NEEDS ASSESSMENT

WIC MONTANA 2021

This project was funded by the Montana WIC Program.

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EXECUTIVE SUMMARY

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is administered under the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS). The Montana WIC Program, established in Montana in 1974, is administered by the Montana Department of Public Health and Human Services (DPHHS). Today, this program includes 29* local agencies and over 80 clinic sites on average across the state, which provide services to all 56 counties and seven Tribal reservations across Montana. In April 2020, the total participant count for the Montana WIC Program was 15,182. This Montana WIC Needs Assessment was conducted to better understand the needs and resources of the WIC program, its participants, and services and to guide a comprehensive statewide nutrition services plan for the Montana WIC Program.

This Needs Assessment was conducted from summer 2020 to summer 2021 by the Montana WIC program in conjunction with a contracted public health consulting organization. Data for this Assessment were sourced from both primary and secondary data sets at the national, state, and local levels. The direction and scope of this Needs Assessment were shaped by the WIC Nutrition Services Standards (FNS WIC Nutrition Standards 2013), the Montana WIC Program Director/ Section Supervisor, and key Montana WIC staff. This Assessment includes an overview of WIC in the State of Montana, demographics of the WIC population, various indicators of program participation including eligibility, maternal and child health indicators, and detailed overviews of breastfeeding and nutrition services.

Two striking aspects of life in Montana provided additional focus areas for this assessment: rurality and the state's high Native American population. Montana consists of more than 147,000 square miles and has a population of fewer than 1.1 million people; when considering how people access services, the state's rural nature cannot be overemphasized. Encompassed in this rural setting are seven Native American reservations. Just over six percent of the population in Montana identifies as Native American—much higher than the national average of just under one percent (ACS 2019 1YR Estm Det). The Montana WIC Program has considered these factors in many aspects of their program planning, including the annual Affirmative Action plan and funding decisions, to ensure that Native communities are provided services that work towards creating equitable health outcomes.

Major recommendations resulting from this assessment center around improving State-level WIC data quality, improving reach to the potentially eligible and at-risk population, expanding services, implementing workforce improvements, identifying funding priorities, continuing efforts to engage and serve special populations equitably and in a culturally appropriate manner, further integrating WIC services into primary care and federally qualified health center settings, and continuing to adjust services to meet current technological standards.

* At the time of writing this program includes 29 local agencies.

Kate Girard, MHS, RD
State WIC Director/Section Supervisor

A MESSAGE FROM OUR DIRECTOR

Dear Montanans,

We are pleased to present the 2021 Montana WIC Needs Assessment, the first official statewide assessment of the WIC program in Montana. This assessment, and its subsequent projects, will lead to positive impacts for the state of Montana for years to come. We would like to thank all those who shared their time and expertise throughout this process.

Nationally and internationally, the last year and a half was difficult for everyone. The need for social services and federal support was highlighted across our country. Here in Montana, we are grateful for the opportunity to improve services for those most in need. This assessment will act as a foundation from which we can all work together to continue our efforts towards improving the wellbeing of Montana's women and children. The information included in this assessment enables us to pinpoint key areas for improvement and highlight areas where we are succeeding. From here, we will conduct a comprehensive self-assessment according to the Nutrition Services Standards. These two documents, the Needs Assessment, and the self-assessment, will inform the Montana State Nutrition Services Plan, which will enable our State program, local agencies, and clinics to effectively work towards the same clearly defined, actionable goals.

This Needs Assessment is only the beginning, and its subsequent documents are living documents. They will continue to be updated, amended, and collaborated on as we adjust to the ever-changing landscape of maternal and child health in our State. Thank you again to everyone involved.

Sincerely,

Kate Girard, MHS, RD
State WIC Director/Section Supervisor
Special Supplemental Nutrition Program for
Women, Infants, and Children (WIC)
Family and Community Health Bureau
Early Childhood and Family Support Division
Department of Public Health & Human Services

ABBREVIATIONS GUIDE

ACRONYM	FULL NAME
AAP	American Academy of Pediatrics
AI / AN*	American Indian / Alaska Native
BFHI	Baby-Friendly Hospital Initiative
BPC	Breastfeeding Peer Counselor
BPCP	Breastfeeding Peer Counseling Programs
BMI	Body Mass Index
CDC	Centers for Disease Control
CGBI	Carolina Global Breastfeeding Institute
CPA	Competent Professional Authority
DGA	Dietary Guidelines for Americans
DPHHS	Department of Public Health and Human Services
ECFSD	Early Childhood and Family Support Division
ERS	Economic Research Service
FMNP	Farmers Market Nutrition Program
FNS	Food and Nutrition Service
FPL	Federal Poverty Line
FQHC	Federally Qualified Health Center
IHS*	Indian Health Services
ITOs*	Indian Tribal Organizations
LA	Local Agency
M-SPIRIT	Montana Successful Partners in Reaching Innovative Technology
NA*	Native American
NSA	Nutrition Services Administration
NSS	Nutrition Service Standards
PAR	Primary Authorized Representative
PHQ	Patient Health Questionnaire
PRAMS	Pregnancy Risk Assessment Monitoring System
RDN	Registered Dietitian Nutritionist
RSB	Ready, Set, BABY
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
USDA	United States Department of Agriculture
WIC	Women, Infants, Children

* Please note that American Indian / Alaska Native / Indian terminology is only used in relation to federal programs and data to be consistent with the cited data source. Outside of federal sources, more widely appropriate terms such as Native American are used.

METHODOLOGY

This Needs Assessment was conducted from summer 2020 to spring 2021 by the Montana State WIC program in conjunction with Yarrow LLC, a contracted public health consulting organization. This Needs Assessment includes over 60 indicators that will allow the Montana WIC Program and its local agencies the opportunity to evaluate trends in reaching intended communities and nutrition goals across Montana. These participant and health indicators were selected based on input from Montana WIC subject matter experts and guidance from the WIC Nutrition Services Standards, to evaluate the successes and challenges faced by the State and by local agencies. This assessment, and the subsequent Nutrition Services Standards self-assessment, will be important for tracking progress and establishing goals to be outlined in the statewide nutrition services plan.

Data for this assessment were collated from various national, state, and local primary and secondary resources.

Major primary data resources included the annual Montana WIC Participant Satisfaction Survey and a Customer Satisfaction survey specifically conducted for this Needs Assessment. The Montana WIC Participant Satisfaction Survey was conducted via the texting system Teletask, as a link in a WIC Shopper App banner, and as an in-person or over-the-phone request from the local agency staff to the participants in their appointments in the summer of 2020. The survey was conducted primarily via Qualtrics, and paper surveys were made available to those who needed them. The data were analyzed in Excel. Results are aggregated, and all identifying information is removed to protect the privacy of the participants. Appropriate data is suppressed when the numbers are too small to report and to maintain participant confidentiality. This survey has been conducted similarly since 2019. Some questions have changed and have been adjusted over the years. The survey highlights participant preferences about WIC nutrition and breastfeeding education and comfortability and views about WIC store experiences.

The Customer Satisfaction Survey 2017-2020 provided input on how local agencies feel about the services provided to them by the State agency. Every year during the summer, from July to September, the Montana WIC State Office (State Office) conducts a survey of the local agency WIC Staff (LA Staff). This is to ensure that the State Office is adequately meeting the LA staff's needs and addressing any concerns or conflicts. The information from the survey is used to inform policy changes, training topics, and education. The survey was disseminated to the LA Staff in 2020 via the weekly Montana WIC Newsletter. The State WIC Director also sent emails to the LA Staff, provided the survey link, and asked them to participate in the survey. Participation is variable over the years. The survey was conducted via Qualtrics, and the data were analyzed in Excel. This survey has been conducted similarly enough since 2017 to enable comparison. Some questions have changed and been adjusted over the years.

For both the Participant and Customer Satisfaction Surveys, responses to each question have been presented with the past year's responses wherever possible. There was one question specifically added in 2020 to address the State Office response to the COVID-19 pandemic. It is useful to note that the pandemic could have influenced the response rate and some responses. That information will be taken into consideration in subsequent reports.

The WIC Needs Assessment Survey 2021 was conducted online via Qualtrics in March 2021. While skip logic was used to direct certain questions to directors, all respondents answered the main set of questions. This survey was sent to all 130 WIC staff, including the 29 WIC local agency directors who received additional questions. The response rate for the survey was 25%. Quantitative results were analyzed using descriptive analyses via Google Sheets. Qualitative data were hand-coded for emergent themes.

Sources for secondary data at the national level included the U.S. Census Bureau, U.S. Department of Agriculture (USDA), and the Centers for Disease Control and Prevention (CDC), including Breastfeeding Report Cards, the Pregnancy Risk Assessment Monitoring System (PRAMS), and other datasets. Montana-specific secondary data came primarily from the Department of Public Health and Human Services (DPHHS) epidemiologist for the Early Childhood and Family Support Division and Vital Statistics office and directly from the Montana WIC Program. Data that were not publicly available were accessed via data requests from these departments and collected primarily for 2016–2019. Secondary data related to the Montana WIC Program includes demographic information (such as race/ethnicity, age, education levels, poverty rates), the prevalence of nutritional risks, prenatal care quality, food security measures, breastfeeding prevalence and trends, and program participation and retention.

The most prolific sources of secondary data were the USDA's "WIC Participant and Program Characterization" Reports for 2016 and 2018 and their unpublished data for the Montana WIC Program. These reports and datasets profile WIC participation rates, demographics, economic status, WIC eligibility, and specific nutrition and health indicators. These reports occur every two years during the sample month of April. They are composed of participant data submitted by each State agency, then analyzed and curated for national comparison. Once the national report is completed, state-specific data that has been analyzed is then returned to State WIC agencies. Such data is useful for comparing individual states to the national averages and evaluating specific subpopulations within WIC (i.e., infants, children, pregnant women, etc.). These comparisons are available because the WIC program is a federally standardized USDA Food and Nutrition Service (FNS) program administered locally by states. In addition, the FNS determines many programmatic parameters on which to collect standardized data and nutritional risk codes used by WIC programs to identify participants at nutritional risk.

Basic descriptive data analyses were run on certain sets of internal, unpublished data to aggregate and stratify those indicators. Key stakeholders were periodically contacted to provide direction and subject matter expertise throughout the process of conducting the Needs Assessment.

DATA QUALITY

While this assessment includes numerous participant and health indicators, it does not encompass all components that may determine the health status of the WIC population. The data in this Needs Assessment should not be viewed as a formal study but rather as a profile of the available data at the local agency, county, state, and national levels. Small populations in rural parts of Montana pose a risk for skewing data. In addition, some indicators are presented using different data sources that may use different defining parameters. Caution should be taken when comparing this data across these levels or sources. These comparisons were made to provide insight into differences across populations in order to assess the current status of the Montana WIC Programs at the local agency level across the state, not as direct comparisons. Additionally, some sources changed collection methods between collection years. In some cases, certain data pieces were not collected due to these changes, and therefore cannot be displayed. This was most commonly noted with the USDA sources; these instances are denoted where they occur.

The epidemiology section for the Early Childhood & Family Support Division (ECFSD) of the Montana Department of Public Health and Human Services' (DPHHS) curated a substantial amount of data specifically for this assessment. The majority of this data was specific to WIC populations and was used when comparing to federal data. While this data was expertly compiled for this task, caution is advised when making comparisons. Parameters, population definitions, and statistical analyses sometimes differ between sources. Measures were consistently taken to mitigate these potential data differences throughout all steps of data collection and management. Additionally, there are known difficulties in using electronic health record data at the population level, and the Montana Successful Partners in Reaching Innovative Technology (M-SPIRIT) system is no exception. Data quality issues can arise from user and system errors that are difficult to address through data analysis alone. Considerations were taken to address the most severe data reliability issues, including the exclusion of certain indicators.

WOMEN, INFANTS, & CHILDREN

INTRODUCTION TO WIC IN MONTANA

WHAT IS WIC?

According to the USDA, "The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk" (USDA WIC Eligibility Criteria 2021).

WIC eligibility requires that participants meet the four following criteria (USDA WIC Eligibility Criteria 2021):

1. Be a Woman who is Pregnant (during pregnancy and up to six weeks after the birth of an infant or the end of the pregnancy), Postpartum (up to six months after the birth of the infant or the end of the pregnancy), Breastfeeding (up to the infant's first birthday), or Infant (up to the infant's first birthday) or Child (up to the child's fifth birthday),
   A child or infant must have a Primary Authorized Representative (PAR) to enroll in WIC services. PARs must live with the person they are enrolling in WIC, and be the pregnant, postpartum, or breastfeeding participant or the parent/caretaker of the infant or child participant.
2. Reside in the state or Tribal area where they are enrolling,
3. Meet income standards such as an income less than 185% of the Federal Poverty Level (FPL) or have eligibility in a different income-based social program such as Medicaid, SNAP, or TANF, or household participation in the free or reduced school lunch program,
4. Be at nutritional risk, which is a determination made according to a set of nutritional risk codes which are evaluated during standardized assessments conducted by WIC staff at certification appointments. Common nutritional risks include high body mass index (BMI), inappropriate nutrition practices, failure to meet Dietary Guidelines for Americans (DGA), and pregnancy-related risks.

WIC Program benefits to eligible participants include:

- **Food Package.** Depending on the category a participant is placed in (pregnant, breastfeeding, postpartum, infant, child), a food package (consisting of specific foods as outlined by USDA-FNS) is assigned and then tailored, if necessary, to consider allergies and other specific health needs of the participant. A participant's food package can then be redeemed at participating vendors (such as grocery stores). It is important to note that this benefit is specific to WIC and is distinct from SNAP benefits (previously known as food stamps).
- **Nutrition Education.** At each certification period, participants are provided with standard nutrition information tailored to their needs or interests. Sometimes these are provided 1:1 with a WIC staff member, and other times the WIC local agency will offer online education options, group nutrition or cooking classes. Those who require high-risk individualized nutrition education or assessment are referred to a Registered Dietitian Nutritionist (RDN).
- **Referrals to Health Resources.** Staff at the WIC local agencies routinely provide referrals to local community resources when determining that a participant could benefit from those outside services. These may include very specific referrals to medical specialists or more general social services.

