflect current nutrition science and dietary recommendations, promote and support more effectively the establishment of successful long-term breastfeeding, provide WIC participants with a wider variety of food than do current food packages, and provide WIC State agencies with greater flexibility in prescribing food packages to accommodate participants with cultural food preferences. The final rule makes additional administrative and food package changes that will allow local WIC agencies to better meet the nutritional needs and dietary preferences of program participants.

Costs. FNS estimates that the cost of all mandatory and optional provisions in this final rule will total $1.17 billion over 5 years assuming State implementation beginning May 1, 2014 (for all provisions except the split tender and soy-based beverage for children provisions, which have effective dates of October 1, 2014) and yogurt for women and children with an effective date of April 1, 2015. If the optional provisions are adopted by fewer than all State agencies, then the cost of the rule will be lower. The cost of the mandatory provisions across all State agencies, plus the cost of the optional provisions by State agencies that serve half of WIC participants, is estimated to be $999 million over 5 years.

Accounting statement. The following accounting statement gives the estimated discounted, annualized costs of the rule assuming full State agency implementation of the rule's mandatory and optional provisions. The figures are computed from the nominal 5-year estimates developed in the full RIA. The accounting statement contains figures computed with 7 percent and 3 percent discount rates.

	Estimate	Year dollar	Discount rate (percent)	Period covered
Benefits				
Qualitative: The final rule modifies several provisions of the interim rule based on comments from State and local agencies, interest groups, participants, and others. These modifications better fulfill the intent of the interim rule and the IOM recommendations that are the basis for the WIC food package changes. The rule would increase the quantity of fruits and vegetables contained in the food packages for children to the level recommended by the IOM. The rule also gives States and local agencies more flexibility to meet the medical needs and cultural preferences of WIC participants. Recent research on WIC participants indicates that changes in the WIC food package have resulted in increases in consumption of healthful foods recommended by IOM (see RIA text). The effect of the rule, therefore is a benefit to participants and not simply a transfer of Federal funds replacing costs that WIC participants would have incurred in the absence of this rule. Because we do not quantify the value of the benefits in the impact analysis, and therefore cannot separate them from the estimated Federal transfer to WIC participants, we show our entire dollar impact under transfers. No longer requiring medical documentation for children to receive soy-based beverage and tofu as milk substitutes will save participants some time, although we believe the overall impact on that their time will be minimal and the savings will be nominal. There may also be a benefit in that some WIC participants may not have been taking the soy-based beverage and tofu substitution because getting medical documentation was presenting a barrier. Providing a mechanism to access soy-based beverage and tofu by working with a WIC Competent Professional Authority will help to remove that barrier and may result in nutrition benefits for this group of participants.				
Transfers				
Annualized Monetized	$225.2	2014	7	FY2014–2018
($millions/year)	230.5	2014	3	
Quantified: The rule contains a mix of mandatory provisions and State options. For purposes of this impact analysis we estimate the value of both the mandatory and optional provisions assuming full implementation by all WIC State Agencies. The figures shown here are estimates of the value of full implementation of mandatory and optional provisions assuming no offsetting savings. The figures shown here which are limited to the food benefit, are transfers from the Federal government to WIC participants.				
Costs				

	Estimate	Year dollar	Discount rate (percent)	Period covered

Qualitative: Local and State WIC agencies will incur some administrative costs, other than reporting and recordkeeping, to implement the final rule. However, we are unable to quantify the potential increases in administrative burden due to the final provisions. These include the costs of training WIC clinic and administrative staff and the periodic review and updating of WIC-approved food lists. The State option to authorize farmers' markets to accept WIC cash-value vouchers may introduce administrative costs, however in general, we anticipate that State Agencies and local WIC providers will be able to absorb the burden associated with implementing this rule with current NSA funds. State and local agencies have substantial flexibility in how they spend their NSA funds and may need to reprioritize or postpone some initiatives to undertake the implementation activities, as well as adapt to certain ongoing administrative requirements associated with the final rule. FNS will continue to provide technical assistance to State and local agencies to assist them in implementing the new provisions of the final rule.

Regulatory Flexibility Act

This final rule has been reviewed with regard to the requirements of the Regulatory Flexibility Act (RFA) of 1980, (5 U.S.C. 601–612). Pursuant to that review, FNS Administrator Audrey Rowe certified that this rule would not have a significant impact on a substantial number of small entities. State and local agencies and WIC participants will be most affected by the rule and WIC authorized vendors and the food industry may be indirectly affected.

Although not required by the RFA, FNS prepared a Regulatory Flexibility Analysis describing the impact of this interim rule on small entities that reflects comments that were received on the Regulatory Flexibility Analysis that was included in the WIC Food Package interim rule published at 72 FR 68982, December 6, 2007.

Need for and Objectives of the Final Rule

The interim rule, published in the **Federal Register** on December 6, 2007 (72 FR 68966), revised the WIC food packages. The revisions align the WIC food packages with the Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics. The interim rule revisions largely reflect recommendations made by the Institute of Medicine (IOM) of the National Academies in its report, ''WIC Food Packages: Time for a Change,'' with certain cost containment and administrative modifications found necessary by the Department to ensure cost neutrality. The interim rule allowed FNS to obtain feedback on the major changes as recommended by IOM, as well as the implementation of procedures, while allowing implementation to move forward. State agencies, including Indian Tribal Organizations, were required to implement the changes by October 1, 2009, and new food packages are now being provided to WIC participants in all States. The interim rule comment period ended February 1, 2010. Public comments received on the interim rule are reflected in the final rule.

The interim rule required substantial changes by State and local agencies. Overall, implementation proceeded smoothly and all States have successfully implemented the changes. This final rule makes a much more limited number of modifications than those contained in the interim rule and requires less significant changes in response to the public comments received. Therefore, the expected effects are minimal for FNS and other Federal Agencies. FNS will continue to provide technical assistance to State and local agencies to assist them in fully implementing the changes. This rule will require State and local agencies to make further modifications to their procedures that are far less substantial than the changes required under the Interim rule. Foreign countries will not be affected.

Description and Estimate of Number of Small Entities to Which the Final Rule Would Apply

This final rule applies to WIC State agencies with respect to their selection of foods to be included on their food lists. As a result, vendors will be indirectly affected. The rule may have an indirect economic affect on certain small businesses because they may have to carry a larger variety of certain foods to be eligible for authorization as a WIC vendor. Currently, approximately 46,000 stores are authorized to accept WIC food instruments, some of which are small businesses. With the high degree of State flexibility allowable under this final rule, small vendors will be impacted differently in each State depending upon how that State chooses to meet the new requirements. Since neither FNS nor the State agencies regulate food producers under the WIC Program, it is not known how many small entities within that industry may be indirectly affected by the final rule.

A 2011 evaluation conducted by Altarum Institute [7] sought to understand the impact that the WIC food package changes had on small stores. The study demonstrated that most small WIC stores were able to maintain their authorization with the WIC Program during the period the food package changes were implemented. Small stores appear to have added healthy foods to their inventory in response to the WIC food package changes. The report concludes that adequate vendor preparation likely factored into the overall success of implementation, and cites the need for ongoing engagement of these and other WIC stakeholders.

[7] Altarum Institute 2011. Impact of the Revised WIC Food Package on Small WIC Vendors: Insight from a Four State Evaluation.

Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

Modifications included in the final rule to eliminate certain medical documentation requirements imposed by the interim rule will decrease the Information Collection Burden associated with this rule.

Steps Taken To Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

FNS considered significant alternatives in developing the interim rule including those that may reduce the indirect impact on small business. These considerations included (among others) the establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; the clarification, consolidation, or simplification of compliance and reporting requirements under the rule for small entities; the use of performance, rather than design, standards; and an exemption from coverage of the rule, or any part thereof, for small entities.

In general, the alternatives of exempting small entities from the requirements in the interim rule or altering the requirements for small entities were rejected. The WIC food packages provide supplemental foods designed to address the nutritional needs of low-income pregnant, breastfeeding, non-breastfeeding postpartum women, infants and

children up to age 5 who are at nutritional risk. Exempting small entities from providing the specific foods intended to address the nutritional needs of participants or altering the requirements for small entities would undermine the purpose of the WIC Program and endanger the health status of participants. Therefore, this final rule retains those requirements.

FNS did, however, modify the new food provisions in an effort to mitigate the impact on small entities. As in the past, State agencies must establish minimum requirements for the variety and quantity of foods that a vendor must stock in order to receive WIC Program authorization. The interim rule added new food items, such as fruits and vegetables and whole grain breads, which may require some WIC vendors, particularly smaller stores, to expand the types and quantities of food items stocked in order to maintain their WIC authorization. In addition, vendors also have to make available more than one food type from each WIC food category, except for the categories of peanut butter and eggs, which may be a change for some vendors. To mitigate the impact of the fruit and vegetable requirement, the interim rule allowed canned, frozen and dried fruits and vegetables to be substituted for fresh produce. These provisions are all retained in this final rule.

The interim rule authorized State agencies the option to allow participants to pay the difference if the fruit and vegetable purchase exceeds the value of the cash-value voucher, a transaction known as ''split tender.'' In response to public comments received on the interim rule, this final rule requires State agencies to allow split tender transactions with the cash-value voucher.

Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), Public Law 104–4, establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local and tribal governments and the private sector. Under section 202 of the UMRA, the Department generally must prepare a written statement, including a cost benefit analysis, for proposed and final rules with ''Federal mandates'' that may result in expenditures by State, local or tribal governments, in the aggregate, or the private sector, of $100 million or more in any one year. When such a statement is needed for a rule, Section 205 of the UMRA generally requires the Department to identify and consider a reasonable number of regulatory alternatives and adopt the most cost effective or least burdensome alternative that achieves the objectives of the rule.

This final rule contains no Federal mandates (under the regulatory provisions of Title II of the UMRA) for State, local and tribal governments or the private sector of $100 million or more in any one year. Thus, the rule is not subject to the requirements of sections 202 and 205 of the UMRA.

Executive Order 12372

The WIC Program is listed in the Catalog of Federal Domestic Assistance Programs under 10.557. For the reasons set forth in the final rule in 7 CFR part 3015, subpart V, and related Notice (48 FR 29115, June 24, 1983), this program is included in the scope of Executive Order 12372 which requires intergovernmental consultation with State and local officials.

Federalism Summary Impact Statement

Executive Order 13132 requires Federal agencies to consider the impact of their regulatory actions on State and local governments. Where such actions have federalism implications, agencies are directed to provide a statement for inclusion in the preamble to the regulations describing the agency's considerations in terms of the three categories called for under Section (6)(b)(2)(B) of Executive Order 13121.