LOCAL AGENCY REGIONS AND CLINIC STRUCTURE

Montana is divided into 29 regions, which includes seven Tribal nation jurisdictions. Most regions cover multiple counties. Each region has a local agency that administers WIC services via contract through the State DPHHS WIC Program. As a recently designated federally recognized Tribe, Montana's eighth Tribal nation, the Little Shell Tribe of Chippewa Cree, does not yet have a Tribal WIC agency. Most local agencies have additional clinics, referred to as satellite or outlying clinics. As of 2021, Montana had 29 local agencies and 84 clinics. Satellite clinics are operated by WIC staff who travel out to a location to provide services in a smaller community at regular intervals depending on size and need. For instance, this may include one day a month on a college campus or a day every other month at a local church site. Outlying clinics are permanent WIC-specific locations that hold regular hours and are often generally sub-contracted by the local lead agency. An example may be a Public Health Nurse who provides WIC for their small maternal and child population via contract from a larger WIC clinic in a neighboring county.

In 2018, Montana made up 0.2% of the national total WIC participants, but 1.5% of the local agencies nationwide, and 0.84% of the clinics nationwide. Agencies in Montana can cover from as little as one to as many as six counties, with an average of 3.05 counties per region in 2021. Likewise, in 2021 each agency included an average of 2.89 clinics. The large number of local agencies and clinics in Montana compared to other states is due to the state's rural nature. Of the 29 local agencies, seven are Tribal agencies, and an additional five also serve Tribal communities. In Montana, all the Tribal entities contract their WIC Program services through the State WIC Program. Two of the six large agencies are in cities with Native populations over four percent (four times the national average). These are Cascade County Public Health Department in Great Falls and RiverStone Health in Billings (ACS 2019 1YR Est. Det).

Local agencies may also implement the Breastfeeding Peer Counselor Programs (BPCP) and the Farmers Market Nutrition Programs (FMNP) to supplement the WIC program they administer. More information about the Farmers Market Nutrition Program can be found in this document's "Nutrition Services" section. More about the Breastfeeding Peer Counselor Programs can be found in the section titled, "Breastfeeding Services".

Integration of WIC services into primary care facilities such as Federally Qualified Health Centers (FQHCs) or Rural Health Clinics, Urban Indian Health Clinics, pediatrician offices, and women's healthcare clinics is a practice that has taken root in some other states but has not been significantly developed in Montana. In Montana, WIC clinics are rarely integrated into full-service healthcare clinics. Integrated WIC services may be important for several reasons, including ease of access for participants to multiple services, and the ability to provide integrated care for patients across providers and resources. Integrated care has been shown to improve service quality, ensure patients get appropriate care and converge provider decisions in a consistent direction (Allen, Gillen, & Rixson 2009).

WIC STAFFING

Federal mandates require specific roles to be filled at both the state and local agency levels.

Descriptions of how the Montana WIC Program commonly staffs the local agencies are outlined in Figure 1 below. Due to the small population, rural nature of the state, and accessible workforce, many staff hold multiple federally mandated roles in local agencies.

The average ratio of direct service local agency WIC staff to participants in Montana is 1:229, with the highest ratio occurring between RDNs and participants at a ratio of 1:1,151. While staffing ratios may not provide a full picture of capability and service quality at each local agency or clinic, it is a way to consider staffing needs and effective models for rural and small WIC programs. The State's need for additional Registered Dietitian Nutritionists (RDNs) has been recognized and is supported by these findings.

MONTANA WIC PROGRAM STAFFING DESCRIPTIONS, LOCAL AGENCIES

Position Title	Basic Position Description
WIC Director	The local agency leader who acts as a primary contact with the WIC State agency and is often the supervisor of WIC staff locally. The Director is key to ensuring program administration is compliant with the contract, federal regulations, and state policies. The Director may also fulfil other positions. For example, the Director may also spend a portion of their time as a CPA or RDN.
Competent Professional Authority (CPA)*	A position necessary in each WIC clinic to perform, at a minimum, the nutrition assessment, care plan development, risk code assignment, food package development and nutrition education, assistance with goal development and appropriate referrals. The CPA role is ideally filled by a Registered Dietitian Nutritionist (RDN), Registered Nurse, or other qualified health professional with a substantive education and background in nutrition and public health. States may make exceptions and hire paraprofessionals for this role if adequate training and oversight are provided. Montana exercises this option due to the difficulty in staffing clinics with the criteria defined in the federal regulations.
Nutrition Coordinator	This position coordinates nutrition and breastfeeding services, which may include the training and supervision of staff. This position is often fulfilled by the Director, RDN, or CPA with appropriate credentials.
Nutrition Services Support Staff, or Aides*	The Aide role may be clerical or may include responsibilities such as collecting income, demographic, basic health and anthropometric data, as well as issuing benefits, providing referrals, offering low-risk nutrition education, retailer coordination and training, and/or assisting with the administration of other programs such as FMNP or BFPC. This position may or may not be employed depending on the size and budget of the local agency.
Breastfeeding Coordinators	This position supports local agency breastfeeding activities, including staff training and support. This position is often fulfilled by the Director, RDN, or CPA with appropriate credentials. This position is always filled regardless of whether the local agency has a Breastfeeding Peer Counselor Program (BPCP).
Breastfeeding Peer Counselors Coordinator/ Supervisor	This position develops, supports, and trains staff for the breastfeeding peer counselor program. This position is not filled for LAs that do not have a Breastfeeding Peer Counselor Program (BPCP).
Breastfeeding Peer Counselor (BPC)*	BPC's are peers who provide breastfeeding support to local agency WIC participants. This position is not filled for LAs that do not have a Breastfeeding Peer Counselor Program (BPCP).
WIC-Designated Breastfeeding Experts (DBE)*	These experts provide breastfeeding support for complex breastfeeding situations. The Designated Breastfeeding Expert at a local agency could be a CPA, RDN, or Breastfeeding Coordinator.
Registered Dietitian Nutritionist (RDN)*	RDNs provide services for participants with high-risk nutrition situations, including creating and implementing care plans, prescribing food packages, and making referrals. An RDN must be available to all local agencies but does not necessarily need to be a direct staff member.

**These positions provide direct services to WIC participants. Other positions are administrative or coordinator functions.*

Figure 1: Montana WIC Program Staffing Descriptions, Local Agencies

WIC FUNDING SUMMARY

WIC is a federally-authorized and regulated program that is funded by Congress through the discretionary appropriations process annually. Once the annual award is known, the USDA-FNS headquarters office uses a funding formula to determine available funding for base grants in all WIC state agencies based on several factors, which include, but is not limited to, participation and prior year base awards and utilization. Additional funds are set aside federally for infrastructure grants, technology, research, and other special projects depending on priorities and funding availability. WIC funding that goes into the base grant calculation is split roughly 75% for food and 25% for nutrition services administration (NSA). The formula is then funneled through regional USDA-FNS offices, where it is determined how much to withhold for operational adjustment, generally about 10% of the base grants. States then receive quarterly funding allocations, with additional options to ask for "reallocation" (prior year unused funds swept by FNS) and/or Operational Adjustment from their regional office.

WIC funding is somewhat complex, unpredictable, and ever-changing due to the annual process described above, which often includes starting a new fiscal year on a continuing resolution if a federal budget is not finalized by September 30th. However, this structure also provides some flexibility and assurance that their unique needs will be considered and often met at the State level. To learn more about WIC funding and other WIC basics, visit https://www.nwica.org/overview-and-history.

As a state agency, budgeting starts several months prior to the beginning of the fiscal year to allow for projected budgets to be included in the annual submission of the State Plan (subject to approval by the Mountain Plains Regional WIC Office); spending authority and cost allocation estimates to be obtained and included in the budget projections; program planning and contract execution for local agencies and other contracts requiring updates. Since the final federal budget is seldom known during this timeframe, we use a projected figure that includes the current year's base value for planning purposes.

For local agency contracts, a funding formula is also used to update values annually, dependent on several factors, including participation, technology support, training/professional development, dietitian support, retailer coordination, and other factors that are subject to change. The largest variable is the amount included in the overall formula, and the value per participant served in each region. Local agencies are asked to submit a draft budget in late Spring annually, which projects the following federal fiscal year budget. This is taken into consideration in adjusting the funding formula. If an agency requests less than the formula would calculate, the agency will receive the requested amount. The funds not needed by those agencies with smaller budget requests are then re-calculated into the formula to allow for elevated values for other agencies who request more.

Montana is one of the few states whose Tribal WIC agencies and clinics receive WIC funding through the State rather than directly from the federal government. Because of this, Montana Tribal WIC agencies are not considered "Indian Tribal Organizations (ITOs)" for WIC purposes.

During the late Spring annually, the State Office provides an opportunity to review the formula and discuss any issues or questions with local agency leadership contacts. This allows for a feedback loop and opportunity for quality improvement in the process. Additionally,

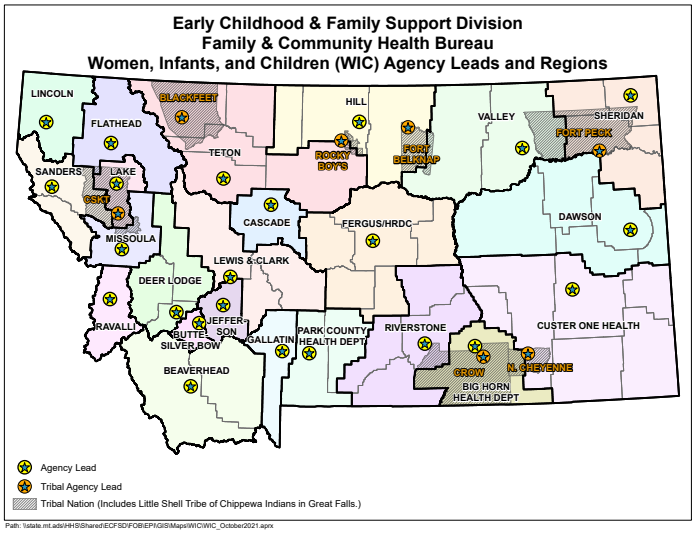
each agency has the ongoing opportunity to submit a request for a contract amendment, which is nearly always awarded, to help fill any gaps identified and balance local budgets during the fiscal year. Generally, about 65-70% of the State NSA grant is contracted out for local agency services.

In 2020, the WIC Program sent out a funding survey to the 29 agencies to evaluate the efficacy of the current funding formula for Montana at the local level. A total of 22 agencies responded to the survey, and of those, six stated that they had not received adequate funding in previous years. These clinics said that their lack of funding limited their staffing, clinic hours, and the services they could provide.

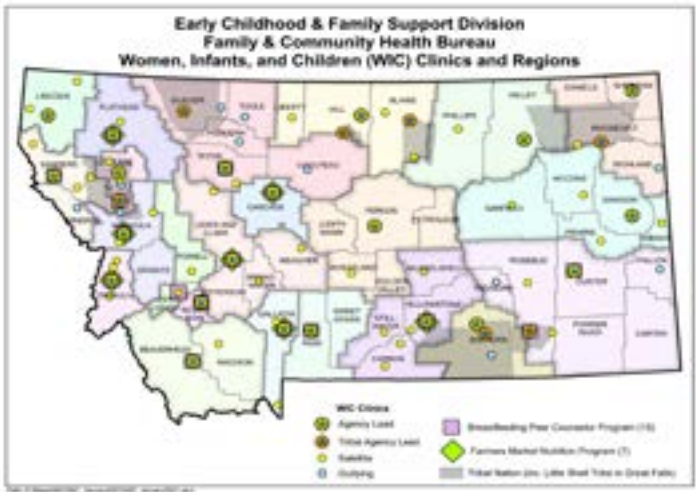
Many other agencies detailed that their current funding allocation was sufficient for basic functioning but did not allow for additional supplies, travel, or training. The primary funding challenge faced by the Montana WIC Program involves the decrease in funding equivalent to the reduction in participant count over the past several years. Funding per participant does not take into consideration the varying needs of participants. This decline in funding further limits the local agencies' services and may therefore further decrease participation. Throughout the process of making decisions around funding distributions, the Montana WIC Program is working to evaluate equity in their funding to local agencies, as well as considering various adjustments based on Affirmative Action Plan and cost of living.

WIC AGENCIES

The sizes of the WIC local agencies include small (<400), medium (400-1000), and large (>1000), which is based on the average annual participation at federal fiscal year-end. This designation is used in the funding formula, data analysis, to determine monitoring chart reviews, and is considered for membership representation on the WIC Workgroup. In addition to these sizing changes, some agencies have had clinics merge or separate over the past five years to meet local participant needs or improve services locally. Some WIC local agencies cover multiple counties, while others share county coverage with another WIC local agency. Tribal agencies overlap geographically with other local agencies because Tribal lands overlap county jurisdictions and generally serve the population living on the reservation. However, any agency may provide services to any Montana resident who applies and is eligible for the program, regardless of region boundary.



The above map depicts all 29 local agency leads, including the seven Tribal agency leads, in relation to the 29 WIC regions and 56 counties. The newly established Little Shell Reservation is considering plans to establish an integrated WIC clinic within its new health clinic.



The above map depicts the location of all 29 Local Agencies and any satellite or outlying clinic locations and if any of these locations have Breastfeeding Peer Counselor or Farmers Market Nutrition Programs. Although these maps depict regions, counties, and reservations, participants are not held to these boundaries and can go to any clinic of their choosing within the State of Montana.

SMALL AGENCIES <400 AVERAGE ANNUAL PARTICIPATION | 17 AGENCIES | 47 CLINICS

Anaconda-Deer Lodge County Public Health Dept.
Beaverhead County Public Health Department
Bighorn Valley Health Center (Bvhc)/One Health
Crow Tribal Health Department
Dawson County Public Health
Fergus County/Human Resource Development Council (HRDC)
Fort Belknap Tribal Health Department
Hill County Health Department
Jefferson (NEW FFY22)
Lake County Health Department
Lincoln County/Northwest Community Health Center
Park County Health Department
Rocky Boy Health Center
Salish & Kootenai Tribal Health
Sanders County Public Health Department
Sheridan County Health Department
Valley County/Frances Mahone Deaconess Hospital (FMFH)

MEDIUM AGENCIES 400-1,000 AVERAGE ANNUAL PARTICIPATION | 8 AGENCIES | 14 CLINICS

Blackfeet Tribal Health
Butte-Silver Bow Health Department
Fort Peck Tribal Health Department
Gallatin County Public Health Department
Lewis & Clark Public Health Department
Northern Cheyenne Tribal Board of Health
Ravalli County Public Health Department
Teton County Health Department

LARGE AGENCIES >1,000 AVERAGE ANNUAL PARTICIPATION | 4 AGENCIES | 14 CLINICS

Cascade County Health Department
Flathead City-County Health Department
Missoula City-County Health Department
RiverStone Health

Figure 2: WIC Agencies and Clinics Distributed Across Region, Montana, 2021

STAFFING

In 2021, the average ratio of WIC staff to participants in Montana is 1:216. This ratio increases when stratified by specific staff roles, with the highest ratio among RDNs and participants at 1:1,151. Registered Dietitian Nutritionists (RDNs) are affiliated with WIC clinics in four distinct ways. Currently, clinics can either (1) have an RDN employed directly at the clinic, (2) utilize an RDN at an agency affiliated with a WIC clinic, (3) utilize an RDN affiliated with another local agency via contract, or (4) contract directly with an RDN in the community. On average, there is less than one full-time equivalent (FTE) for each of the primary staff roles (CPA, Aide, RDN) in WIC local agencies in Montana. The Director role is mandated at each local agency.

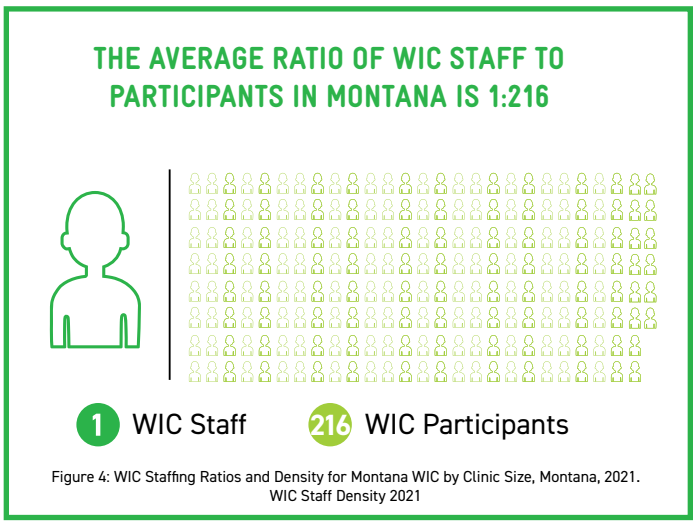


Figure 4: WIC Staffing Ratios and Density for Montana WIC by Clinic Size, Montana, 2021. WIC Staff Density 2021

However, the role of the Director varies from a core clinic staff member to an agency administrator who does not provide direct services. Therefore, this ratio was not calculated here.

Of the MT WIC staff who completed the Montana WIC Needs Assessment Survey 2021, nearly three out of four felt they were provided with sufficient orientation when they were hired, were provided a complete job description with performance standards, and still participated in ongoing training for their work. Fewer (65%) felt that they were provided with position or task-specific training that helped them learn to do their job at hiring.

MONTANA WIC STAFF JOB SATIFACTION

Montana WIC staff who completed the Montana WIC Needs Assessment Survey 2021 had a considerable amount of job satisfaction, with 79.5% indicating a 4 or 5 ranking of satisfaction on a 5-point Likert scale with 1 being low and 5 being high.

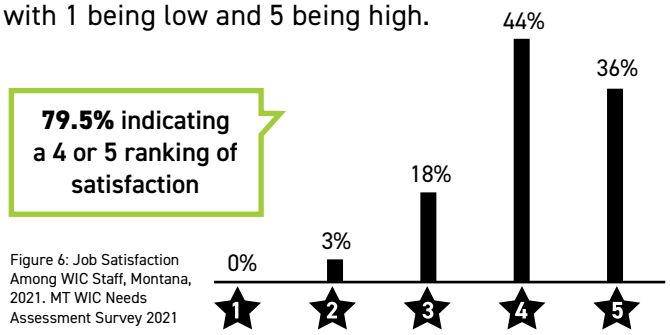


Figure 6: Job Satisfaction Among WIC Staff, Montana, 2021. MT WIC Needs Assessment Survey 2021

WIC STAFF ONBOARDNG AND COMPETENCY INDICATORS

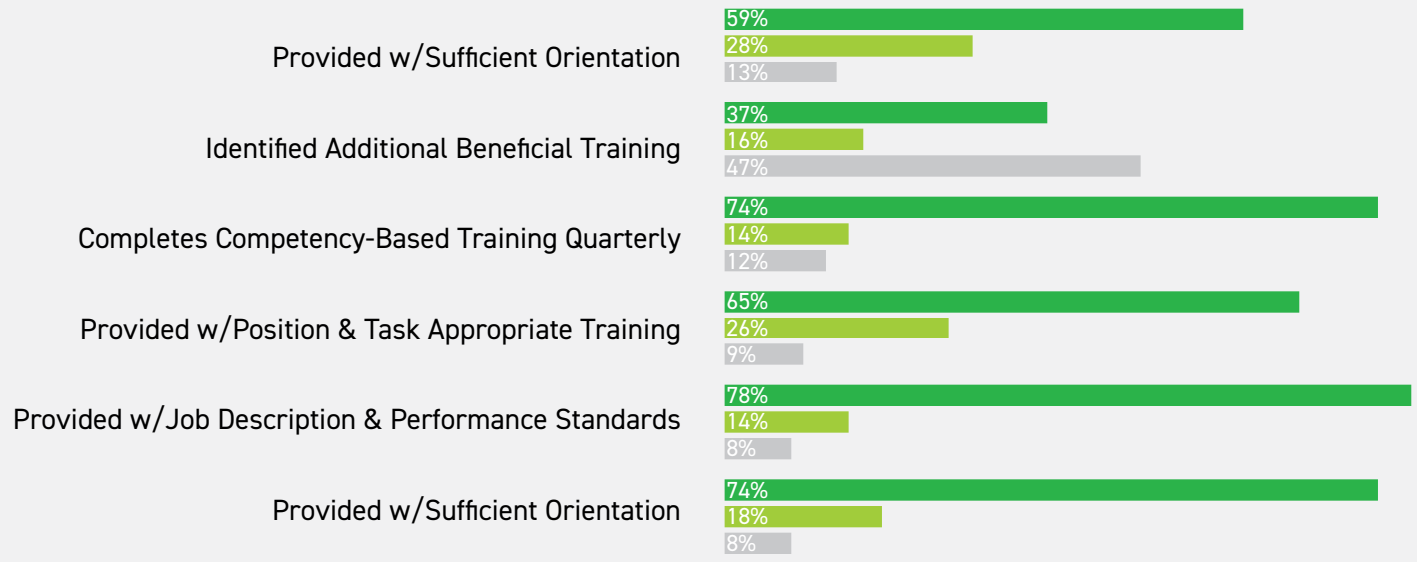


Figure 5: Self-Reported WIC Staff On-Boarding and Competency Indicators, Montana, 2021. MT WIC Needs Assessment Survey 2021

When asked what might improve their job satisfaction, respondents overwhelmingly wanted to spend more time in meaningful interaction with their clients and feel less overwhelmed by paperwork and documentation. The following are additional general suggestions: less documentation and improvements to M-SPIRIT; maintaining flexibility in remote work and access for patients; more time to work with clients on meaningful nutrition and breastfeeding education; more time to work as a staff team and to consider and implement improvements to services; consistent access to an RDN in the clinic; ability to serve more families; and higher wages. Some directors specifically cited needing fewer programs to oversee, in general, so that they could dedicate more energy toward WIC.

Of those Montana WIC staff who completed the Montana WIC Needs Assessment Survey 2021, nearly 20% were unsure whether their staffing was based on participant case load. Still, almost 30% felt their clinic was understaffed, and that additional staff would be helpful.

When asked to expand on what staffing would be helpful to include, the following requests surfaced from the different sources: the need for an on-site RDN and more RDN time in general; additional CPAs, and Aides to take on the caseloads; and additional Breastfeeding Peer Counselors and generally for the Breastfeeding Peer Counselors to have more time with clients.

Figure 7: Staffing Considerations as Reported by WIC Directors, Montana, 2021. MT WIC Needs Assessment Survey 2021

When asked about their primary challenges around recruiting and retaining staff, the following themes emerged: low wages, often with only part-time positions available; lack of qualified and educated individuals in the area, frequently due to low workforce capacity in rural areas, to fill desired positions (primarily regarding RDNs and CPAs).

According to the Nutrition Services Standards (NSS), there are 16 standards to which local agencies should adhere to provide effective nutrition services to participants. A standard is "a reasonable expectation and level of quality or excellence that is accepted as the norm and by which the provision of nutrition services is assessed" (FNS WIC Nutrition Standards 2013). In Standard 1: State and local agency Nutrition Services Plan and Evaluation, the NSS suggests States and local agencies conduct a needs assessment which includes an NSS self-assessment. The self-assessment consists of two templates, one for Standards 1, 2, and 6–16 and one for Standards 3–5. These templates guide WIC programs through evaluating their services according to the 15 NSS standards. This section of the WIC Needs Assessment Survey 2021 consolidated aspects of the NSS self-assessment to provide a general overview of how WIC staff, including directors, perceive their program's ability to meet each NSS standard. A more comprehensive self-assessment will be completed later in 2021 as a companion guiding document to this Needs Assessment.

The WIC Needs Assessment Survey 2021 highlighted areas for improvement and areas achieving success.

Areas that are being well-implemented were considered as those which had rankings of 5 on a 5-point Likert scale in over 50% of the staff responses. These included: Clinic Environment and Customer Service; Staff Qualifications; Nutrition Assessment; WIC Food Selection & Authorization; and Food Package Prescriptions.

Areas that stood out for needing improvement were considered as those areas where 20% or more of respondents ranked the item as a 1, 2, or 3 on a 5-point Likert scale. These included: Staffing Patterns; Staffing Recruitment & Retention; Staff Training; Breastfeeding Education, Promotion, and Support; Breastfeeding Peer Counseling; Program Coordination; Breastfeeding Data Collection; and Quality Improvement. Breastfeeding Peer Counseling Programs (BPCP) ranked low likely since the majority of local agencies do not have a BPCP.

In 2019, the percentage of LA staff who felt comfortable in their position within the first year was 63%.
That same group was 77% in 2020.

SERVICES THAT ARE BEING WELL IMPLEMENTED ACCORING TO WIC STAFF

WIC Food Selection & Authorization	**61%**	*of respondants ranked this area 5 out of 5*
Staff Qualifications	**58%**	*of respondants ranked this area 5 out of 5*
Food Package Prescriptions	**58%**	*of respondants ranked this area 5 out of 5*
Nutrition Assessment	**55%**	*of respondants ranked this area 5 out of 5*
Clinic Environment and Customer Service	**53%**	*of respondants ranked this area 5 out of 5*

Figure 8: WIC Nutrition Services Standards Scores According to WIC Staff, Montana, 2021. MT WIC Needs Assessment Survey 2021

SERVICES THAT NEED IMPOVEMENT ACCORING TO WIC STAFF

Breastfeeding Peer Counseling	**67%**	*of respondants ranked this area a 1,2, or 3*
Quality Improvement	**42%**	*of respondants ranked this area a 1,2, or 3*
Breastfeeding Education, Promotion & Support	**35%**	*of respondants ranked this area a 1,2, or 3*
Program Coordination	**32%**	*of respondants ranked this area a 1,2, or 3*
Staff Training	**31%**	*of respondants ranked this area a 1,2, or 3*

Figure 9: WIC Nutrition Services Standards Scores According to WIC Staff, Montana, 2021. MT WIC Customer Service Survey 2017-2020

PARTICIPANT DEMOGRAPHICS

Demographic indicators covered in this section include age, race, ethnicity, family size, education, income, poverty level, and participation in other benefit programs. Socioeconomic indicators such as these provide a wider overview of the WIC population than just their participation in WIC services, enabling the WIC program to further understand and thereby better serve the people utilizing the services of Montana WIC agencies and clinics.

Overall, pregnant participants tend to be in their twenties, and children participants are mostly 3–4 years old. Two-thirds of participants are white, and one-fourth are American Indian. The rate of participation among American Indians is much higher than the proportion of American Indians in the general population of Montana, and higher than the usual rate of participation seen at the National level. This indicates successful recruitment, participation, and retention of the Native American population by the WIC program in Montana. Most primary authorized representatives have a high school degree or less and an average household annual income of around $18,000, which is to be expected due to the low-income eligibility requirement. Likely linked to the low-income status of most participants is the high rate of participation in other benefit programs such as Medicaid and SNAP.

AGE OF PREGNANT WOMEN ENROLLED IN WIC

In 2019, most pregnant women enrolled in WIC in Montana were 20–29 years old, followed by those aged 30–39 years old. Teen mothers made up 10.3% of the pregnant women enrolled in WIC in Montana and 11% in the United States.

	<15 Yrs	15-17	18-19	20-29	30-39	>40yrs	Unknown	Total
Montana	0.1%	3%	7%	64%	25%	2%	0.1%	1,528
National	0.1%	3%	8%	62%	25%	2%	0.1%	675,227

Figure 10: WIC Participation by Participant Category, Montana vs National, 2018. USDA PC Data 2018, USDA MT WIC Data 2018

RATES OF WIC PARTICIPANTS UNDER 5 YEARS OF AGE

In 2019 the age of participation among infants and children in Montana and the United States was similar among all age groups. Of note, in Montana, participation appeared to decrease at 6–11 months of age to 12.7% from 22.7% at 0–5 months. The age group of less than one year, making up 35.4% of the infant and children MT WIC participants, made up the largest population of participants when grouped by one-year age intervals.