Prior Consultation With State Officials

Since publication of the interim rule revising the WIC food packages, FNS has obtained input from WIC State and local agency staff about the provisions and implementation of the changes. Examples of the different forums and methods FNS has used to solicit WIC State and local agency staff input on the WIC food packages include the following:

- Hosting annual meetings of the National Advisory Council on Maternal, Infant and Fetal Nutrition that includes WIC staff as members of the Council; the Council develops recommendations for FNS on how to improve operations of WIC, including aspects related to the authorized foods and food packages;
- Consulting and collaborating with the National WIC Association (NWA) on a wide variety of WIC issues, including those related to the WIC food packages. NWA is a non-profit organization that was founded in 1983 by State and local agencies that administer the WIC Program. NWA's paid membership includes 72 of the 90 WIC State agencies, 813 local agencies, 7 State WIC Associations, and 27 sustaining members (i.e., for-profit and non-profit businesses or organizations). Functioning as a coalition of WIC agencies, NWA is dedicated to maximizing WIC resources through effective management practices. NWA also serves in a leadership role for WIC agencies by developing position papers on issues of concern to the WIC community; and
- Regular meetings and consultation with State health officials and other WIC stakeholders, including the medical community, advocacy groups, and retailers.

Nature of Concerns and the Need To Issue This Rule

This final rule considers public comments submitted in response to the interim rule revising the WIC food packages published in December 2007 (72 FR 68966). The interim rule implemented the first comprehensive revisions to the WIC food packages since 1980. This final rule addresses public comments received on the interim rule and makes adjustments that improve clarity of the provisions set forth in the interim rule.

Extent to Which We Meet Those Concerns

FNS has considered the impact of final rule on State and local agencies. FNS believes that the rule is responsive to the expressed concerns and requests of commenters representing State and local concerns.

Executive Order 12988

This final rule has been reviewed under Executive Order 12988, Civil Justice Reform. This final rule is not intended to have preemptive effect with respect to any State or local laws, regulations or policies which conflict with its provisions or which would otherwise impede its full and timely implementation. This rule is not intended to have retroactive effect unless so specified in the DATES section of the final rule. Prior to any judicial challenge to the provisions of the final rule, all applicable administrative procedures must be exhausted.

Civil Rights Impact Analysis

The intent of this final rulemaking is not to limit participation or to have an adverse effect on current participants. FNS does not expect any protected populations to be adversely affected by the implementation of the requirements in this rule. State agencies must ensure participant access to supplemental foods. The foods available to WIC participants as a result of this final rule are intended to broaden the appeal of the WIC food packages for all groups

and encourage participation in WIC. This final rule revises certain provisions to better address the needs of participants with certain medical conditions, and provides State agencies increased flexibility in prescribing culturally appropriate packages for diverse groups. FNS does not anticipate this rulemaking will result in any adverse civil rights impacts.

Executive Order 13175

Executive Order 13175 requires Federal agencies to consult and coordinate with tribes on a government-to-government basis on policies that have tribal implications, including regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes. In late 2010 and early 2011, USDA engaged in a series of consultative sessions to obtain input by Tribal officials or their designees concerning the impact of this rule on the tribe or Indian Tribal governments, or whether this rule may preempt Tribal law. USDA did not receive any input during these sessions that this rule preempts any Tribal law. Input received relative to this rule included overall satisfaction with the new WIC foods, especially the fruits and vegetables and whole grains, and changes related to supporting breastfeeding mothers. Some tribes reported that WIC participants who were enrolled in WIC during the transition from the previous food packages to the revised food packages expressed displeasure with issuance of lower fat milks and less cheese. The input from Indian tribes during these sessions was consistent with the general comments received for the interim rule, and have been addressed in this final rule. Reports from these consultations will be made part of the USDA annual reporting on Tribal Consultation and Collaboration. USDA will respond in a timely and meaningful manner to all Tribal government requests for consultation concerning this rule and will provide additional venues, such as webinars and teleconferences, to periodically host collaborative conversations with Tribal officials or their designees concerning ways to improve this rule in Indian country.

Paperwork Reduction Act of 1995

The Paperwork Reduction Act of 1995 (44 U.S.C. Chap. 35; see 5 CFR 1320) requires that the Office of Management and Budget (OMB) approve all collections of information by a Federal agency before they can be implemented. Respondents are not required to respond to any collection of information unless it displays a current valid OMB control number. This final rule changes the information collection burden previously approved under OMB 0584–0545. Implementation of the data collection requirements resulting from this final rule is contingent upon OMB approval under the Paperwork Reduction Act of 1995.

The proposed food package rule was published in the **Federal Register** [71 FR 44784] with a 60-day notice on August 7, 2006, which provided the public an opportunity to submit comments on the information collection burden resulting from the proposed rule. FNS received no public comments in response to this solicitation. On November 1, 2006, OMB filed comment in accordance with 5 CFR 1320.11(c), requiring FNS to review public comments in response to the proposed rule and address any such comments in the preamble of the final rule.

The interim food package rule was published in the **Federal Register** [72 FR 68966] on December 6, 2007, and included an estimated annual information collection burden of 14,919 burden hours, which was approved as OMB Number 0584–0545. These information collection burden hours were merged into the information collection, WIC Program Reporting and Recordkeeping Requirements, OMB Number 0584–0043, changing the total approved burden hours for OMB Number 0584–0043 from 3,595,075 to 3,609,994. Information collection OMB Number 0584–0545 was then discontinued. Information collection OMB Number 0584–0043 was renewed as of December 27, 2012, changing the total approved burden hours from 3,609,994 to 4,024,697.

In this final rule, FNS will no longer require a health care professional licensed to write medical prescriptions to provide documentation for children to receive soy-based beverage and tofu as milk substitutes. Also, FNS will no longer require documentation from a health care professional licensed to write medical prescriptions for women to receive tofu in excess of the maximum substitution allowance. As a result of this final rulemaking, the overall information collection burden associated with OMB Number 0584–0043 is estimated to have decreased by 4,200 burden hours annually due to program changes in this rulemaking. The total estimated burden hours for OMB Number 0584–0043 will decrease from 4,024,697 to 4,020,497.

The breakdown of the changes is described below:

OMB Number 0584–0043;

WIC Program Reporting and Recordkeeping Requirements; expiration date December 31, 2015.

Type of Request: Revision of a currently approved collection.

Abstract: Federal regulations at 7 CFR 246.10(d)(1)(vi) and (viii) require medical documentation for the issuance of soy-based beverage and tofu for children, and tofu above the maximum substitution amount for women. Federal regulations at 7 CFR 246.10(d)(1)(v) require medical documentation for the issuance of supplemental foods to participants who receive Food Package III (for participants with qualifying conditions).

Under the interim rule, medical documentation by a health care professional licensed to write medical prescriptions is required for the issuance of certain milk alternatives for children and women. A total of 180 comment letters (53 of these form letters) opposed this requirement, primarily the documentation for children to receive soy-based beverage. Commenters stated that the provision is unnecessary, costly and burdensome for participants and physicians, creates barriers to services, and undermines FNS' efforts to provide foods that meet the cultural needs of participants. The NWA and the American Dietetic Association (now known as the Academy of Nutrition and Dietetics) stressed that WIC dietitians and nutritionists are health professionals trained and capable of doing a complete nutrition assessment, selecting WIC foods, and providing appropriate education to participants and caregivers, in consultation with the health care provider when warranted.

Based on the experiences cited by WIC State and local agencies related to medical documentation throughout implementation of the new food packages, FNS will no longer require a health care professional licensed to write medical prescriptions to provide documentation for children to receive soy-based beverage and tofu as milk substitutes. Also, FNS will no longer require documentation from a health care professional licensed to write medical prescriptions for women to receive tofu in excess of the maximum substitution allowance.

Estimate of Burden

This final rule amends the supplemental foods that require medical documentation as described in 7 CFR

246.10(d)(1) However, medical documentation continues to be required for issuance of supplemental foods in Food Package III. After revising to reflect the changes made by this final rule, the total annual reporting and recordkeeping burden estimated for medical documentation is decreased by 4,200 hours.

FNS estimates that approximately 1 percent of participants (89,606) will be issued supplemental foods under Food Package III. FNS estimates that it will take three minutes (0.05 hours) for the documentation required to issue the authorized foods, thus resulting in an estimated reporting burden for participants of 8,961 hours (89,606 total participants × 0.05 person hours × 2 certification periods per year). This results in a decrease in the approved reporting burden under OMB 0584–0043 for participants providing medical documentation for supplemental foods from 13,160 burden hours to 8,961 burden hours (a decrease of 4,200 burden hours).

FNS will submit an Information Collection Request clearance package to OMB based on the provisions of this final rule. These amended information collection requirements will not become effective until approved by OMB. When OMB has approved these information collection requirements, FNS will publish separate action in the **Federal Register** announcing OMB approval.

E-Government Act Compliance

The Food and Nutrition Service is committed to complying with the E-Government Act, 2002, to promote the use of the Internet and other information technologies to provide increased opportunities for citizen access to Government information and services, and for other purposes.

List of Subjects in 7 CFR Part 246

Administrative practice and procedure, Civil rights, Food assistance programs, Grant programs-health, Grant programs-social programs, Indians, Infants and children, Maternal and child health, Nutrition, Penalties, Reporting and recordkeeping requirements, Women.

■ For reasons set forth in the preamble, 7 CFR Part 246 is amended as follows:

PART 246—SPECIAL SUPPLEMENTAL NUTRTION PROGRAM FOR WOMEN, INFANTS AND CHILDREN

■ 1. The authority citation for 7 CFR part 246 continues to read as follows:

Authority: 42 U.S.C. 1786.

■ 2. In § 246.2:

■ a. Add a definition for ''Farmers' market'' in alphabetical order;

■ b. Add a definition for ''Full nutrition benefit'' in alphabetical order;

■ c. Remove the definition heading ''WIC-eligible medical foods'' and add in its place ''WIC-eligible nutritionals for participants with qualifying conditions (hereafter referred to as ''WIC-eligible nutritionals)''; and

■ d. Remove the term ''WIC-eligible medical foods'' and add in its place the term ''WIC-eligible nutritionals'' wherever it appears.

■ The revisions and additions read as follows:

§ 246.2 Definitions.

* * * * *

Farmers' market means an association of local farmers who assemble at a defined location for the purpose of selling their produce directly to consumers.

* * * * *

Full nutrition benefit means the minimum amount of reconstituted fluid ounces of liquid concentrate infant formula as specified in Table 1 of § 246.10(e)(9) for each food package category and infant feeding variation (e.g., Food Package IA fully formula fed, IA–FF).