	0-5mo	6-11mo	1-2yr	2-3yr	3-4yr	Total
Montana	23%	13%	20%	17%	28%	14,357

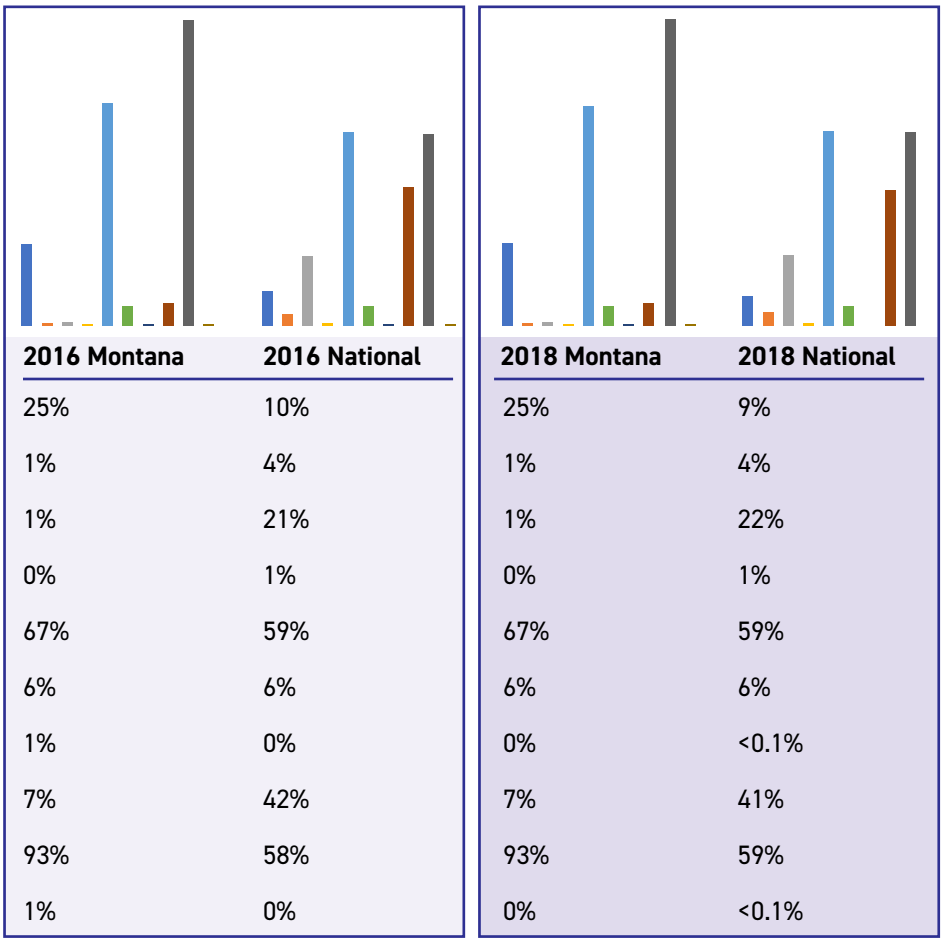
	0-11mo	1-2yr	2-4yr	Total
National	33%	22%	46%	6,020,284

Figure 11: WIC Participation by Participant Category, Montana vs National, 2018. USDA PC Data 2018, USDA MT WIC Data 2018

The racial distribution of MT WIC participants mainly remained unchanged from 2016 to 2018, with no more than a 1% increase or decrease across any racial group. Compared to the entire nation, Montana had significantly fewer Black or African American participants: 1.1% for both years, compared to 20.8% and 21% nationally (2016 and 2018, respectively). Montana had twice the number of American Indian or Alaska Native participants than nationally as a whole. Additionally, Montana's Hispanic/Latino population was substantially lower than the national participation rate, and the White population in Montana was higher.

American Indian and Alaska Native, Black or African American, Pacific Islander or Native Hawaiian, those describing themselves as two or more races, and those with Hispanic/Latino ethnicity show greater participation in WIC services than the distribution of these races in the state of Montana, illustrating that these populations experience a disproportionate need for WIC services compared to other races. Only Asian and White races show a smaller proportion of WIC participants compared to their racial distribution in Montana.

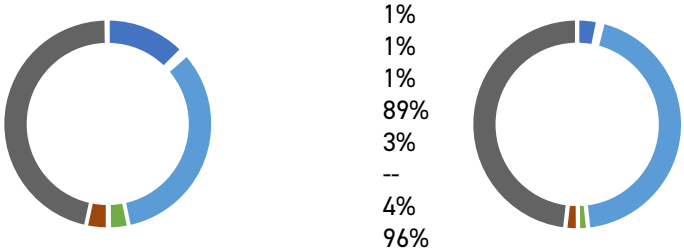
RACIAL AND ETHNIC DISTRIBUTION OF WIC PARTICIPANTS, MONTANA VS. NATIONAL, 2016 & 2018



	2016 Montana	2016 National	2018 Montana	2018 National
American Indian or Alaska Native	25%	10%	25%	9%
Asian	1%	4%	1%	4%
Black or African American	1%	21%	1%	22%
Pacific Islander or Native Hawaiian	0%	1%	0%	1%
White	67%	59%	67%	59%
Two or More Races	6%	6%	6%	6%
Race Not Reported	1%	0%	0%	<0.1%
Hispanic/Latino	7%	42%	7%	41%
Non-Hispanic/Latino	93%	58%	93%	59%
Ethnicity Not Reported	1%	0%	0%	<0.1%

Figure 12: Racial and Ethnic Distribution of WIC Participants, Montana vs National, 2016 & 2018. USDA PC Data 2016 & 2018, USDA MT WIC Data 2016 & 2018

RACIAL AND ETHNIC DISTRIBUTION OF MONTANA WIC PARTICIPANTS VS THE STATE OF MONTANA, 2018



	Montana WIC Participants	State of Montana
American Indian or Alaska Native	25%	6%
Asian	1%	1%
Black or African American	1%	1%
Pacific Islander or Native Hawaiian	0%	1%
White	67%	89%
Two or More Races	6%	3%
Race Not Reported	0%	--
Hispanic/Latino	7%	4%
Non-Hispanic/Latino	93%	96%
Ethnicity Not Reported	1%	--

Figure 13. Racial and Ethnic Distribution of Montana WIC Participants vs Racial and Ethnic Distribution for the State of Montana, 2018. USDA PC DATA 2018, ACS 2018 1YR Estm Dat

Rates of participation among families of different sizes were relatively similar between Montana and the United States in 2016 and 2018, except Montana had double the number of "1 Person" families (pregnant women) compared to the United States. Most WIC participants had families of three or four people.

SIZE OF WIC PARTICIPANT FAMILIES MONTANA VS NATIONAL, 2016 & 2018

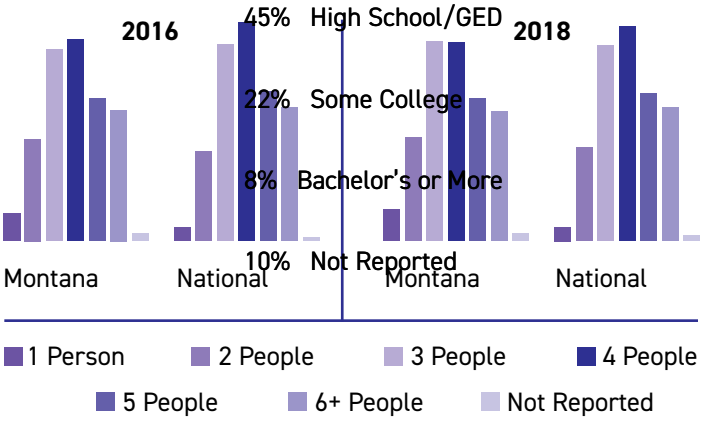


Figure 14: Size of WIC Participant Families, Montana vs National, 2016 & 2018.
USDA MT WIC Data 2016 & 2018, USDA PC Data 2016 & 2018

Education levels for WIC primary authorized representatives stayed relatively the same over the last five years. However, fewer primary authorized representatives had less than a high school degree in 2020 than in 2016, though most primary authorized representatives still only had a high school degree or less. Nearly a third of Montana's primary authorized representatives had some college or a bachelor's degree or more. The increasing percentage of unknown/not reported education levels may be a data quality issue worth investigating.

EDUCATION LEVEL FOR WIC PRIMARY AUTHORIZED REPRESENTATIVE BY HOUSEHOLD, MONTANA, 2020

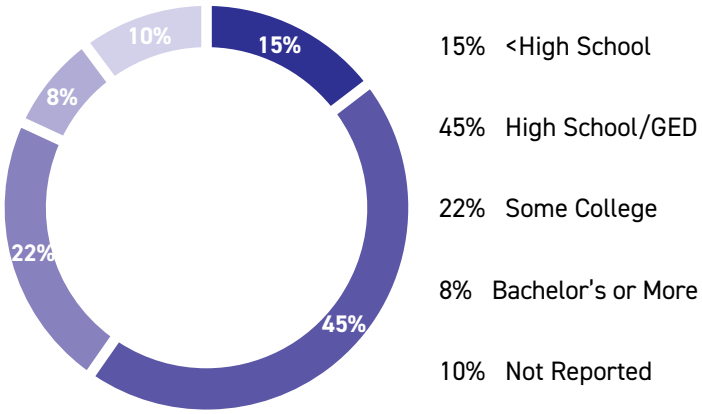
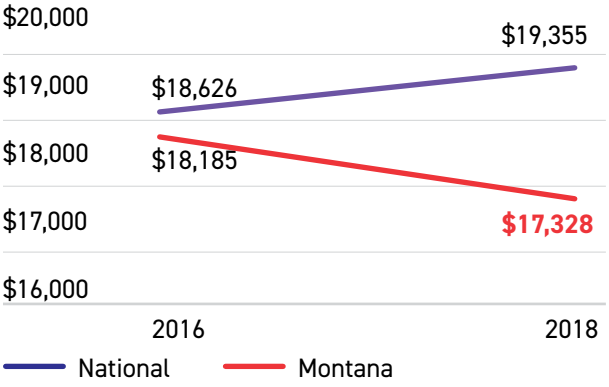


Figure 15: Education Level for WIC Primary Authorized Representative by Household, Montana, 2016–2020. MT WIC Vital Stats—Birth Characteristics Data 2021

WIC participants in Montana had a lower average and median income than participants nationally in 2016 and 2018. During those years, income increased at the national level but decreased among Montanans participating in WIC.

ANNUAL INCOME OF WIC PARTICIPANTS, MONTANA VS NATIONAL, 2016 & 2018*



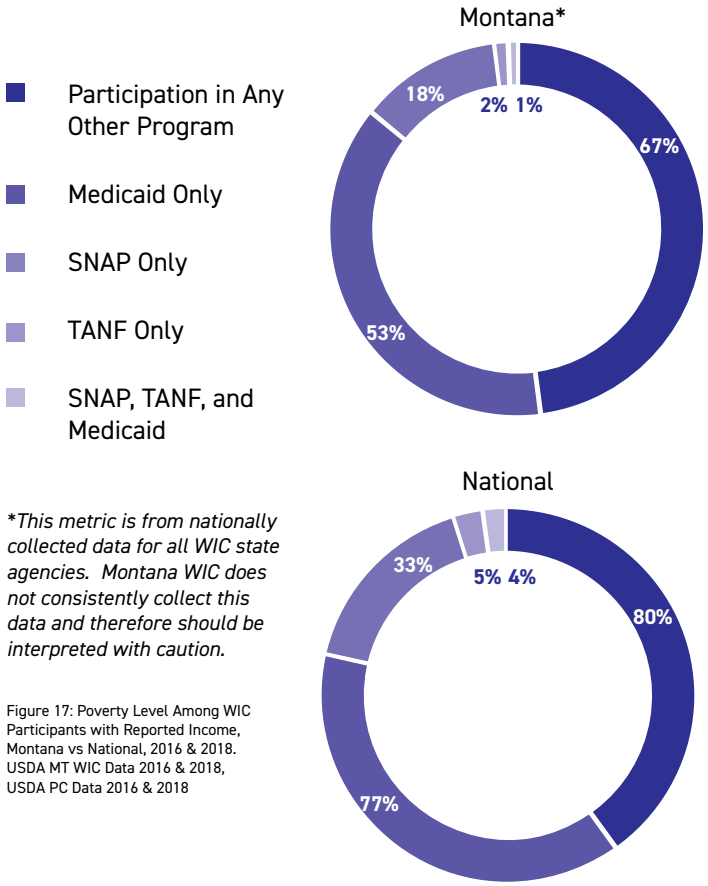
In 2016, some reporting state agencies denoted a value of zero for missing information, which makes it impossible to distinguish between households with missing income information and households reporting income as zero. This measurement was omitted for the 2018 assessment.

Figure 16: Annual Income of WIC Participants, Montana vs National, 2016 & 2018
USDA MT WIC Data 2016 & 2018, USDA PC Data 2016 & 2018

In 2016 and 2018, the US poverty level threshold of annual incomes for a family of four was and average of **$24,500.** You can see WIC participants are well below the threshhold.

In 2016 and 2018, most WIC participants participated in other benefit programs, most frequently Medicaid. While this was true for Montana and the US, the participation rate in benefit programs was lower in Montana than nationally. The USDA stated that these participation rates in other programs are often underreported for WIC participants.

2018 PARTICIPANTS WITH REPORTED PARTICIPATION IN OTHER BENEFIT PROGRAMS, MONTANA VS NATIONAL



This metric is from nationally collected data for all WIC state agencies. Montana WIC does not consistently collect this data and therefore should be interpreted with caution.

Figure 17: Poverty Level Among WIC Participants with Reported Income, Montana vs National, 2016 & 2018.
USDA MT WIC Data 2016 & 2018,
USDA PC Data 2016 & 2018

POVERTY LEVEL AMONG WIC PARTICIPANTS WITH REPORTED INCOME, MONTANA VS NATIONAL, 2016 & 2018

In 2016 and 2018, the US poverty level threshold of annual incomes for a family of four was $24,300 and $25,100, respectively. Most WIC participants, both in Montana and nationally, have incomes below the federal poverty level, though people can participate in WIC with incomes up to 185% of the federal poverty level.

100% or below the federal poverty level means an individual or family is considered to be impoverished. Percentages above 100% are not considered in poverty. www.investopedia.com/terms/f/fpl.asp

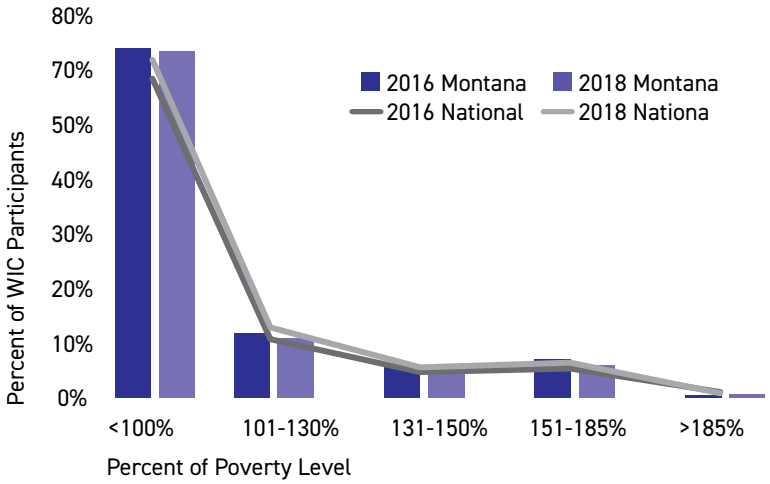


Figure 18: Poverty Level Among WIC Participants with Reported Income, Montana vs. National, 2016 & 2018

PROGRAM PARTICIPATION

The most essential aspect of any WIC program is its participants. WIC was established to serve women and children in need and ensure that these important populations receive adequate nutrition to lead healthy and successful lives. However, recruitment and retention of participants can be difficult for many reasons, including stigma around receiving social services, lack of awareness of service availability, and difficulty accessing services themselves. This section provides an overview of participation across all WIC categories, primary authorized representatives, differences in eligibility versus participation, characteristics of children and parents according to eligibility and participation, when women enter WIC during pregnancy, ranked need for maternal and child health support, and length of participation.

WIC participation in Montana and nationally has been steadily declining over the last several years, with the most significant decrease seen among women participants. Throughout this decline, most WIC participants are children aged 1–5 years, although this category is also experiencing a decline in participation. One potential contributor to a decline in overall participation is that fewer Montanans are eligible for WIC services. Despite this, only half of the eligible infants and children are participating. It is important to note that Medicaid and SNAP data do not show a decline in participation among their programs, or in WIC when these institutions' data are compared. On average, Tribal WIC programs serve higher percentages of their eligible population than other WIC programs across the State. When stratified according to race, participation has increased among all non-White populations in Montana over the last several years but decreased among Whites. As a majority White state, this decrease in participation is outpacing the increase in participation among other racial categories. It is also notable that while Native American women participate in Montana WIC at higher rates than do their White counterparts, they tend to enter WIC services later in their pregnancy. Once participating in WIC, nearly half of participants are engaged with the program for three or more years. One potential reason for decreasing participation in WIC may be barriers to accessing services. Barriers to participation, such as transportation, stigma, operating hours and locations, and childcare, vary between different populations. Findings from the WIC Needs Assessment Survey 2021 suggest that the major barriers to care for the Montana WIC population, as perceived by WIC staff, are the time required of participants to take off of work or school or other commitments, transportation barriers, and that WIC participants may not find enough value or interest in the nutrition education services provided.

When discussing WIC participation, it is important to note the differences between eligibility, certification, and receipt of benefits. While someone can be eligible for WIC if they are found to meet the four criteria, an eligible person cannot receive WIC benefits until they undergo the certification process. Once certified, participants can claim the benefits for which they have been deemed eligible. Certifications for breastfeeding women, infants, and children are valid for up to one year, while the length of certification for pregnant women depends on when the woman entered WIC services and lasts until six weeks after delivery. If an infant is certified after six months of age, the certification only lasts for six months. While certifications generally last a year, benefits are only issued for three months at a time. To keep receiving benefits, participants must make contact (either through an in-person visit, phone call, or online) with their WIC program to receive the next set of benefits. In addition to the quarterly contact between a local agency and participants, participants with a yearlong certification must also receive a mid-year assessment to remain eligible for benefits. Quarterly visits, mid-year assessments, and re-certifications are points when participation often drops. More specifics around benefit utilization can be found in the Nutrition section.

The table below provides definitions for WIC terms related to Participation.

DEFINITIONS FOR WIC TERMS RELATED TO PARTICIPATION

TERM	DESCRIPTION
Affirmative Action Plan	Affirmative Action Plan means that portion of the State Plan which describes how the Program will be initiated and expanded within the State's jurisdiction in accordance with § 246.4(a).
Applicants	Pregnant women, breastfeeding women, postpartum women, infants, and children who are applying to receive WIC benefits, and the breastfed infants of applicant breastfeeding women. Applicants include individuals who are currently participating in the program but are re-applying because their certification period is about to expire.
Cash-Value Voucher	A fixed-dollar amount check, voucher, electronic benefit transfer (EBT) card or other document used by a participant to obtain authorized fruits and vegetables. Cash-value voucher is also known as cash-value benefit (CVB) in an EBT environment.
Categorical Eligibility	Persons who meet the definitions of pregnant women, breastfeeding women, postpartum women, or infants or children.
Certification	The implementation of criteria and procedures to assess and document each applicant's eligibility for the Program.
Electronic Benefit Transfer	Electronic Benefit Transfer (EBT) means a method that permits electronic access to WIC food benefits using a card or other access device approved by the Secretary.
Local Agency	(a) A public or private, nonprofit health or human service agency which provides health services, either directly or through contract, in accordance with §246.5; (b) an IHS service unit; (c) an Indian tribe, band or group recognized by the Department of the Interior which operates a health clinic or is provided health services by an IHS service unit; or (d) an intertribal council or group that is an authorized representative of Indian tribes, bands or groups recognized by the Department of the Interior, which operates a health clinic or is provided health services by an IHS service unit.
Participants	Pregnant women, breastfeeding women, postpartum women, infants and children who are receiving supplemental foods or food instruments or cash-value vouchers under the Program, and the breastfed infants of participant breastfeeding women.
Participation	The sum of: (1) The number of persons who received supplemental foods or food instruments during the reporting period; (2) The number of infants who did not receive supplemental foods or food instruments but whose breastfeeding mother received supplemental foods or food instruments during the report period; and (3) The number of breastfeeding women who did not receive supplemental foods or food instruments but whose infant received supplemental foods or food instruments during the report period.

Figure 19. Definitions for WIC Terms Related to Participation. CFR 2020

Most participants for both Montana and the United States were children aged 1–5 years during 2016 and 2018. Participation across all categories was similar for Montana and the United States during these years.

2018 WIC PARTICIPATION, MONTANA VS NATIONAL

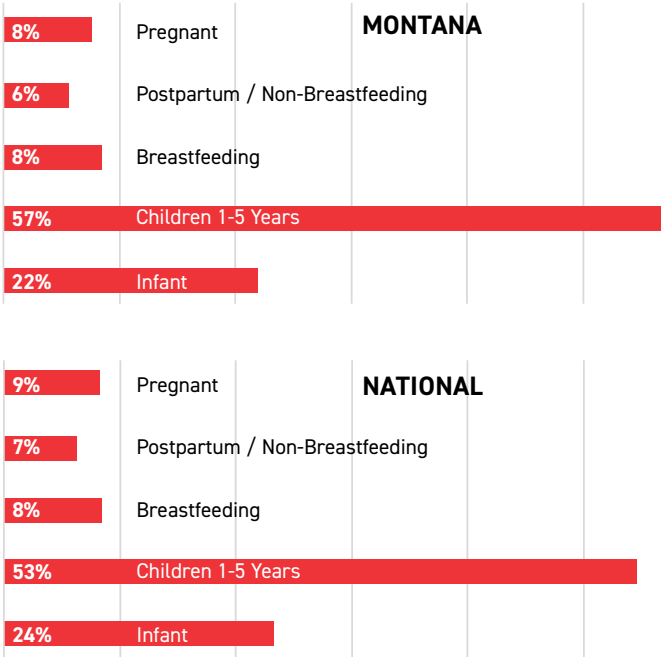


Figure 20: WIC Participation by Participant Category, Montana vs National, 2016 & 2018. USDA PC Data 2016 & 2018, USDA MT WIC Data 2016 & 2018

When looking at participation trends in the Montana WIC Program from 2016 to 2021, overall participation in the Montana WIC program decreased by 22%. The largest drop in participation was seen among women (pregnant, breastfeeding, and postpartum), with a 32.9% decrease from 2016 to 2021. Total children participants exhibited the smallest participation decrease: 13% from 2016 to 2021.

WIC PARTICIPATION TRENDS IN MONTANA 2016-2021

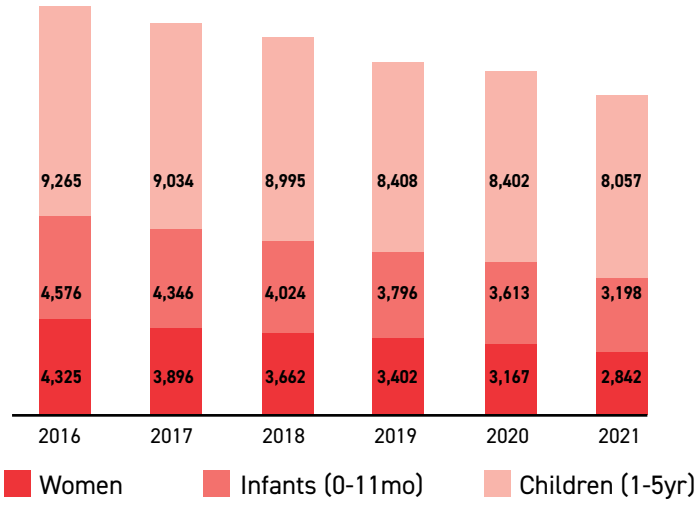


Figure 21: WIC Participation by Participation Category, Montana, 2016–2020. WIC Part Count 2016–2020

From 2016 to 2021, the total number of certified WIC participants has decreased 26.3%. Except for April 2019, when all certified participants were also actively participating in WIC services, the drop in total participation paralleled that of total participants, with participation decreasing about 22% over the six years. The total participants who were tentatively eligible for reinstatement remained relatively stable from 2016 to 2020. In 2021, likely due to COVID, the number of participants tentatively eligible for reinstatement increased, meaning more people lost their certifications for not participating.

- **Total Participation:** The actual participation count for the month, meaning that these participants received benefits.
- **Total Certified Participants:** The number of participants who were in an active certification during the month. This group did not necessarily participate during the month.
- **Total Participants Tentatively Eligible for Reinstatement:** These participants were terminated early (for "Non-participation (failed to pick up)") in their certification, but could theoretically be reinstated to receive more benefits, depending on their continued eligibility and interest. This number is not included in the "Total Certified Participants" count.

WIC PARTICIPATION BY CERTIFICATION, MONTANA, 2016–2021

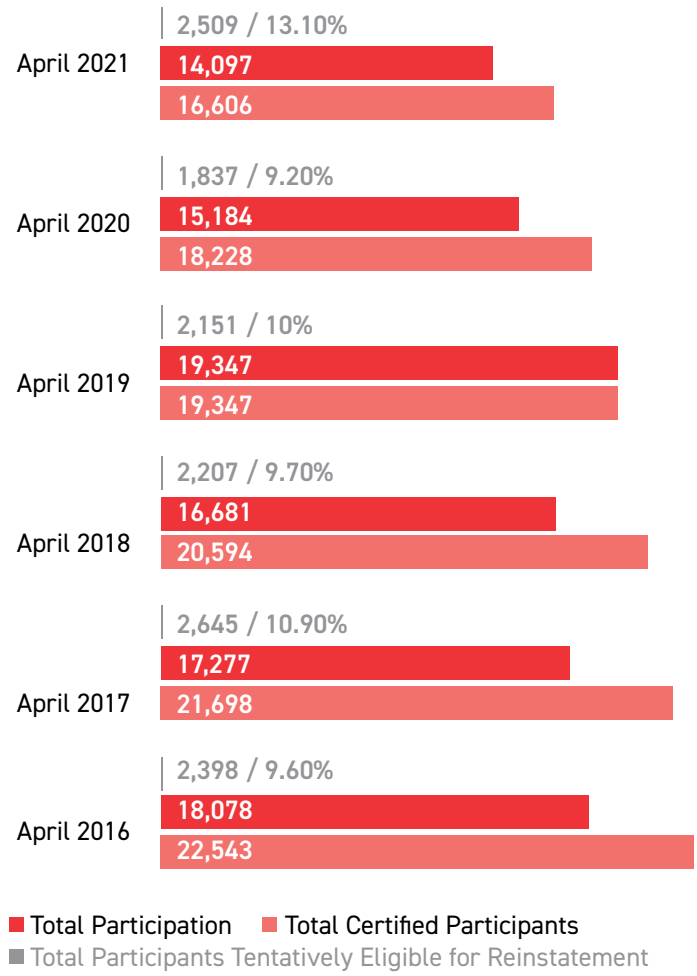


Figure 22: WIC Participation by Certification, Montana, 2016–2021. MT WIC M-SPIRIT Retention Data 2021

WIC participants are certified to receive benefits based on their eligibility assessment. Depending on the category, a certification period may last up to 12 months. However, participants are not issued benefits for the entire certification period at one time. The information below (Figure 24) shows the proportion of months that participants utilized benefits that were issued to them.

In 2020, the percentage of certification months utilized varied slightly from agency to agency, with Dawson at the low end of utilization (65.0%) and Crow at the high end (88.2%).