* * * * *

■ 3. In § 246.4:

■ a. Amend paragraph (a)(11)(iii) by removing ''§ 246.10(b)(1)'' and adding in its place ''§ 246.10(b)(2)(i)''.

■ b. Revise paragraph (a)(14)(iii);

■ c. Redesignate paragraphs (a)(14)(v) through (xvii) as paragraphs (vi) through (xviii) and add a new paragraph (a)(14)(v);

■ d. Amend newly designated paragraph (a)(14)(vi) by removing ''§ 246.12(k)(1)(i)'' and adding in its place ''§ 246.12(l)(1)(i)'';

■ e. Revise newly designated paragraph (a)(14)(xii); and

■ f. Amend paragraph (a)(18) by removing the words ''and food vendors'' and adding in their place the phrase '', food vendors, farmers and farmers' markets''.

The revisions and additions read as follows:

§ 246.4 State plan.

(a) * * *

(14) * * *

(iii) *A sample vendor, farmer and/or farmers' market, if applicable, agreement.* The sample vendor agreement must include the sanction schedule, the process for notification of violations in accordance with § 246.12(l)(3), and the State agency's policies and procedures on incentive items in accordance with § 246.12(g)(3)(iv), which may be incorporated as attachments or, if the sanction schedule, the process for notification of violations, or policies on incentive items are in the State agency's regulations, through citations to the regulations. State agencies that intend to delegate signing of vendor, farmer and/or farmers' market agreements to local agencies must describe the State agency supervision and instruction that will be provided to ensure the uniformity and quality of local agency activities;

* * * * *

(v) *Farmer monitoring.* The system for monitoring farmers and/or farmers' markets within its jurisdiction, if applicable, for compliance with program requirements;

* * * * *

(xii) *Vendor, farmer and/or farmers' market training.* The procedures the State agency will use to train vendors (in accordance with § 246.12(i)), farmers and/or farmers' markets (in accordance with § 246.12(v)). State agencies that intend to delegate any aspect of training to a local agency, contractor, vendor or farmer representative must describe the supervision and instructions that will be provided by the State agency to ensure the uniformity and quality of vendor, farmer and/or farmers' market training;

* * * * *

■ 4. In § 246.10:

■ a. Remove the term ''WIC-eligible medical food'' and add in its place the term ''WIC-eligible nutritional'' wherever it appears; and remove the term ''WIC-eligible medical foods'' and replace it with ''WIC-eligible nutritionals'' wherever it appears;

■ b. Revise paragraph (b)(1)(i);

■ c. Amend paragraph (b)(2)(ii)(C) by removing the words ''age and'' before ''nutritional'' and adding the words ''and breastfeeding'' after ''nutritional'';

■ d. Amend paragraph (d)(1)(ii) by removing the phrase ''a child'' and adding in its place the phrase ''an infant, child,'';

■ e. Remove paragraphs (d)(1)(vi) through (d)(1)(viii);

■ f. Redesignate paragraph (d)(1)(ix) as (d)(1)(vi);

■ g. Revise the heading of paragraph (d)(2);

■ h. Amend paragraph (d)(2)(ii) by adding a space between ''formula'' and ''and'';

■ i. Revise paragraph (d)(3)(i);

■ j. Revise paragraph (d)(4)(ii)(D);

■ k. Revise paragraphs (e) introductory text through (e)(1)(iii);

■ l. Revise paragraph (e)(1)(v);

■ m. Revise paragraph (e)(2)(ii);

■ n. Revise paragraph (e)(2)(iv);

■ o. Revise paragraph (e)(3)(v);

■ p. Revise paragraphs (e)(4)(ii) through (e)(7)(ii); and

■ q. Revise paragraphs (e)(9) through (e)(12).

The revisions and additions read as follows:

§ 246.10 Supplemental foods.

* * * * *

(b) * * *

(1) * * *

(i) Establish criteria in addition to the minimum Federal requirements in Table 4 of paragraph (e)(12) of this section for the supplemental foods in their States, except that the State agency may not selectively choose which eligible fruits and vegetables are available to participants. These State agency criteria could address, but not be limited to, other nutritional standards, competitive cost, State-wide availability, and participant appeal. For eligible fruits and vegetables, State agencies may restrict packaging, e.g., plastic containers, and package sizes, such as single serving, of processed fruits and vegetables available for purchase with the cash-value voucher. In addition, State agencies may identify certain processed WIC-eligible fruits and vegetables on food lists where the potential exists for vendor or participant confusion in determining authorized WIC-eligible items.

* * * * *

(d) * * *

(2) *Medical documentation for other supplemental foods.* * * *

(3) * * *

(i) Made a medical determination that the participant has a qualifying condition as described in paragraphs (e)(1) through (e)(7) of this section that dictates the use of the supplemental foods, as described in paragraph (d)(1) of this section; and

* * * * *

(4) * * *

(ii) * * *

(D) The qualifying condition(s) for issuance of the authorized supplemental food(s) requiring medical documentation, as described in paragraphs (e)(1) through (e)(7) of this section; and

* * * * *

(e) *Food packages.* There are seven food packages available under the Program that may be provided to participants. The authorized supplemental foods must be prescribed from food packages according to the category and nutritional needs of the participants. Breastfeeding assessment and the mother's plans for breastfeeding serve as the basis for determining food package issuance for all breastfeeding women. The intent of the WIC Program is that all breastfeeding women be supported to exclusively breastfeed their infants and to choose the fully breastfeeding food package without infant formula. Breastfeeding mothers whose infants receive formula from WIC are to be supported to breastfeed to the maximum extent possible with minimal supplementation with infant formula. Formula amounts issued to breastfed infants are to be tailored to meet but not exceed the infant's nutritional needs. The seven food packages are as follows:

(1) *Food Package I—Infants birth through 5 months.*—(i) *Participant category served.* This food package is designed for issuance to infant participants from birth through age 5 months who do not have a condition qualifying them to receive Food Package III. The following infant feeding variations are defined for the purposes of assigning food quantities and types in Food Packages I: Fully breastfeeding (the infant doesn't receive formula from the WIC Program); partially (mostly) breastfeeding (the infant is breastfed but also receives infant formula from WIC up to the maximum allowance described for partially (mostly) breastfed infants in Table 1 of paragraph (e)(9) of this section; and fully formula fed (the infant is not breastfed or is breastfed minimally (the infant receives infant formula from WIC in quantities that exceed those allowed for partially (mostly) breastfed infants).

(ii) *Infant feeding age categories.*—(A) *Birth to one month.* Two infant food packages are available during the first month after birth—fully breastfeeding and fully formula-feeding. State agencies also have the option to make available a third food package containing not more than one can of powder infant formula in the container size that provides closest to 104 reconstituted fluid ounces to breastfed infants on a case-by-case basis. The infant receiving this food package is considered partially breastfeeding. State agencies choosing to make available a partially breastfeeding package in the first month may not standardize issuance of this food package. Infant formula may not be routinely provided during the first month after birth to breastfed infants in order to support the successful establishment of breastfeeding.

(B) *One through 5 months.* Three infant food packages are available from 1 months through 5 months—fully breastfeeding, partially (mostly) breastfeeding, or fully formula-fed.

(iii) *Infant formula requirements.* This food package provides iron-fortified infant formula that is not an exempt infant formula and that meets the requirements in Table 4 of paragraph (e)(12) of this section. The issuance of any contract brand or noncontract brand infant formula that contains less than 10 milligrams of iron per liter (at least 1.5 milligrams iron per 100 kilocalories) at standard dilution is prohibited. Except as specified in paragraph (d) of this section, local agencies must issue as the first choice of issuance the primary contract infant formula, as defined in § 246.2, with all other infant formulas issued as an alternative to the primary contract infant formula. Noncontract brand infant formula and any contract brand infant formula that does not meet the requirements in Table 4 of paragraph (e)(12) of this section may be issued in this food package only with medical documentation of the qualifying condition. A health care professional licensed by the State to write prescriptions must make a medical determination and provide medical documentation that indicates the need for the infant formula. For situations that do not require the use of an exempt infant formula, such determinations include, but are not limited to, documented formula intolerance, food allergy or inappropriate growth pattern. Medical documentation must meet the requirements described in paragraph (d) of this section.

* * * * *

(v) *Authorized category of supplemental foods.* Infant formula is the only category of supplemental foods authorized in this food package. Exempt infant formulas and WIC-eligible nutritionals are authorized only in Food Package III. The maximum monthly allowances, allowed options and substitution rates of supplemental foods for infants in Food Packages I are stated in Table 1 of paragraph (e)(9) of this section.

(2) * * *

(ii) *Infant food packages.* Three food packages for infants 6 through 11 months are available — fully breastfeeding, partially (mostly) breastfeeding, or fully formula fed.

* * * * *

(iv) *Authorized categories of supplemental foods.* Infant formula, infant cereal, and infant foods are the categories of supplemental foods authorized in this food package. The maximum monthly allowances, allowed options and substitution rates of supplemental foods for infants in Food Packages II are stated in Table 1 of paragraph (e)(9) of this section.

* * * * *

(3) * * *

(v) *Authorized categories of supplemental foods.* The supplemental foods authorized in this food package require medical documentation for issuance and include WIC formula (infant formula, exempt infant formula, and WIC-eligible nutritionals), infant cereal, infant foods, milk, cheese, eggs, canned fish, fresh fruits and vegetables, breakfast cereal, whole wheat/whole grain bread, juice, legumes and/or peanut butter. The maximum monthly allowances, allowed options and substitution rates of supplemental foods for infants in Food Package III are stated in Table 1 of paragraph (e)(9) of this section. The maximum monthly allowances, allowed options, and substitution rates of supplemental foods for children and women in Food Package III are stated in Table 3 of paragraph (e)(11) of this section.

* * * * *

(4) * * *

(ii) *Authorized categories of supplemental foods.* Milk, breakfast cereal, juice, fresh fruits and vegetables, whole wheat/whole grain bread, eggs, and legumes or peanut butter are the categories of supplemental foods authorized in this food package. The maximum monthly allowances, allowed options and substitution rates of supplemental foods for children in Food Package IV are stated in Table 2 of paragraph (e)(10) of this section.