WIC CERTIFICATION MONTHS UTILIZED BY AGENCY - 2020

Agency	Number of Participants	Number of Benefit Months Used/Issued	Percent Certification Months Utilized
Beaverhead County Public Health	171	960/1,223	78.50%
Big Horn Health Department	607	2,871/3,967	72.40%
Blackfeet	791	3,931/5,947	66.10%
Butte-Silver Bow	865	4,346/6,013	72.30%
Cascade	1,694	7,935/10,127	78.40%
Crow	35	246/279	88.20%
Custer/One Health	382	2,107/2,821	74.40%
Dawson	182	858/1,319	65.00%
Deer Lodge	209	1,091/1,402	77.80%
Fergus/HRDC	275	1,492/1,833	81.40%
Flathead	1,538	7,302/9,435	77.40%
Fort Belknap	283	1,312/1,699	77.20%
Fort Peck	455	2,270/2,734	83.00%
Gallatin	1,252	5,594/7,852	71.20%
Hill	472	2,392/3,186	75.10%
Lake	453	2,342/3,070	76.30%
Lewis & Clark	1,153	5,148/7,258	70.90%
Lincoln	421	2,136/3,021	70.70%
Missoula	2,124	10,253/14,157	72.40%
Northern Cheyenne	596	2,611/3,935	66.40%
Park County Health Department	197	861/1,219	70.60%
Ravalli	556	2,743/3,833	71.60%
Riverstone	4,114	20,748/28,524	72.70%
Rocky Boy	260	1,308/1,942	67.40%
Salish & Kootenai	419	1,936/2,677	72.30%
Sanders	225	1,164/1,476	78.90%
Sheridan	321	1,544/2,098	73.60%
Teton	507	2,559/3,439	74.40%
Frances Mahone Deaconess Hospital/Valley	211	1,245/1,544	80.60%

Figure 23: WIC Certification Months Utilized out of Total Months Certified by WIC Agency, Montana, 2020. MT WIC M-SPIRIT Benefit Package Data 2021

The COVID-19 pandemic heavily impacted participation in the Montana WIC Program in 2020. Though sites made every effort to see participants virtually, many of the local agencies experienced chronic staffing shortages throughout the year, and nearly every aspect of American life was affected.

In 2019, nearly 11% fewer Montana infants were certified in the Montana WIC Program than in 2011, resulting in a drop in participation of nearly 22% during the same timeframe. The percentage of infants certified in the Montana WIC Program was reached by comparing the total infants (0–11 months) enrolled in Montana WIC Program each year to the number of births in Montana in the same year. This allows the Montana WIC Program to estimate the percent of Montana infants who received WIC services each year.

AVERAGE CERTIFICATION UTILIZED OUT OF TOTAL MONTHS ELIGIBLE, 2018–2020

2018	2019	2020
92%	90%	73%

Figure 24: Percentage of Average Montana WIC Certification Utilized out of Total Months Eligible, 2018–2020. MT WICM-SPIRIT Benefit Package Data 2021

According to matched WIC and Census data from 2014–2018, there was a continual decrease in the percentage of infants and children in Montana eligible for WIC, with 54% of children being presumed eligible in 2014 and 48% in 2018. Similarly, during this same time, participation among eligible children decreased from 64% in 2014 to 56% in 2018. Nearly half of the eligible infants and children were not participating in WIC.

INFANTS CERTIFIED IN MT WIC BY TOTAL BIRTHS 2011–2019

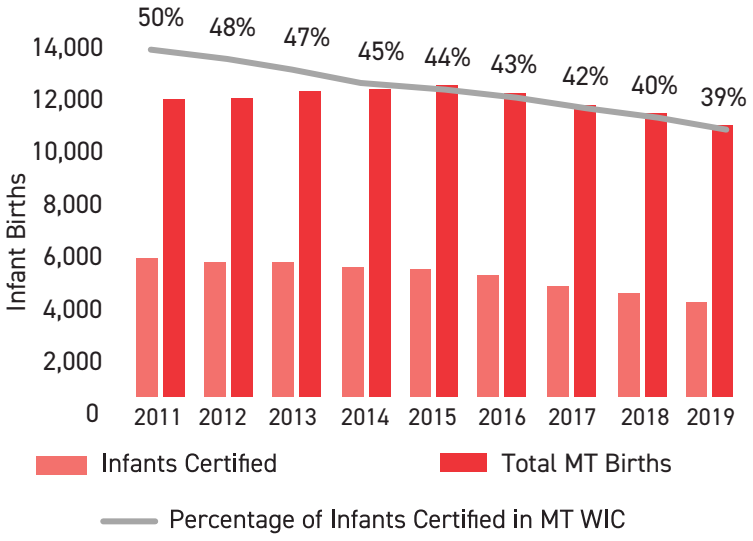


Figure 25: Infants Certified in MT WIC by Total Births, Montana, 2011–2019. MT Vital Stat 2019, MT WIC Certified Infants Data 2021

In 2018, 48% of infants and children in Montana were eligible for WIC services. Of that 48% who were eligible, only 56% participated in the WIC Program. In 2018, more than half of the children in 22 of the 56 counties in Montana were eligible for WIC. Of the ten counties with the highest eligibility rates, eight geographically overlapped with Tribal communities. The county with the highest eligibility rate, Liberty County, at 89%, did not serve a Tribal community. There were 17 counties that overlapped with Montana's federally recognized tribes, but Tribal WIC Programs served only 11 of those counties. The Little Shell Tribe did not have a Tribal WIC program, but was served by the Cascade County WIC, for a total of 12 counties serving high Native populations.

The average eligibility rate amongst the 12 specific Native-serving counties was 82%. The highest eligibility rate was 85% in Blaine County, which overlaps with Fort Belknap Nation.

Many of the counties that covered Tribal Nations had the highest participation rates amongst eligible participants across Montana. Of the ten counties with the highest participation rates, seven served Native communities. The highest participation rate of any county in Montana was 95% in Glacier County, which overlapped with Blackfeet Nation. Overall, Tribal WIC Programs served more of their eligible population than other WIC Programs in Montana.

INFANT AND CHILD POPULATION ELIGIBLE FOR WIC

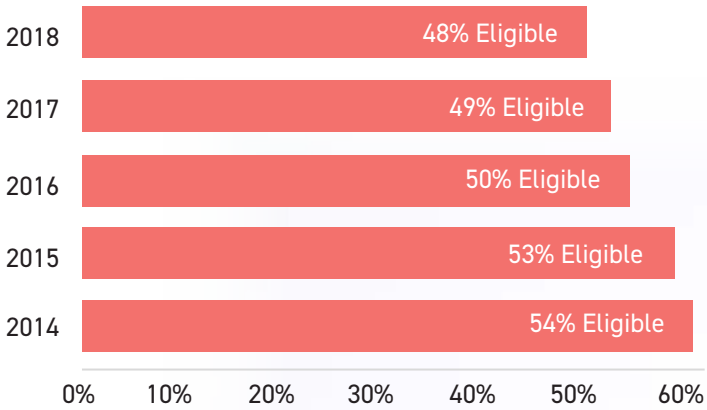


Figure 26: WIC Eligibility and Participation Among Infants and Children, Montana, 2016–2018.
WIC MT Elg Census 2013–2018

2018 ELIGIBILITY AND PARTICIPATION AMONG INFANTS AND CHILDREN, BY COUNTY

	Eligible	Participation of Eligible
State Total	**48.00%**	**55.50%**
Beaverhead	49.60%	--
Big Horn	81.80%	74.30%
Blaine	84.90%	74.70%
Broadwater	70.80%	--
Carbon	44.10%	--
Carter	--	--
Cascade	53.80%	60.00%
Chouteau	71.70%	61.00%
Custer	44.10%	61.40%
Daniels	--	--
Dawson	43.40%	62.90%
Deer Lodge	60.80%	58.60%
Fallon	53.60%	--
Fergus	62.80%	49.60%
Flathead	52.50%	40.30%
Gallatin	32.60%	51.50%
Garfield	--	--
Glacier	72.00%	95.10%
Golden Valley	--	--
Granite	57.10%	--
Hill	61.30%	70.30%
Jefferson	32.00%	--
Judith Basin	--	--
Lake	74.30%	61.10%
Lewis and Clark	45.00%	58.00%
Liberty	89.10%	--
Lincoln	65.60%	67.90%
Madison	45.00%	35.60%
McCone	--	--
Meagher	--	--
Mineral	--	--
Missoula	43.90%	60.90%
Musselshell	50.50%	--
Park	39.10%	60.60%
Petroleum	--	--
Phillips	27.80%	--
Pondera	76.40%	77.70%
Powder River	--	--
Powell	49.10%	--
Prairie	--	--
Ravalli	61.60%	47.10%
Richland	32.60%	--
Roosevelt	79.90%	80.80%
Rosebud	66.00%	93.90%
Sanders	60.70%	58.90%
Sheridan	44.20%	--
Silver Bow	55.20%	64.80%
Stillwater	31.30%	--
Sweet Grass	31.50%	--
Teton	38.50%	45.00%
Toole	57.70%	--
Treasure	--	--
Valley	33.60%	--
Wheatland	--	--
Wibaux	--	--
Yellowstone	47.00%	61.40%

Figure 27: WIC Eligibility and Participation of Eligible, Among Infants and Children, by County, Montana, 2018. WIC MT Elg Census 2013–2018

In 2018, of all infants and children in Montana who were identified as Non-Hispanic American Indian or Alaska Native Alone, 88.6% were eligible for WIC, and 85.0% of those who were eligible participated.

This reflects the highest eligibility and highest participation among the racial categories listed. From 2016 to 2018, participation of those eligible increased in every racial category, except among Non-Hispanic White Alone, which decreased in participation by almost 10% during this time. During the same time, participation dropped in both urban and rural settings, along with a decrease in eligibility among those in rural areas.

TOP PARTICIPATING GROUPS WITH ELIGIBILITY OF ALL MONTANA INFANTS AND CHILDREN

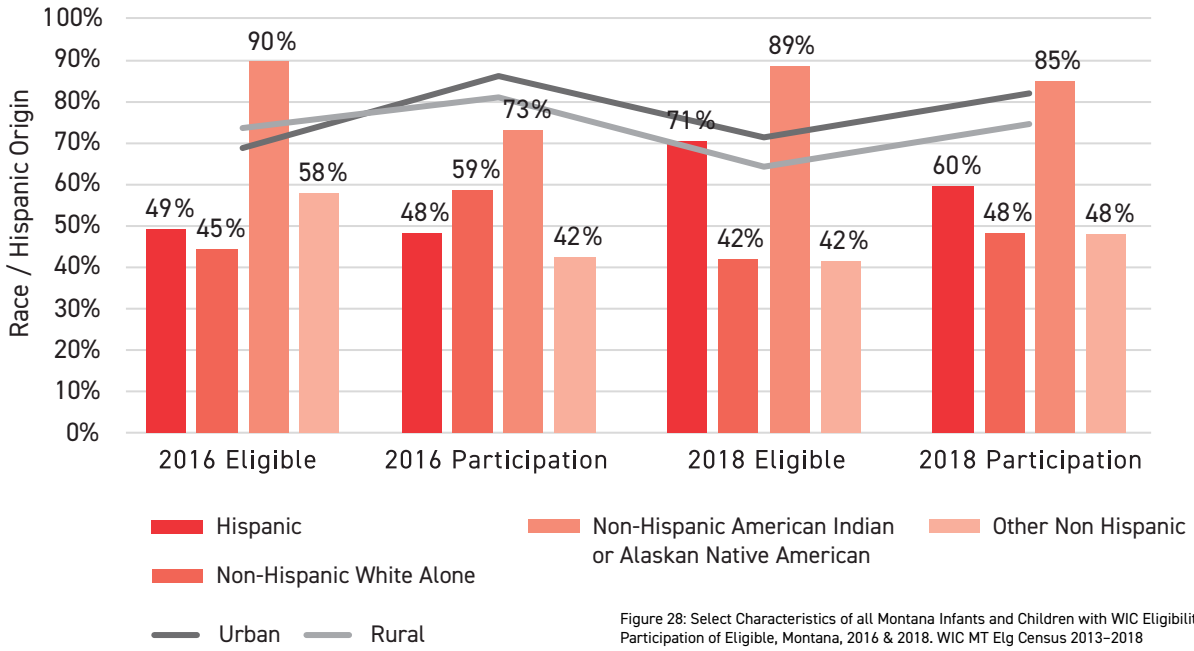


Figure 28: Select Characteristics of all Montana Infants and Children with WIC Eligibility and Participation of Eligible, Montana, 2016 & 2018. WIC MT Elg Census 2013–2018

These percentages are based on a population sample rather than the entire state of Montana. For the state of Montana, the "Non-Hispanic Black alone" and "Non-Hispanic Asian alone" populations had data that did not meet these requirements for all years reported and are not included in this analysis.

In 2016 and 2018, when stratified by marital status, the infants and children whose parents were never married had the highest eligibility rate for WIC.

When stratified by education level, those infants and children whose parents had less than a high school education had the highest rate of eligibility and had the highest participation rates when compared to higher educational attainment. As education increased, both eligibility and participation decreased. Despite this, nearly a quarter of people with a bachelor's degree or higher were eligible for WIC in Montana.

When stratified by employment status, more than half of the infants and children whose parents were not in the labor force were eligible for WIC, while less than half of those whose parents were in the labor force were eligible. There was more participation among those whose parents were not in the labor force than among those whose parents were in the labor force.

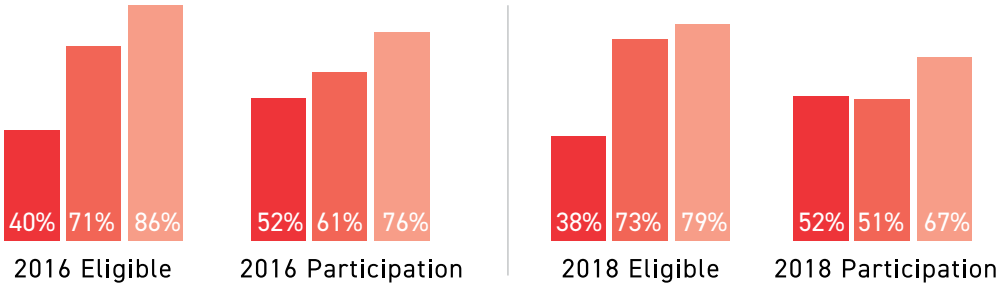
The percent of infants and children in Montana whose parents had a disability and were eligible for WIC fell between 2016 and 2018, as did participation. As of 2018, participation rates among infants and children whose parents had a disability were the same as those whose parents did not have a disability.

While many more infants and children whose parents were enrolled in Medicaid were eligible for WIC in 2016 and 2018, they participated at a similar rate to those whose parents had other insurance.

PARENTAL CHARACTERISTICS OF WIC PARTICIPANTS AND ELIGIBILITY FOR MONTANA 2016–2018

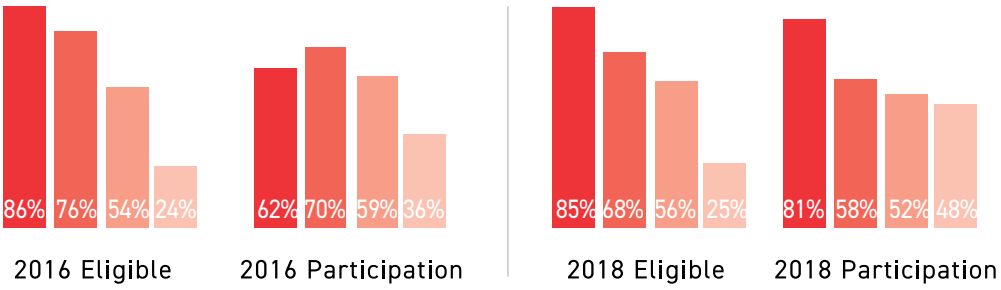
MARITAL STATUS

- Married
- Widowed, Divorced, Separated
- Never Married



EDUCATION

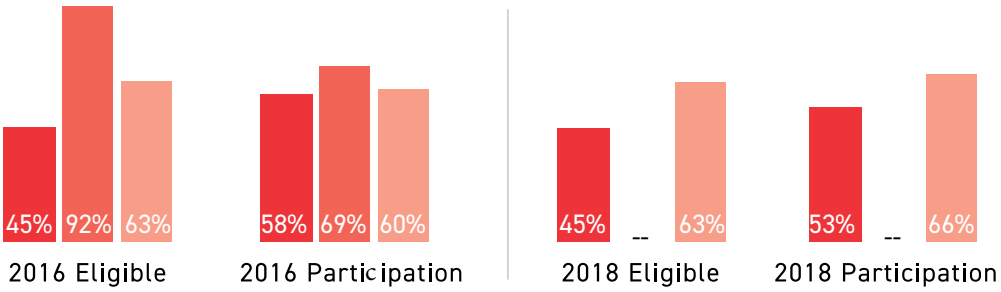
- Less than a High School Diploma
- High School Diploma
- Some College
- Bachelor Degree or Higher



EMPLOYMENT STATUS

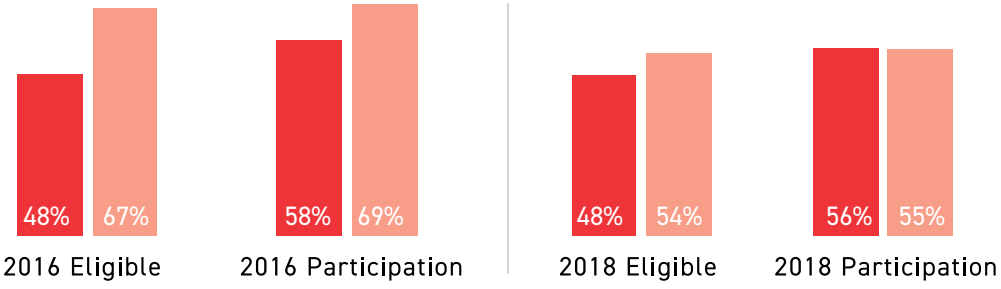
- Employed
- Unemployed
- Not in Labor Force

--Denotes data that does not meet Census Bureau Disclosure Review Board Requirements



DISABILITY STATUS

- No Disability
- Parent with Disability



MEDICAL INSURANCE STATUS

- Other Insurance
- Medicaid or Other Means Tested

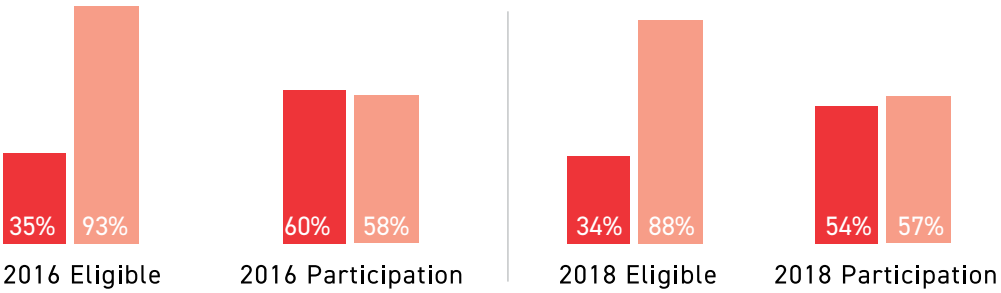


Figure 29: Parental Characteristics of WIC Infants and Children Participants and Eligibility for Montana 2016–2018. WIC MT Elg Census 2013–2018

Among WIC participants surveyed in 2019 and 2020, the most common length of participation was more than three years, while just under a third participated for less than a year.

WIC LENGTH OF PARTICIPATION

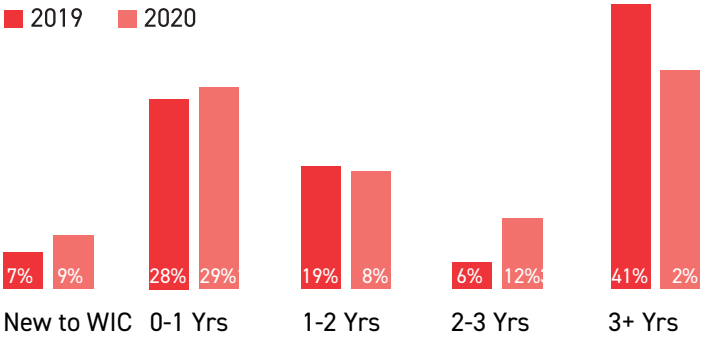


Figure 30: Longevity of Participation Among WIC Participant Satisfaction Survey Respondents, Montana, 2019 & 2020. MT Participant Satisfaction Survey 2020

From 2017 through 2019, most women entering WIC during pregnancy entered during their second trimester.

RELATIONSHIP OF INFANT OR CHILD TO WIC PRIMARY AUTHORIZED REPRESENTATIVE

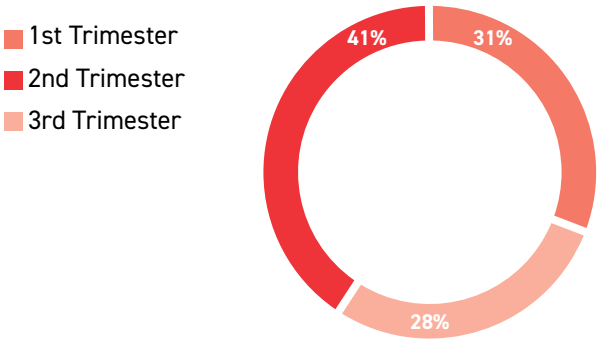
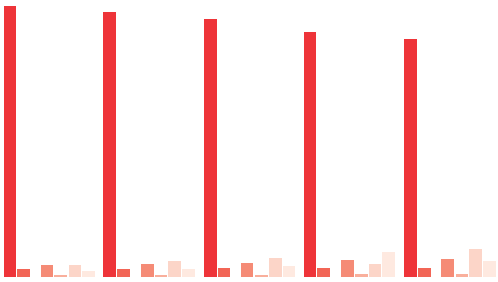


Figure 32: Pregnancy Trimester Women Enter WIC, Montana, 2017–2019. MT Preg Entry 2017–2019

Across the five-year span from 2016 to 2020, mothers made up most primary authorized representative relationships to infants or children. However, mothers as the primary authorized representative for infants and children declined by 10.8% between 2016 and 2020. Simultaneously, the percentage of infants and children with foster parents as their primary authorized representative more than doubled. Further investigation should be made into why there is an increasing percentage of primary authorized representatives that are foster parents and what additional supports might be needed for these families.

RELATIONSHIP OF INFANT OR CHILD TO WIC PRIMARY AUTHORIZED REPRESENTATIVE



	2016	2017	2018	2019	2020
Mother	87%	85%	83%	79%	76%
Father	3%	3%	3%	3%	3%
Step-parent	0%	0%	0%	0%	0%
Grandparent	4%	4%	4%	5%	6%
Aunt/Uncle	1%	1%	1%	1%	1%
Foster Parent	4%	5%	6%	4%	9%
Other	2%	2%	3%	8%	5%

Figure 31: Relationship of Infant or Child to WIC Primary Authorized Representative, Montana, 2016–2020. MT WIC M-SPIRIT Participant Authorization Data 2021

Between 2017–2019, women began participation in WIC, usually in the second trimester of their pregnancy. Overall, White women engaged in WIC services earlier in their pregnancy than American Indian/Alaskan Native women or women identifying as another race. The bar graph below represent the percent of women, by race, entering WIC, by trimester.

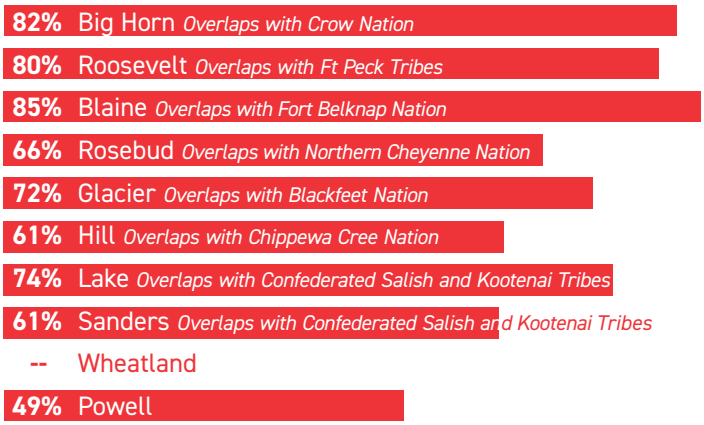
Figure 33: Pregnancy Trimester Women Enter WIC by Race, Montana, 2017–2019. MT Preg Entry 2017–2019

"NOT ONLY DOES WIC PROVIDE FORMULA FOR ME MONTHLY BUT THEY OFFER GREAT SERVICES FOR THOSE WHO NEED MORE [THAN] JUST HELP WITH FOOD AND FORMULA."

- WIC PARTICIPANT

In 2018, Montana's WIC Affirmative Action Plan ranked counties based on six maternal and child health metrics. This plan was used to determine where additional WIC support may have been needed. The ten counties included in the graph below are those with the top need according to the Affirmative Action plan ranking and are compared to the percentage of their county's infants and children that are eligible for WIC benefits. The top eight counties with the highest need overlapped with Tribal Nations. These areas had high eligibility rates, usually over 50%, but also had high participation rates amongst eligible infants and children.

MATERNAL AND CHILD HEALTH NEED, RANKED, AND PERCENT ELIGIBLE FOR WIC, BY COUNTY, MONTANA, 2018



These percentages are based on a population sample rather than the entire state of Montana.
--Denotes data that does not meet Census Bureau Disclosure Review Board Requirements

Figure 34: Maternal and Child Health Need, Ranked, and Percent Eligible for WIC, by County, Montana, 2018. MT Affirm Action 2014–2018, WIC MT Elg Census 2013–2018

As perceived by WIC staff, the most common barrier to participation in WIC was the time required of participants to take off work or school or other commitments. This was followed by transportation barriers and the perception that WIC participants may not find enough value or interest in the nutrition education services provided. Providing documentation to prove eligibility was ranked the lowest of the barriers. Some of the responses provided as "Other" barriers to participation included: participants getting enough SNAP or other benefits that they do not feel the need to also participate in WIC; lack of phone access; and limitations in food package benefits.

BARRIERS AMONG PARTICIPANTS AS REPORTED BY WIC STAFF, MONTANA, 2021

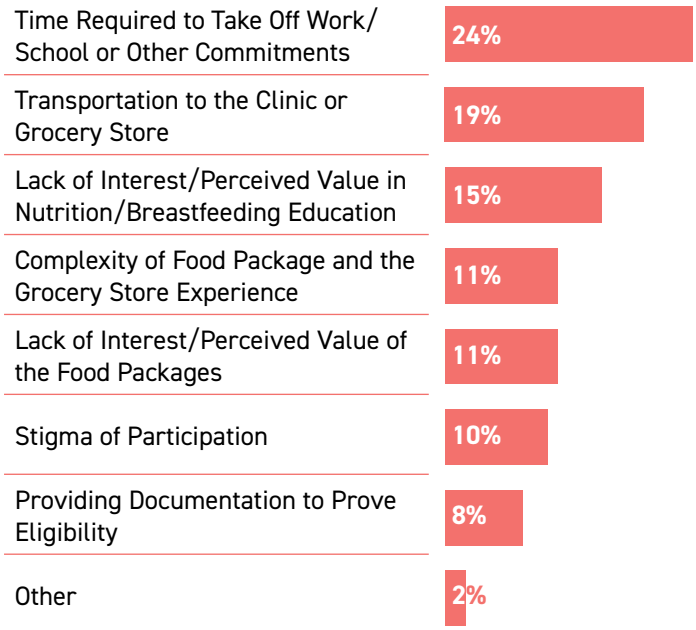


Figure 35: Barriers to Participation Among Participants as Reported by WIC Staff, Montana, 2021. MT WIC Needs Assessment Survey 2021

PERINATAL HEALTH INDICATORS

Through the process of assessing pregnant and postpartum women, infants, and children as part of certification in the Montana WIC Program, the WIC staff are provided an important window into the health needs of some of the State's more vulnerable citizens. Understanding the existing health disparities and risks of this population can inform the types of screenings, referrals, and support provided to participants. This section reviews health indicators including overall and teen birth rates, birth types, preterm and low birthweight births, the trimester at which prenatal care was initiated, and perinatal mood disorders.