(5) *Food Package V—Pregnant and partially (mostly) breastfeeding women.*—(i) *Participant category served.* This food package is designed for issuance to women participants with singleton pregnancies who do not have a condition qualifying them to receive Food Package III. This food package is also designed for issuance to partially (mostly) breastfeeding women participants, up to 1 year postpartum, who do not have a condition qualifying them to receive Food Package III and whose partially (mostly) breastfed infants receive formula from the WIC program in amounts that do not exceed the maximum allowances described in Table 1 of paragraph (e)(9) of this section. Women participants partially (mostly) breastfeeding more than one infant from the same pregnancy, pregnant women fully or partially breastfeeding singleton infants, and women participants pregnant with two or more fetuses, are eligible to receive Food Package VII as described in paragraph (e)(7) of this section.

(ii) *Authorized categories of supplemental foods.* Milk, breakfast cereal, juice, fresh fruits and vegetables, whole wheat/whole grain bread, eggs, legumes and peanut butter are the categories of supplemental foods authorized in this food package. The maximum monthly allowances, allowed options and substitution rates of supplemental foods for women in Food Package V are stated in Table 2 of paragraph (e)(10) of this section.

(6) *Food Package VI—Postpartum women.*—(i) *Participant category served.* This food package is designed for issuance to women up to 6 months postpartum who are not breastfeeding their infants, and to breastfeeding women up to 6 months postpartum whose participating infant receives more than the maximum amount of formula allowed for partially (mostly) breastfed infants as described in Table 1 of paragraph (e)(9) of this section, and who do not have a condition qualifying them to receive Food Package III.

(ii) *Authorized categories of supplemental foods.* Milk, breakfast cereal, juice, fresh fruits and vegetables, eggs, and legumes or peanut butter are the categories of supplemental foods authorized in this food package. The maximum monthly allowances, allowed options and substitution rates of supplemental foods for women in Food Package VI are stated in Table 2 of paragraph (e)(10) of this section.

(7) *Food Package VII—Fully breastfeeding.*—(i) *Participant category served.* This food package is designed for issuance to breastfeeding women up to 1 year postpartum whose infants do not receive infant formula from WIC (these breastfeeding women are assumed to be exclusively breastfeeding their infants), and who do not have a condition qualifying them to receive Food Package III. This food package is also designed for issuance to women participants pregnant with two or more fetuses, women participants partially (mostly) breastfeeding multiple infants from the same pregnancy, and pregnant women who are also partially (mostly) breastfeeding singleton infants, and who do not have a condition qualifying them to receive Food Package III. Women participants fully breastfeeding multiple infants from the same pregnancy receive 1.5 times the supplemental foods provided in Food Package VII.

(ii) *Authorized categories of supplemental foods.* Milk, cheese, breakfast cereal, juice, fresh fruits and vegetables, whole wheat/whole grain bread, eggs, legumes, peanut butter, and canned fish are the categories of supplemental foods authorized in this food package. The maximum monthly allowances, allowed options and substitution rates of supplemental foods for women in Food Package VII are stated in Table 2 of paragraph (e)(10) of this section.

* * * * *

(9) Full nutrition benefit and maximum monthly allowances, options and substitution rates of supplemental foods for infants in Food Packages I, II and III are stated in Table 1 as follows:

TABLE 1—FULL NUTRITION BENEFIT (FNB) AND MAXIMUM MONTHLY ALLOWANCES (MMA) OF SUPPLEMENTAL FOODS FOR INFANTS IN FOOD PACKAGES I, II AND III

Foods [1]	Fully formula fed (FF)		Partially (mostly) breastfed (BF/FF)		Fully breastfed (BF)	
	Food Packages I–FF & III–FF A: 0 through 3 months B: 4 through 5 months	Food Packages II–FF & III–FF 6 through 11 months	Food Packages I–BF/FF & III BF/FF (A: 0 to 1 month [2 3]) B: 1 through 3 months C: 4 through 5 months	Food Packages II–BF/FF & III BF/FF 6 through 11 months	Food Package I–BF 0 through 5 months	Food Package II–BF 6 through 11 months
WIC Formula [4 5 6 7 8]	A: FNB=806 fl oz, MMA=823 fl oz, reconstituted liquid concentrate or 832 fl. oz. RTF or 870 fl oz reconstituted powder.	FNB=624 fl oz, MMA=630 fl oz, reconstituted liquid concentrate. or 643 fl. oz RTF or 696 fl oz reconstituted powder.	A: 104 fl oz reconstituted powder. B: FNB=364 fl oz, MMA=388 fl oz, reconstituted liquid concentrate or 384 fl oz RTF or 435 fl oz reconstituted powder.	FNB=312 fl oz, MMA=315 fl oz, reconstituted liquid concentrate or 338 fl oz RTF or 384 fl oz reconstituted powder.		

TABLE 1—FULL NUTRITION BENEFIT (FNB) AND MAXIMUM MONTHLY ALLOWANCES (MMA) OF SUPPLEMENTAL FOODS FOR INFANTS IN FOOD PACKAGES I, II AND III—Continued

Foods[1]	Fully formula fed (FF)		Partially (mostly) breastfed (BF/FF)		Fully breastfed (BF)	
	Food Packages I–FF & III–FF A: 0 through 3 months B: 4 through 5 months	Food Packages II–FF & III–FF 6 through 11 months	Food Packages I–BF/FF & III BF/FF (A: 0 to 1 month[2 3]) B: 1 through 3 months C: 4 through 5 months	Food Packages II–BF/FF & III BF/FF 6 through 11 months	Food Package I–BF 0 through 5 months	Food Package II–BF 6 through 11 months
	B: FNB=884 fl oz, MMA=896 fl oz, reconstituted liquid concentrate or 913 fl oz RTF or 960 fl oz reconstituted powder.		C: FNB=442 fl oz, MMA=460 fl oz, reconstituted liquid concentrate or 474 fl oz RTF or 522 fl oz reconstituted powder.			
Infant Cereal[9 11]		24 oz		24 oz		24 oz.
Infant food fruits and vegetables[9 10 11 12 13].		128 oz		128 oz		256 oz.
Infant food meat[9]						77.5 oz.

Table 1 footnotes: (Abbreviations in order of appearance in table): FF = fully formula fed; BF/FF = partially (mostly) breastfed; BF = fully breastfed; RTF = Ready-to-feed; N/A = the supplemental food is not authorized in the corresponding food package.

[1] Table 4 of paragraph (e)(12) of this section describes the minimum requirements and specifications for the supplemental foods. The competent professional authority (CPA) is authorized to determine nutritional risk and prescribe supplemental foods as established by State agency policy in Food Packages I and II. In Food Package III, the CPA, as established by State agency policy, is authorized to determine nutritional risk and prescribe supplemental foods per medical documentation.

[2] State agencies have the option to issue not more than one can of powder infant formula in the container size that provides closest to 104 reconstituted fluid ounces to breastfed infants on a case-by-case basis.

[3] Liquid concentrate and ready-to-feed (RTF) may be substituted at rates that provide comparable nutritive value.

[4] WIC formula means infant formula, exempt infant formula, or WIC-eligible nutritionals. Infant formula may be issued for infants in Food Packages I, II and III. Medical documentation is required for issuance of infant formula, exempt infant formula, WIC-eligible nutritionals, and other supplemental foods in Food Package III. Only infant formula may be issued for infants in Food Packages I and II.

[5] The full nutrition benefit is defined as the minimum amount of reconstituted fluid ounces of liquid concentrate infant formula as specified for each infant food package category and feeding variation (e.g., Food Package IA-fully formula fed).

[6] The maximum monthly allowance is specified in reconstituted fluid ounces for liquid concentrate, RTF liquid, and powder forms of infant formula and exempt infant formula. Reconstituted fluid ounce is the form prepared for consumption as directed on the container.

[7] State agencies must provide at least the full nutrition benefit authorized to non-breastfed infants up to the maximum monthly allowance for the physical form of the product specified for each food package category. State agencies must issue whole containers that are all the same size of the same physical form. Infant formula amounts for breastfed infants, even those in the fully formula fed category should be individually tailored to the amounts that meet their nutritional needs.

[8] State agencies may round up and disperse whole containers of infant formula over the food package timeframe to allow participants to receive the full nutrition benefit. State agencies must use the methodology described in accordance with paragraph (h)(1) of this section.

[9] State agencies may round up and disperse whole containers of infant foods (infant cereal, fruits and vegetables, and meat) over the Food Package timeframe. State agencies must use the methodology described in accordance with paragraph (h)(2) of this section.

[10] At State agency option, for infants 6–12 months of age, fresh banana may replace up to 16 ounces of infant food fruit at a rate of 1 pound of bananas per 8 ounces of infant food fruit. State agencies may also substitute fresh bananas at a rate of 1 banana per 4 ounces of jarred infant food fruit, up to a maximum of 16 ounces.

[11] In lieu of infant foods (cereal, fruit and vegetables), infants greater than 6 months of age in Food Package III may receive infant formula, exempt infant formula or WIC-eligible nutritionals at the same maximum monthly allowance as infants ages 4 through 5 months of age of the same feeding option.

[12] At State agency option, infants 9 months through 11 months in Food Packages II and III may receive a cash-value voucher to purchase fresh (only) fruits and vegetables in lieu of a portion of the infant food fruits and vegetables. Partially (mostly) breastfed infants and fully formula fed infants may receive a $4 cash-value voucher plus 64 ounces of infant food fruits and vegetables; fully breastfeeding infants may receive a $8 cash-value voucher plus 128 ounces of infant food fruit and vegetables.

[13] State agencies may not categorically issue cash-value vouchers for infants 9 months through 11 months. The cash-value voucher is to be provided to the participant only after an individual nutrition assessment, as established by State agency policy, and is optional for the participant, i.e., the mother may choose to receive either the maximum allowance of jarred foods or a combination of jarred foods and a fruit and vegetable cash-value voucher for her infant. State agencies must ensure that appropriate nutrition education is provided to the caregiver addressing safe food preparation, storage techniques, and feeding practices to make certain participants are meeting their nutritional needs in a safe and effective manner.

(10) *Maximum monthly allowances of supplemental foods in Food Packages IV through VII.* The maximum monthly allowances, options and substitution rates of supplemental foods for children and women in Food Package IV through VII are stated in Table 2 as follows:

TABLE 2—MAXIMUM MONTHLY ALLOWANCES OF SUPPLEMENTAL FOODS FOR CHILDREN AND WOMEN IN FOOD PACKAGES IV, V, VI AND VII

Foods [1]	Children	Women		
	Food Package IV: 1 through 4 years	Food Package V: Pregnant and Partially (Mostly) Breastfeeding (up to 1 year postpartum) [2]	Food Package VI: Postpartum (up to 6 months postpartum) [3]	Food Package VII: Fully Breastfeeding (up to 1 year post-partum) [4 5]
Juice, single strength [6]	128 fl oz	144 fl oz	96 fl oz	144 fl oz.
Milk, fluid	16 qt [7 8 9 10 11]	22 qt [7 8 9 10 12]	16 qt [7 8 9 10 12]	24 qt [7 8 9 10 12].
Breakfast cereal [13]	36 oz	36 oz	36 oz	36 oz.
Cheese	N/A	N/A	N/A	1 lb.
Eggs	1 dozen	1 dozen	1 dozen	2 dozen.
Fresh fruits and vegetables [14 15]	$8.00 in cash-value vouchers.	$10.00 in cash-value vouchers.	$10.00 in cash-value vouchers.	$10.00 in cash-value vouchers.
Whole wheat or whole grain bread [16].	2 lb	1 lb	N/A	1 lb.
Fish (canned)	N/A	N/A	N/A	30 oz.
Legumes, dry [17] *and/or* Peanut butter.	1 lb or 18 oz	1 lb and 18 oz	1 lb or 18 oz	1 lb and 18 oz.

Table 2 Footnotes: N/A = the supplemental food is not authorized in the corresponding food package.

[1] Table 4 of paragraph (e)(12) of this section describes the minimum requirements and specifications for the supplemental foods. The competent professional authority (CPA) is authorized to determine nutritional risk and prescribe supplemental foods as established by State agency policy.

[2] Food Package V is issued to two categories of WIC participants: Women participants with singleton pregnancies; breastfeeding women whose partially (mostly) breastfed infants receive formula from the WIC Program in amounts that do not exceed the maximum formula allowances, as appropriate for the age of the infant as described in Table 1 of paragraph (e)(9) of this section.

[3] Food Package VI is issued to two categories of WIC participants: Non-breastfeeding postpartum women and breastfeeding postpartum women whose infants receive more than the maximum infant formula allowances, as appropriate for the age of the infant as described in Table 1 of paragraph (e)(9) of this section.

[4] Food Package VII is issued to four categories of WIC participants: Fully breastfeeding women whose infants do not receive formula from the WIC Program; women pregnant with two or more fetuses; women partially (mostly) breastfeeding multiple infants from the same pregnancy; and pregnant women who are also fully or partially (mostly) breastfeeding singleton infants.

[5] Women fully breastfeeding multiple infants from the same pregnancy are prescribed 1.5 times the maximum allowances.

[6] Combinations of single-strength and concentrated juices may be issued provided that the total volume does not exceed the maximum monthly allowance for single-strength juice.

[7] Whole milk is the standard milk for issuance to 1-year-old children (12 through 23 months). At State agency option, fat-reduced milks may be issued to 1-year-old children for whom overweight or obesity is a concern. The need for fat-reduced milks for 1-year-old children must be based on an individual nutritional assessment and consultation with the child's health care provider if necessary, as established by State agency policy. Lowfat (1%) or nonfat milks are the standard milk for issuance to children ≥ 24 months of age and women. Reduced fat (2%) milk is authorized only for participants with certain conditions, including but not limited to, underweight and maternal weight loss during pregnancy. The need for reduced fat (2%) milk for children ≥ 24 months of age (Food Package IV) and women (Food Packages V–VII) must be based on an individual nutritional assessment as established by State agency policy.

[8] Evaporated milk may be substituted at the rate of 16 fluid ounces of evaporated milk per 32 fluid ounces of fluid milk or a 1:2 fluid ounce substitution ratio. Dry milk may be substituted at an equal reconstituted rate to fluid milk.

[9] For children and women, cheese may be substituted for milk at the rate of 1 pound of cheese per 3 quarts of milk. For children and women in Food Packages IV–VI, no more than 1 pound of cheese may be substituted. For fully breastfeeding women in Food Package VII, no more than 2 pounds of cheese may be substituted for milk. State agencies do not have the option to issue additional amounts of cheese beyond these maximums even with medical documentation. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for children and women in Food Packages IV–VI. No more than a total of 6 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in Food Package VII.)

[10] For children and women, yogurt may be substituted for fluid milk at the rate of 1 quart of yogurt per 1 quart of milk; a maximum of 1 quart of milk can be substituted. Additional amounts of yogurt are not authorized. Whole yogurt is the standard yogurt for issuance to 1-year-old children (12 through 23 months). At State agency option, lowfat or nonfat yogurt may be issued to 1-year-old children for whom overweight and obesity is a concern. The need for lowfat or nonfat yogurt for 1-year-old children must be based on an individual nutritional assessment and consultation with the child's health care provider if necessary, as established by State agency policy. Lowfat or nonfat yogurts are the only types of yogurt authorized for children ≥ 24 months of age and women. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for children and women in Food Packages IV–VI. No more than a total of 6 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in Food Package VII.)

[11] For children, issuance of tofu and soy-based beverage as substitutes for milk must be based on an individual nutritional assessment and consultation with the participant's health care provider if necessary, as established by State agency policy. Such determination can be made for situations that include, but are not limited to, milk allergy, lactose intolerance, and vegan diets. Soy-based beverage may be substituted for milk for children on a quart for quart basis up to the total maximum allowance of milk. Tofu may be substituted for milk for children at the rate of 1 pound of tofu per 1 quart of milk. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for children in Food Package IV.) Additional amounts of tofu may be substituted, up to the maximum allowance for fluid milk for lactose intolerance or other reasons, as established by State agency policy.

[12] For women, soy-based beverage may be substituted for milk on a quart for quart basis up to the total maximum allowance of milk. Tofu may be substituted for milk at the rate of 1 pound of tofu per 1 quart of milk. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in Food Packages V and VI. No more than a total of 6 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in Food Package VII.). Additional amounts of tofu may be substituted, up to the maximum allowances for fluid milk, for lactose intolerance or other reasons, as established by State agency policy.

[13] At least one-half of the total number of breakfast cereals on the State agency's authorized food list must have whole grain as the primary ingredient and meet labeling requirements for making a health claim as a "whole grain food with moderate fat content" as defined in Table 4 of paragraph (e)(12) of this section.

[14] Both fresh fruits and fresh vegetables must be authorized by State agencies. Processed fruits and vegetables, i.e., canned (shelf-stable), frozen, and/or dried fruits and vegetables may also be authorized to offer a wider variety and choice for participants. State agencies may choose to authorize one or more of the following processed fruits and vegetables: canned fruit, canned vegetables, frozen fruit, frozen vegetables, dried fruit, and/or dried vegetables. The cash-value voucher may be redeemed for any eligible fruit and vegetable (refer to Table 4 of paragraph (e)(12) of this section and its footnotes). Except as authorized in paragraph (b)(1)(i) of this section, State agencies may not selectively choose which fruits and vegetables are available to participants. For example, if a State agency chooses to offer dried fruits, it must authorize all WIC-eligible dried fruits.

[15] The monthly value of the fruit/vegetable cash-value vouchers will be adjusted annually for inflation as described in § 246.16(j).

[16] Whole wheat and/or whole grain bread must be authorized. State agencies have the option to also authorize brown rice, bulgur, oatmeal, whole-grain barley, whole wheat macaroni products, or soft corn or whole wheat tortillas on an equal weight basis.

[17] Canned legumes may be substituted for dry legumes at the rate of 64 oz. (e.g., four 16-oz cans) of canned beans for 1 pound dry beans. In Food Packages V and VII, both beans and peanut butter must be provided. However, when individually tailoring Food Packages V or VII for nutritional reasons (e.g., food allergy, underweight, participant preference), State agencies have the option to authorize the following substitutions: 1 pound dry and 64 oz. canned beans/peas (and no peanut butter); or 2 pounds dry or 128 oz. canned beans/peas (and no peanut butter); or 36 oz. peanut butter (and no beans).

(11) *Maximum monthly allowances of supplemental foods for children and women with qualifying conditions in Food Package III.* The maximum monthly allowances, options and substitution rates of supplemental foods for participants with qualifying conditions in Food Package III are stated in Table 3 as follows:

TABLE 3—MAXIMUM MONTHLY ALLOWANCES (MMA) OF SUPPLEMENTAL FOODS FOR CHILDREN AND WOMEN WITH QUALIFYING CONDITIONS IN FOOD PACKAGE III

Foods [1]	Children	Women		
	1 through 4 years	Pregnant and partially breastfeeding (up to 1 year postpartum) [2]	Postpartum (up to 6 months postpartum) [3]	Fully breastfeeding, (up to 1 year post-partum) [4 5]
Juice, single strength [6]	128 fl oz	144 fl oz	96 fl oz	144 fl oz.
WIC Formula [7 8]	455 fl oz liquid concentrate.	455 fl oz liquid concentrate	455 fl oz liquid concentrate	455 fl oz liquid concentrate.
Milk	16 qt [9 10 11 12 13]	22 qt [9 10 11 12 14]	16 qt [9 10 11 12 14]	24 qt [9 10 11 12 14].
Breakfast cereal [15 16]	36 oz	36 oz	36 oz	36 oz.
Cheese	N/A	N/A	N/A	1 lb.
Eggs	1 dozen	1 dozen	1 dozen	2 dozen.
Fruits and vegetables [17 18 19]	$8.00 in cash-value vouchers.	$10.00 in cash-value vouchers.	$10.00 in cash-value vouchers.	$10.00 in cash-value vouchers.
Whole wheat or whole grain bread [20].	2 lb	1 lb	N/A	1 lb.
Fish (canned)	N/A	N/A	N/A	30 oz.
Legumes, dry [21] *and/or* Peanut butter.	1 lb Or 18 oz	1 lb And 18 oz	1 lb Or 18 oz	1 lb. And. 18 oz.

Table 3 Footnotes: N/A=the supplemental food is not authorized in the corresponding food package.

[1] Table 4 of paragraph (e)(12) of this section describes the minimum requirements and specifications for the supplemental foods. The competent professional authority (CPA), as established by State agency policy, is authorized to determine nutritional risk and prescribe supplemental foods per medical documentation.

[2] This food package is issued to two categories of WIC participants: Women participants with singleton pregnancies and breastfeeding women whose partially (mostly) breastfed infants receive formula from the WIC Program in amounts that do not exceed the maximum formula allowances as appropriate for the age of the infant as described in Table 1 of paragraph (e)(9) of this section.

[3] This food package is issued to two categories of WIC participants: Non-breastfeeding postpartum women and breastfeeding postpartum women whose breastfed infants receive more than the maximum infant formula allowances as appropriate for the age of the infant as described in Table 1 of paragraph (e)(9) of this section.

[4] This food package is issued to four categories of WIC participants: Fully breastfeeding women whose infants do not receive formula from the WIC Program; women pregnant with two or more fetuses; women partially (mostly) breastfeeding multiple infants from the same pregnancy, and pregnant women who are also partially (mostly) breastfeeding singleton infants.

[5] Women fully breastfeeding multiple infants from the same pregnancy are prescribed 1.5 times the maximum allowances.

[6] Combinations of single-strength and concentrated juices may be issued provided that the total volume does not exceed the maximum monthly allowance for single-strength juice.

[7] WIC formula means infant formula, exempt infant formula, or WIC-eligible nutritionals.

[8] Powder and ready-to-feed may be substituted at rates that provide comparable nutritive value.

[9] Whole milk is the standard milk for issuance to 1-year-old children (12 through 23 months). Fat-reduced milks may be issued to 1-year old children as determined appropriate by the health care provider per medical documentation. Lowfat (1%) or nonfat milks are the standard milks for issuance for children ≥ 24 months of age and women. Whole milk or reduced fat (2%) milk may be substituted for lowfat (1%) or nonfat milk for children ≥ 24 months of age and women as determined appropriate by the health care provider per medical documentation.

[10] Evaporated milk may be substituted at the rate of 16 fluid ounces of evaporated milk per 32 fluid ounces of fluid milk or a 1:2 fluid ounce substitution ratio. Dry milk may be substituted at an equal reconstituted rate to fluid milk.

[11] For children and women, cheese may be substituted for milk at the rate of 1 pound of cheese per 3 quarts of milk. For children and women in the pregnant, partially breastfeeding and postpartum food packages, no more than 1 pound of cheese may be substituted. For women in the fully breastfeeding food package, no more than 2 pounds of cheese may be substituted for milk. State agencies do not have the option to issue additional amounts of cheese beyond these maximums even with medical documentation. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for children and women in the pregnant, partially breastfeeding and postpartum food packages. No more than a total of 6 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in the fully breastfeeding food package.)

[12] For children and women, yogurt may be substituted for fluid milk at the rate of 1 quart of yogurt per 1 quart of milk; a maximum of 1 quart of milk can be substituted. Additional amounts of yogurt are not authorized. Whole yogurt is the standard yogurt for issuance to 1-year-old children (12 through 23 months). Lowfat or nonfat yogurt may be issued to 1-year-old children (12 months to 23 months) as determined appropriate by the health care provider per medical documentation. Lowfat or nonfat yogurts are the standard yogurt for issuance to children ≥ 24 months of age and women. Whole yogurt may be substituted for lowfat or nonfat yogurt for children ≥ 24 months of age and women as determined appropriate by the health care provider per medical documentation. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for children and women in the pregnant, partially breastfeeding and postpartum food packages. No more than a total of 6 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in the fully breastfeeding food package.)

[13] For children, soy-based beverage and tofu may be substituted for milk as determined appropriate by the health care provider per medical documentation. Soy-based beverage may be substituted for milk on a quart for quart basis up to the total maximum allowance of milk. Tofu may be substituted for milk for children at the rate of 1 pound of tofu per 1 quart of milk. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for children.) Additional amounts of tofu may be substituted, up to the maximum allowance for fluid milk for children, as determined appropriate by the health care provider per medical documentation.

[14] For women, soy-based beverage may be substituted for milk on a quart for quart basis up to the total maximum monthly allowance of milk. Tofu may be substituted for milk at the rate of 1 pound of tofu per 1 quart of milk. (No more than a total of 4 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in the pregnant, partially breastfeeding and postpartum food packages. No more than a total of 6 quarts of milk may be substituted for a combination of cheese, yogurt or tofu for women in the fully breastfeeding food package.) Additional amounts of tofu may be substituted, up to the maximum allowances for fluid milk, as determined appropriate by the health care provider per medical documentation.

[15] 32 dry ounces of infant cereal may be substituted for 36 ounces of breakfast cereal as determined appropriate by the health care provider per medical documentation.

[16] At least one half of the total number of breakfast cereals on the State agency's authorized food list must have whole grain as the primary ingredient and meet labeling requirements for making a health claim as a ''whole grain food with moderate fat content'' as defined in Table 4 of paragraph (e)(12) of this section.

[17] Both fresh fruits and fresh vegetables must be authorized by State agencies. Processed fruits and vegetables, i.e., canned (shelf-stable), frozen, and/or dried fruits and vegetables may also be authorized to offer a wider variety and choice for participants. State agencies may choose to authorize one or more of the following processed fruits and vegetables: canned fruit, canned vegetables, frozen fruit, frozen vegetables, dried fruit, and/or dried vegetables. The cash-value voucher may be redeemed for any eligible fruit and vegetable (refer to Table 4 of paragraph (e)(12) of this section and its footnotes). Except as authorized in paragraph (b)(1)(i) of this section, State agencies may not selectively choose which fruits and vegetables are available to participants. For example, if a State agency chooses to offer dried fruits, it must authorize all WIC-eligible dried fruits.

[18] Children and women whose special dietary needs require the use of pureed foods may receive commercial jarred infant food fruits and vegetables in lieu of the cash-value voucher. Children may receive 128 oz of commercial jarred infant food fruits and vegetables and women may receive 160 oz of commercial jarred infant food fruits and vegetables in lieu of the cash-value voucher. Infant food fruits and vegetables may be substituted for the cash-value voucher as determined appropriate by the health care provider per medical documentation.

[19] The monthly value of the fruit/vegetable cash-value vouchers will be adjusted annually for inflation as described in § 246.16(j).

[20] Whole wheat and/or whole grain bread must be authorized. State agencies have the option to also authorize brown rice, bulgur, oatmeal, whole-grain barley, whole wheat macaroni products, or soft corn or whole wheat tortillas on an equal weight basis.

[21] Canned legumes may be substituted for dry legumes at the rate of 64 oz. (e.g., four 16-oz cans) of canned beans for 1 pound dry beans. In Food Packages V and VII, both beans and peanut butter must be provided. However, when individually tailoring Food Packages V or VII for nutritional reasons (e.g., food allergy, underweight, participant preference), State agencies have the option to authorize the following substitutions: 1 pound dry and 64 oz. canned beans/peas (and no peanut butter); or 2 pounds dry or 128 oz. canned beans/peas (and no peanut butter); or 36 oz. peanut butter (and no beans).

(12) *Minimum requirements and specifications for supplemental foods.* Table 4 describes the minimum requirements and specifications for supplemental foods in all food packages:

TABLE 4—MINIMUM REQUIREMENTS AND SPECIFICATIONS FOR SUPPLEMENTAL FOODS

Categories/foods	Minimum requirements and specifications
WIC FORMULA:	
Infant formula	All authorized infant formulas must: (1) Meet the definition for an infant formula in section 201(z) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(z)) and meet the requirements for an infant formula under section 412 of the Federal Food, Drug and Cosmetic Act, as amended (21 U.S.C. 350a) and the regulations at 21 CFR parts 106 and 107; (2) Be designed for enteral digestion via an oral or tube feeding; (3) Provide at least 10 mg iron per liter (at least 1.5 mg iron/100 kilocalories) at standard dilution; (4) Provide at least 67 kilocalories per 100 milliliters (approximately 20 kilocalories per fluid ounce) at standard dilution. (5) Not require the addition of any ingredients other than water prior to being served in a liquid state.
Exempt infant formula	All authorized exempt infant formula must: (1) Meet the definition and requirements for an exempt infant formula under section 412(h) of the Federal Food, Drug, and Cosmetic Act as amended (21 U.S.C. 350a(h)) and the regulations at 21 CFR parts 106 and 107; and (2) Be designed for enteral digestion via an oral or tube feeding.
WIC-eligible nutritionals.[1]	Certain enteral products that are specifically formulated to provide nutritional support for individuals with a qualifying condition, when the use of conventional foods is precluded, restricted, or inadequate. Such WIC-eligible nutritionals must serve the purpose of a food, meal or diet (may be nutritionally complete or incomplete) and provide a source of calories and one or more nutrients; be designed for enteral digestion via an oral or tube feeding; and may not be a conventional food, drug, flavoring, or enzyme.
MILK AND MILK ALTERNATIVES:	

TABLE 4—MINIMUM REQUIREMENTS AND SPECIFICATIONS FOR SUPPLEMENTAL FOODS—Continued

Categories/foods	Minimum requirements and specifications
Cow's milk [2]	Must conform to FDA standard of identity for whole, reduced fat, lowfat, or nonfat milks (21 CFR 131.110). Must be pasteurized. May be flavored or unflavored. May be fluid, shelf-stable, evaporated (21 CFR 131.130), or dry. Dry whole milk must conform to FDA standard of identity (21 CFR 131.147). Nonfat dry milk must conform to FDA standard of identity (21 CFR 131.127). Cultured milks must conform to FDA standard of identity for cultured milk, e.g. cultured buttermilk, kefir cultured milk, acidophilus cultured milk (21 CFR 131.112). Acidified milk must conform to FDA standard of identity for acidified milk, e.g., acidified kefir milk, acidified acidophilus milk or acidified buttermilk (21 CFR 131.111). All reduced fat, lowfat, and nonfat cow's milk types and varieties must contain at least 400 IU of vitamin D per quart (100 IU per cup) and 2000 IU of vitamin A per quart (500 IU per cup).
Goat's milk	Must be pasteurized. May be flavored or unflavored. May be fluid, shelf-stable, evaporated or dry (i.e., powdered). All reduced fat, lowfat, and nonfat goat's milk must contain at least 400 IU of vitamin D per quart (100 IU per cup) and 2000 IU of vitamin A per quart (500 IU per cup).
Cheese	Domestic cheese made from 100 percent pasteurized milk. Must conform to FDA standard of identity (21 CFR part 133); Monterey Jack, Colby, natural Cheddar, Swiss, Brick, Muenster, Provolone, part-skim or whole Mozzarella, pasteurized process American, or blends of any of these cheeses are authorized. Cheeses that are labeled low, free, reduced, less or light in sodium, fat or cholesterol are WIC eligible.
Yogurt (cow's milk)	Yogurt must be pasteurized and conform to FDA standard of identity for whole fat (21 CFR 131.200), lowfat (21 CFR 131.203), or nonfat (21 CFR 131.206); plain or flavored with ≤40 g of total sugars per 1 cup yogurt. Yogurts that are fortified with vitamin A and D and other nutrients may be allowed at the State agency's option. Yogurts sold with accompanying mix-in ingredients such as granola, candy pieces, honey, nuts and similar ingredients are not authorized. Drinkable yogurts are not authorized.
Tofu	Calcium-set tofu prepared with calcium salts (e.g., calcium sulfate). May not contain added fats, sugars, oils, or sodium. Tofu must be calcium-set, i.e., contain calcium salts, but may also contain other coagulants, i.e., magnesium chloride.
Soy-based beverage	Must be fortified to meet the following nutrient levels: 276 mg calcium per cup, 8 g protein per cup, 500 IU vitamin A per cup, 100 IU vitamin D per cup, 24 mg magnesium per cup, 222 mg phosphorus per cup, 349 mg potassium per cup, 0.44 mg riboflavin per cup, and 1.1 mcg vitamin B12 per cup, in accordance with fortification guidelines issued by FDA. May be flavored or unflavored.
JUICE	Must be pasteurized 100% unsweetened fruit juice. Must contain at least 30 mg of vitamin C per 100 mL of juice. Must conform to FDA standard of identity as appropriate (21 CFR part 146) or vegetable juice must conform to FDA standard of identity as appropriate (21 CFR part 156). With the exception of 100% citrus juices, State agencies must verify the vitamin C content of all State-approved juices. Juices that are fortified with other nutrients may be allowed at the State agency's option. Juice may be fresh, from concentrate, frozen, canned, or shelf-stable. Blends of authorized juices are allowed. Vegetable juice may be regular or lower in sodium.
EGGS	Fresh shell domestic hens' eggs or dried eggs mix (must conform to FDA standard of identity in 21 CFR 160.105) or pasteurized liquid whole eggs (must conform to FDA standard of identity in 21 CFR 160.115). Hard boiled eggs, where readily available for purchase in small quantities, may be provided for homeless participants.
BREAKFAST CEREAL (READY-TO-EAT AND INSTANT AND REGULAR HOT CEREALS).	Must contain a minimum of 28 mg iron per 100 g dry cereal. Must contain ≤21.2 g sucrose and other sugars per 100 g dry cereal (≤6 g per dry oz). At least half of the cereals authorized on a State agency's food list must have whole grain as the primary ingredient by weight AND meet labeling requirements for making a health claim as a "whole grain food with moderate fat content".[3]
FRUITS AND VEGETABLES (FRESH AND PROCESSED) [4 5 6 8 9].	Any variety of fresh (as defined by 21 CFR 101.95) whole or cut fruit without added sugars. Any variety of fresh (as defined by 21 CFR 101.95) whole or cut vegetable, except white potatoes, without added sugars, fats, or oils (orange yams and sweet potatoes are allowed). Any variety of canned fruits (must conform to FDA standard of identity as appropriate (21 CFR part 145)); including applesauce, juice pack or water pack without added sugars, fats, oils, or salt (i.e., sodium). The fruit must be listed as the first ingredient. Any variety of frozen fruits without added sugars, fats, oils, or salt (i.e., sodium). Any variety of canned or frozen vegetables, except white potatoes (orange yams and sweet potatoes are allowed); without added sugars, fats, or oils. Vegetable must be listed as the first ingredient. May be regular or lower in sodium. Must conform to FDA standard of identity as appropriate (21 CFR part 155). Any type of dried fruits or dried vegetable, except white potatoes (orange yams and sweet potatoes are allowed); without added sugars, fats, oils, or salt (i.e., sodium). Any type of immature beans, peas, or lentils, fresh or in canned [5] forms. Any type of frozen beans (immature or mature). Beans purchased with the CVV may contain added vegetables and fruits, but may not contain added sugars, fats, oils, or meat as purchased. Canned beans, peas, or lentils may be regular or lower in sodium content. State agencies must allow organic forms of WIC-eligible fruits and vegetables.
WHOLE WHEAT BREAD, WHOLE GRAIN BREAD, AND WHOLE GRAIN OPTIONS:	
Bread	*Whole wheat bread* must conform to FDA standard of identity (21 CFR 136.180). (Includes whole wheat buns and rolls.) "Whole wheat flour" and/or "bromated whole wheat flour" must be the only flours listed in the ingredient list.

TABLE 4—MINIMUM REQUIREMENTS AND SPECIFICATIONS FOR SUPPLEMENTAL FOODS—Continued

Categories/foods	Minimum requirements and specifications
	OR *Whole grain bread* must conform to FDA standard of identity (21 CFR 136.110) (includes whole grain buns and rolls). AND Whole grain must be the primary ingredient by weight in all whole grain bread products. AND Must meet FDA labeling requirements for making a health claim as a "whole grain food with moderate fat content".[3]
Whole Grain Options	Brown rice, bulgur, oats, and whole-grain barley without added sugars, fats, oils, or salt (i.e., sodium). May be instant-, quick-, or regular-cooking. Soft corn or whole wheat tortillas. Soft corn tortillas made from ground masa flour (corn flour) using traditional processing methods are WIC-eligible, e.g., whole corn, corn (masa), whole ground corn, corn masa flour, masa harina, and white corn flour. For whole wheat tortillas, "whole wheat flour" must be the only flour listed in the ingredient list. Whole wheat macaroni products. Must conform to FDA standard of identity (21 CFR 139.138) and have no added sugars, fats, oils, or salt (i.e., sodium). "Whole wheat flour" and/or "whole durum wheat flour" must be the only flours listed in the ingredient list. Other shapes and sizes that otherwise meet the FDA standard of identity for whole wheat macaroni (pasta) products (139.138), and have no added sugars, fats, oils, or salt (i.e., sodium), are also authorized (e.g., whole wheat rotini, and whole wheat penne).
FISH (CANNED)[5]	Canned only: Light tuna (must conform to FDA standard of identity (21 CFR 161.190)); Salmon (Pacific salmon must conform to FDA standard of identity (21 CFR 161.170)); Sardines; and Mackerel (N. Atlantic *Scomber scombrus;* Chub Pacific *Scomber japonicas;* Jack Mackerel[10] May be packed in water or oil. Pack may include bones or skin. Added sauces and flavorings, e.g., tomato sauce, mustard, lemon, are authorized at the State agency's option. May be regular or lower in sodium content.
MATURE LEGUMES (DRY BEANS AND PEAS)[7].	Any type of mature dry beans, peas, or lentils in dry-packaged or canned[5] forms. Examples include but are not limited to black beans, black-eyed peas, garbanzo beans (chickpeas), great northern beans, white beans (navy and pea beans), kidney beans, mature lima ("butter beans"), fava and mung beans, pinto beans, soybeans/edamame, split peas, lentils, and refried beans. All categories exclude soups. May not contain added sugars, fats, oils, vegetables, fruits or meat as purchased. Canned legumes may be regular or lower in sodium content.[11] Baked beans may only be provided for participants with limited cooking facilities.[11]
PEANUT BUTTER	Peanut butter and reduced fat peanut butter (must conform to FDA Standard of Identity (21 CFR 164.150)); creamy or chunky, regular or reduced fat, salted or unsalted forms are allowed. Peanut butters with added marshmallows, honey, jelly, chocolate or similar ingredients are not authorized.
INFANT FOODS:	
Infant Cereal	Infant cereal must contain a minimum of 45 mg of iron per 100 g of dry cereal.[12]
Infant Fruits	Any variety of single ingredient commercial infant food fruit without added sugars, starches, or salt (i.e., sodium). Texture may range from strained through diced. The fruit must be listed as the first ingredient.[13]
Infant Vegetables	Any variety of single ingredient commercial infant food vegetables without added sugars, starches, or salt (i.e., sodium). Texture may range from strained through diced. The vegetable must be listed as the first ingredient.[14]
Infant Meat	Any variety of commercial infant food meat or poultry, as a single major ingredient, with added broth or gravy. Added sugars or salt (i.e. sodium) are not allowed. Texture may range from pureed through diced.[15]

Table 4 Footnotes: FDA = Food and Drug Administration of the U.S. Department of Health and Human Services.

[1] The following are not considered a WIC-eligible nutritional: Formulas used solely for the purpose of enhancing nutrient intake, managing body weight, addressing picky eaters or used for a condition other than a qualifying condition (e.g., vitamin pills, weight control products, etc.); medicines or drugs, as defined by the Food, Drug and Cosmetic Act (21 U.S.C. 350a) as amended; enzymes, herbs, or botanicals; oral rehydration fluids or electrolyte solutions; flavoring or thickening agents; and feeding utensils or devices (e.g., feeding tubes, bags, pumps) designed to administer a WIC-eligible formula.

[2] All authorized milks must conform to FDA standards of identity for milks as defined by 21 CFR part 131 and meet WIC's requirements for vitamin fortification as specified in Table 4 of paragraph (e)(12) of this section. Additional authorized milks include, but are not limited to: calcium-fortified, lactose-reduced and lactose-free, organic and UHT pasteurized milks. Other milks are permitted at the State agency's discretion provided that the State agency determines that the milk meets the minimum requirements for authorized milk.

[3] FDA *Health Claim Notification for Whole Grain Foods with Moderate Fat Content* at *http://www.fda.gov/food/ingredientspackaginglabeling/labelingnutrition/ucm073634.htm*

[4] Processed refers to frozen, canned,[5] or dried.

[5] "Canned" refers to processed food items in cans or other shelf-stable containers, e.g., jars, pouches.

[6] The following are not authorized: herbs and spices; creamed vegetables or vegetables with added sauces; mixed vegetables containing noodles, nuts or sauce packets, vegetable-grain (pasta or rice) mixtures; fruit-nut mixtures; breaded vegetables; fruits and vegetables for purchase on salad bars; peanuts or other nuts; ornamental and decorative fruits and vegetables such as chili peppers on a string; garlic on a string; gourds; painted pumpkins; fruit baskets and party vegetable trays; decorative blossoms and flowers, and foods containing fruits such as blueberry muffins and other baked goods. Home-canned and home-preserved fruits and vegetables are not authorized.

[7] Mature legumes in dry-packed or canned forms may be purchased with the WIC food instrument only. Immature varieties of fresh or canned beans and frozen beans of any type (immature or mature) may be purchased with the cash-value voucher only. Juices are provided as separate food WIC categories and are not authorized under the fruit and vegetable category.

[8] Excludes white potatoes, mixed vegetables containing white potatoes, dried white potatoes; catsup or other condiments; pickled vegetables; olives; soups; juices; and fruit leathers and fruit roll-ups. Canned tomato sauce, tomato paste, salsa and spaghetti sauce without added sugar, fats, or oils are authorized.

[9] State agencies have the option to allow only lower sodium canned vegetables for purchase with the cash-value voucher.

[10] FDA defines jack mackerel as any of the following six species: Trachurus declivis, trachurus japonicas, trachurur symmetricus, trachurus murphyi, trachurus novaezelandiae, and trachurus lathami in The Seafood List at *http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/Seafood/ucm113260.htm*. King mackerel is not authorized.

[11] The following are not authorized in the mature legume category: soups; immature varieties of legumes, such as those used in canned green peas, green beans, snap beans, yellow beans, and wax beans; baked beans with meat, e.g., beans and franks; and beans containing added sugars (with the exception of baked beans), fats, oils, meats, fruits or vegetables.

[12] Infant cereals containing infant formula, milk, fruit, or other non-cereal ingredients are not allowed.

[13] Mixtures with cereal or infant food desserts (e.g., peach cobbler) are not authorized; however, combinations of single ingredients (e.g., apple-banana) and combinations of single ingredients of fruits and/or vegetables (e.g., apples and squash) are allowed.

[14] Combinations of single ingredients (e.g., peas and carrots) and combinations of single ingredients of fruits and/or vegetables (e.g., apples and squash) are allowed. Mixed vegetables with white potato as an ingredient (e.g., mixed vegetables) are authorized. Infant foods containing white potatoes as the primary ingredient are not authorized.

[15] No infant food combinations (e.g., meat and vegetables) or dinners (e.g., spaghetti and meatballs) are allowed.

■ 5. In § 246.12:

■ a. Remove the phrase ''WIC-eligible medical foods'' and add in its place ''WIC-eligible nutritionals'' wherever it appears;

■ b. Amend paragraph (a)(1) by removing the words ''and farmers'' after ''vendors'' in the second sentence and adding in their place the phrase '', farmers and farmers' markets,'';

■ c. Amend paragraphs (f)(2)(ii) and (f)(2)(iv) by removing the word ''vouchermay'' and adding in its place the words ''voucher may'' whenever it appears in these paragraphs;

■ d. Add a new paragraph (f)(4);

■ e. Amend paragraph (g)(3)(i) by removing the words ''varieties of'' in both places that it appears in the second sentence and adding in their place the word ''different'';

■ f. Amend paragraph (h)(3)(i) by removing the word ''vouchersonly'' and adding in its place the words ''vouchers only'';

■ g. Amend paragraph (h)(3)(vii) by adding the words '', or cash-value vouchers'' after the word ''instruments'';

■ h. Revise the heading and the first two sentences of paragraph (h)(3)(viii);

■ i. Amend paragraph (h)(3)(x) by removing the last sentence of the paragraph;

■ j. Redesignate paragraphs (h)(3)(xi) through (h)(3)(xxv) as paragraphs (h)(3)(xii) through (h)(3)(xxvi) and add a new paragraph (h)(3)(xi);

■ k. Amend paragraph (l)(1)(ii)(A) by adding the words '', or cash-value vouchers,'' after the word ''instruments'';

■ l. Revise paragraph (o);

■ m. Amend paragraphs (r)(3) and (t) by adding the phrase '', farmers' markets,'' after the word ''farmer'';

■ n. Amend paragraph (u)(5) by adding the words '', farmers, farmers' markets,'' after the word ''contractors'';

■ o. Revise the heading and introductory text of paragraph (v);

■ p. Amend paragraph (v)(1) by adding the words ''or farmers' market'' after the word ''farmer'';

■ q. Revise paragraph (v)(1)(iv);

■ r. Amend paragraphs (v)(2) through (v)(6) by adding the words ''or farmers' market'' after the word ''farmer'' wherever it occurs;

■ s. Revise paragraph (v)(3);

■ t. Redesignate paragraphs (v)(4) through (v)(6) as paragraphs (v)(5) through (v)(7), and add a new paragraph (v)(4); and

■ u. Add a new paragraph (v)(8).

The revisions and additions read as follows:

§ 246.12 Food delivery systems.

* * * * *

(f) * * *

(4) *Split tender transactions.* The State agency must implement procedures that allow the participant, authorized representative or proxy to pay the difference when a fruit and vegetable purchase exceeds the value of the cash-value vouchers.

* * * * *

(h) * * *

(3) * * *

(viii) *Food instrument and cash-value voucher redemption.* The vendor must submit food instruments and cash-value vouchers for redemption in accordance with the redemption procedures described in the vendor agreement. The vendor may redeem a food instrument or cash-value voucher only within the specified time period. * * *

(xi) *Split tender for cash-value vouchers.* The vendor must allow the participant, authorized representative or proxy to pay the difference when a fruit and vegetable purchase exceeds the value of the cash-value vouchers (also known as a split tender transaction).

* * * * *

(o) *Participant parent/caretaker, proxy, vendor, farmer, farmers' market, and home food delivery contractor complaints.* The State agency must have procedures to document the handling of complaints by participants, parents or caretakers of infant or child participants, proxies, vendors, farmers, farmers' markets, home food delivery contractors, and direct distribution contractors. Complaints of civil rights discrimination must be handled in accordance with § 246.8(b).

* * * * *

(v) *Farmers and farmers' markets.* The State agency may authorize farmers, farmers' markets, and/or roadside stands to accept the cash-value voucher for eligible fruits and vegetables. The State agency must enter into written agreements with all authorized farmers and/or farmers' markets. The agreement must be signed by a representative who has legal authority to obligate the farmer or farmers' market and a representative of the State agency. The agreement must be for a period not to exceed 3 years. Only farmers or farmers' markets authorized by the State agency may redeem the fruit and vegetable cash-value voucher. The State agency must require farmers or farmers' markets to reapply at the expiration of their agreements and must provide farmers or farmers markets with not less than 15 days advance written notice of the expiration of the agreement.

* * * * *

(1) * * *

(iv) Redeem the cash-value voucher in accordance with a procedure established by the State agency. Such procedure must include a requirement for the farmer or farmers' market to allow the participant, authorized representative or proxy to pay the difference when the purchase of fruits and vegetables exceeds the value of the cash-value vouchers (also known as a split tender transaction);

* * * * *

(3) Neither the State agency nor the farmer or farmers' market has an obligation to renew the agreement. The State agency, the farmer, or farmers' market may terminate the agreement for cause after providing advance written notification.

(4) *Farmer agreements for State agencies that do not authorize farmers.* Those State agencies which authorize farmers' markets but not individual farmers shall require authorized farmers' markets to enter into a written agreement with each farmer within the market that is authorized to accept cash-value vouchers. The State agency shall set forth the required terms for the written agreement as defined in § 246.12(v)(1) and (v)(2), and provide a sample agreement for use by the farmers' market.

* * * * *

(8) *Monitoring farmers and farmers' markets.*—(i) The State agency must design and implement a system for monitoring its authorized farmers and farmers' markets for compliance with

program requirements. The State agency must document, at a minimum, the following information for all monitoring visits: name(s) of the farmer, farmers market, or roadside stand; name(s) and signature(s) of the reviewer(s); date of review; and nature of problem(s) detected.

(ii) *Compliance buys.* For compliance buys, the State agency must also document:

(A) The date of the buy;

(B) A description of the farmer (and farmers' market, as appropriate) involved in each transaction;

(C) The types and quantities of items purchased, current retail prices or prices charged other customers, and price charged for each item purchased, if available. Price information may be obtained prior to, during, or subsequent to the compliance buy; and

(D) The final disposition of all items as destroyed, donated, provided to other authorities, or kept as evidence.

■ 6. In § 246.16, revise paragraph (j)(2) to read as follows:

§ 246.16 Distribution of funds.

* * * * *

(j) * * *

(2) *Base value of the fruit and vegetable voucher.* The base year for calculation of the value of the fruit and vegetable voucher is fiscal year 2008. The base value to be used equals:

(i) $8 for children; and

(ii) $10 for women.

* * * * *

■ 7. In § 246.18:

■ a. Revise paragraph (a)(4);

■ b. Amend paragraphs (b), (d), (e), and (f) by adding the phrase ''or farmers' market'' after the word ''farmer'' whenever it appears;

■ c. Revise the first sentence in paragraph (b)(9);

■ d. Amend paragraph (c) introductory text by adding the phrase '', farmer, or farmers' market'' after the word ''vendor'' in the last sentence; and

■ e. Revise paragraph (c)(2);

The revisions and additions read as follows:

§ 246.18 Administrative review of State agency actions.

(a) * * *

(4) *Farmer or farmers' market appeals.*—(i) *Adverse actions.* The State agency shall provide a hearing procedure whereby farmers or farmers' markets adversely affected by certain actions of the State agency may appeal those actions. A farmer or farmers' market may appeal an action of the State agency denying its application to participate, imposing a sanction, or disqualifying it from participation in the program. Expiration of an agreement is not subject to appeal.

(ii) *Effective date of adverse actions against farmers or farmers' markets.* The State agency must make denials of authorization and disqualifications effective on the date of receipt of the notice of adverse action. The State agency must make all other adverse actions effective no earlier than 15 days after the date of the notice of the adverse action and no later than 90 days after the date of the notice of adverse action or, in the case of an adverse action that is subject to administrative review, no later than the date the farmer receives the review decision. The State agency must make all other adverse actions effective no earlier than 15 days after the date of the notice of adverse action and no later than 90 days after the date of the notice of adverse action or, in the case of an adverse action that is subject to an administrative review, no later than the date the farmer or farmers' market receives the review decision.

(b) * * *

(9) Written notification of the review decision, including the basis for the decision, within 90 days from the date of receipt of the request for an administrative review from a vendor, farmer, or farmer's market, and within 60 days from the date of receipt of a local agency's request for an administrative review. * * *

(c) * * *

(2) A decision-maker who is someone other than the person who rendered the initial decision on the action and whose determination is based solely on whether the State agency has correctly applied Federal and State statutes, regulations, policies, and procedures governing the Program, according to the information provided to the vendor, farmer, or farmers' market concerning the cause(s) for the adverse action and the response from the vendor, farmer, or farmers' market.

* * * * *

■ 8. In § 246.23:

■ a. Amend paragraph (a)(1) by removing the words ''or food instruments'' and by adding in its place the phrase ''food instruments, or cash-value vouchers''; and

■ b. Revise paragraph (a)(2).

The revisions read as follows:

§ 246.23 Claims and penalties.

(a) * * *

(2) If FNS determines that any part of the Program funds received by a State agency; or supplemental foods, either purchased or donated commodities; or food instruments or cash-value vouchers, were lost as a result of thefts, embezzlements, or unexplained causes, the State agency shall, on demand by FNS, pay to FNS a sum equal to the amount of the money or the value of the supplemental foods, food instruments, or cash-value vouchers so lost.

* * * * *

Dated: February 20, 2014.

Janey Thornton,

Acting Under Secretary, Food, Nutrition, and Consumer Services.

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