Health disparities between Montana WIC participants and other state and national populations are seen in the critical areas of the teen birth rate of Montana WIC participants, which was three to four times higher than the state and national rates in 2016 and 2018, as well as higher rates of low birthweight births than the state and national rates in the same time periods.

In 2017, the Montana WIC Program began training staff and implementing the Patient Health Questionnaire (PHQ)-2, which asks two questions to screen for whether a person has experienced a depressed mood over the past two weeks, which may warrant further assessment and follow-up care. By 2018, all women being certified in any category were asked the PHQ-2 questions at the time of certification, including at mid-certification for breastfeeding women. Over the three-year period from 2018 to 2020, more than a quarter of women screened positive for potential depression at least once. During the same time, a similar version of the PHQ-2 was being asked of women across the state through the PRAMS. Though the questions were asked slightly differently in the two settings, a higher number of women (27%) screened positive when screened by WIC from 2018–2020, while fewer women (14.6%) screened positive when screened by PRAMS from 2017–2018.

The crude birth rate in Montana was consistently lower than that of the national crude birth rate from 2016 through 2018. During this time, both the crude birth rate of Montana and the United States declined.

CRUDE BIRTH RATE PER 1,000 PEOPLE

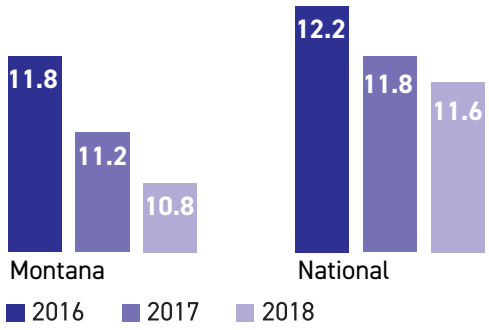


Figure 36: Crude Birth Rates Per 1,000 Person Population for Montana vs. National for 2016–2018. MT Vital Stat 2016–2018, CDC Vital Stat 2019

For every 1,000 women on Montana WIC who gave birth in 2018, 73.8 births were to women between 15 and 19 years old. Montana and national teen birth rates were relatively similar, with both experiencing a decline in teen births between 2016 and 2018.

TEEN BIRTH RATE PER 1,000 PEOPLE

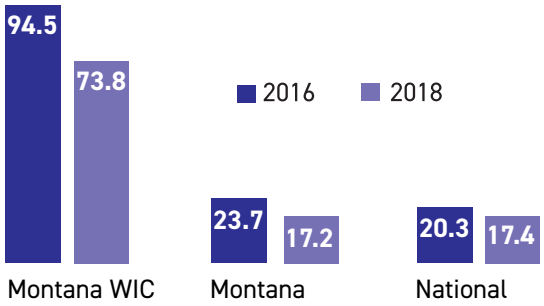


Figure 37: Teen Birth Rate Per 1,000 Births, Montana vs. National, 2016 & 2018.
CDC State Teen Birth Rate 2016 & 2018, CDC Vital Stat 2019, MT WIC Vital Stats—Teen Birth Data 2021

For WIC participants in Montana and Montana as a whole, the percentage of births by Cesarean section is lower than the national average, leading to a higher percentage of vaginal births for women in Montana overall and for those participating in WIC.

TEEN BIRTH RATE PER 1,000 PEOPLE

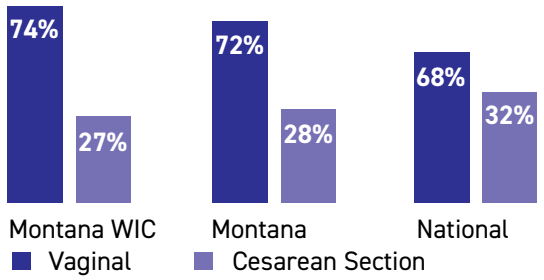


Figure 38: Type of Birth, Montana WIC vs Montana vs. National, 2018. CDC Vital Stat 2019, CDC State Birth Delivery Method 2018 , MT WIC Vital Stats—Birth Method Data 2021

In 2018 and 2019, the proportion of early preterm births among Montana WIC women was similar to the proportion in all of Montana and the US. The percentage of preterm births in 2018 and 2019 among Montana WIC participants was the same as the rest of the state of Montana, but marginally less than the national percentage of preterm births.

2018–2019 PRETERM BIRTHS

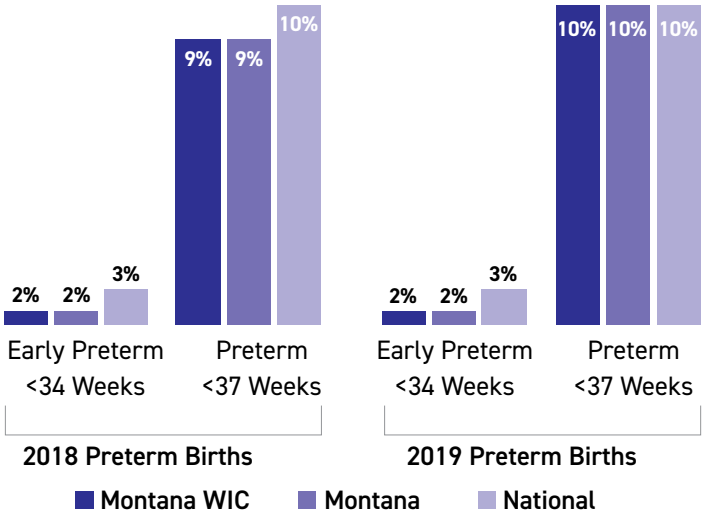


Figure 39: Preterm Births, Montana WIC vs. Montana vs. National, 2018 & 2019.
CDC Vital Stat 2018 & 2019, CDC NCHS Births 2019, MT WIC Vital Stats—Preterm Birth Data 2021

The percentage of infants with low birth weights born to Montana WIC participants was higher than that of all Montana and national births. Between 2016 and 2018, the percentage of low birthweight births among Montana WIC participants increased by 0.5%, while it decreased by 0.5% for Montana

2016–2018 LOW BIRTH WEIGHTS PER 1,000 BIRTHS

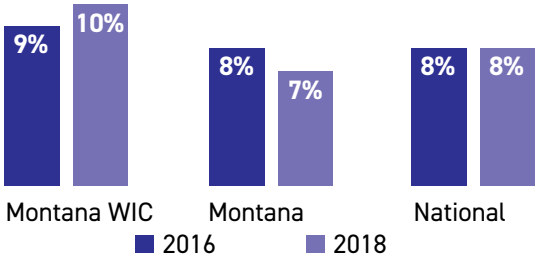


Figure 40: Low Birth Weights Rate Per 1,000 Births, Montana WIC vs. Montana vs. National, 2016 & 2018.
CDC State Low Birthweight Rate 2014–2018, CDC Vital Stat 2018, MTLBWPR 2016–2018

In 2017, the Montana WIC Program began using the PHQ-2 screening with all women at certification and recertification as their participation category changes (prenatal, breastfeeding, postpartum). Due to this, women are often screened multiple times throughout their participation. If a participant screens positive on the PHQ-2, she is referred to a PCP or behavioral health professional for further follow-up.

Over the three-year period from 2018 to 2020 (2017 results having not been included, as screening was implemented late in the year), over a quarter of women screened positive for potential depression at least once. Average rates of positive screenings over the three-year period were similar between prenatal, breastfeeding, and postpartum women, with breastfeeding women screening positive slightly less than prenatal or postpartum women.

In PRAMS PHQ-2 data from 2017–2018 combined (MT WIC Prams PHQ-2 Survey Data 2021), 14.6% of women indicated that they may be at risk for depression. The PRAMS PHQ-2 questions were phrased slightly differently and cover a different period of time than when asked in WIC clinics, so a direct comparison should not be made. The general comparison can still provide some preliminary insight into the mental health of all postpartum women in Montana and the women participating in the Montana WIC Program.

WIC MATERNAL PHQ-2 SCREENING RESULTS, MONTANA, 2018–2020

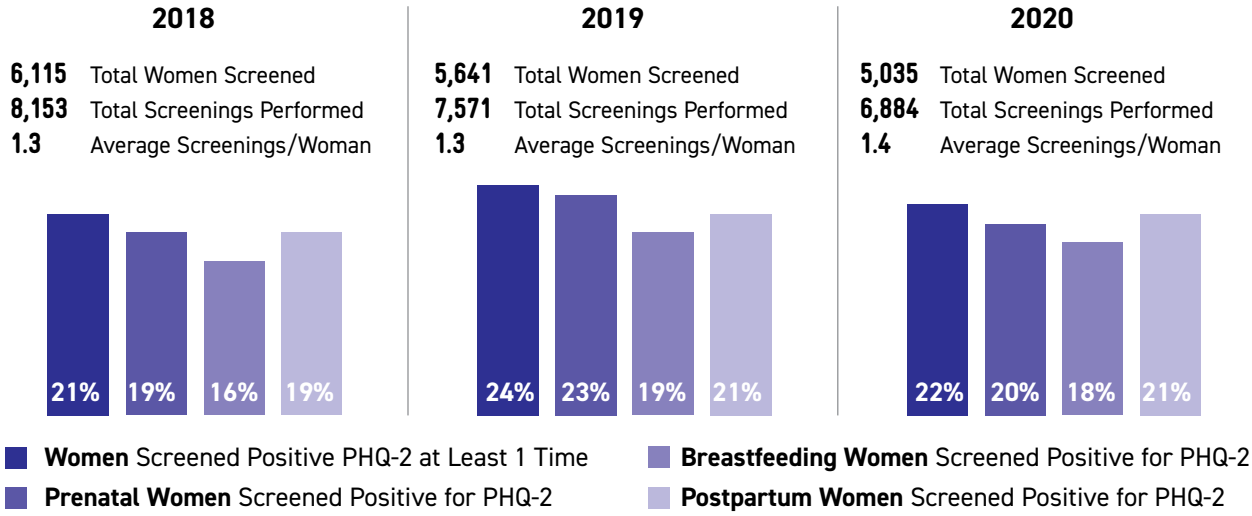


Figure 41: WIC Maternal PHQ-2 Screening Results, Montana, 2018–2020. MT WIC M-SPIRIT PHQ-2 Data 2021

BREASTFEEDING

Breastfeeding support is a top priority for WIC programs across the nation, and the Montana WIC Program is no exception. In this section of the Needs Assessment, data and background information is provided about Breastfeeding Health Indicators and Breastfeeding Services.

- Breastfeeding Health Indicators: Provides information about breastfeeding initiation and duration, over time periods, by race, by local agency, and by local agency size. This section also includes information from the Montana WIC program and Montana PRAMS about when and why breastfeeding was discontinued among participants.
- Breastfeeding Services: At the center of the WIC Program are the services provided to participants to improve breastfeeding. This section looks at the various ways that Montana WIC promotes and supports breastfeeding among participants.

When looking at the larger breastfeeding landscape and considering how breastfeeding health indicators and services may play off one another, there are two areas that stand out. These two areas relate to how a lack of breastfeeding peer counselor services offered in clinics serving Native people may be affecting the breastfeeding rates among Native people across the Montana WIC Program. Though this may be a correlation and not causation, it is important to note the disparity in this service provision to Native communities and the inequity in breastfeeding rates among this population. Similarly, breastfeeding rates are lower among small local agencies and increase among medium and large agencies. There are also fewer breastfeeding peer counselor services among small local agencies. More information could be gathered around the extent to which breastfeeding support services and staff highly knowledgeable in breastfeeding are available and effective in smaller agencies and those agencies serving primarily Native people.

BREASTFEEDING HEALTH INDICATORS

Breastfeeding data has been looked at in several different ways in this section to better understand the breastfeeding patterns of Montana WIC participants. Of significant note are the various ways that breastfeeding is measured throughout this section.

- **Breastfeeding Initiation:** This refers to the provision of any breast milk to an infant either by breastfeeding or through breast milk expression, then spoon, cup, or bottle.
- **Exclusive Breastfeeding:** This term is used to indicate that the infant is receiving no food or drink other than breast milk. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the first six months of life. This definition is primarily used in this Needs Assessment when reviewing CDC data.
- **Any Breastfeeding & Partially Breastfed:** This refers to infants who are breastfed at least once a day and receive infant formula from the WIC Program. The Montana WIC Program uses "Any Breastfeeding" and "Partially Breastfed" is a USDA definition. Both are used in the same ways and only when looking at data derived from WIC Program sources.
- **Fully Breastfeeding:** This refers to infants of participating breastfeeding women who do not receive infant formula from the WIC Program. This is a USDA definition and is used when looking at data derived from WIC Program sources. A fully breastfeeding distinction does not necessarily mean that the woman/infant dyad is exclusively breastfeeding.
- **Fully Formula-Fed Infants:** This refers to infants who are not fully or partially breastfed and receive infant formula from the WIC Program. This is a USDA definition and is used when looking at data derived from WIC Program sources. This does not necessarily mean that a woman/infant dyad is not breastfeeding.

Between 2013 and 2017, breastfeeding initiation in Montana overall decreased from 86% to 78%, and the duration of breastfeeding at 3 months fell from 61% to 55% for Montanans overall (CDC Breastfeeding Report Card 2016 & 2018 & 2020). Among Montana WIC participants specifically, initiation rates have remained steady between 2016 and 2018, at about 78%. During the same time, the rate of breastfeeding duration to 3 months increased from 27% to 34% among Montana WIC participants. However, the percentage of Montana WIC participants with breastfeeding durations of 6 months and 12 months decreased between 2016 and 2018. The percentage of participants who receive a Fully Breastfeeding Package followed a similar trend, with the rate of those who breastfed up to 3 months increasing, and participants with the duration of 6 months and 12 months declining.

Data in this section also begins to show how breastfeeding disparities present among racial categories, with White women in the Montana WIC Program initiating breastfeeding at considerably higher rates than their Native American counterparts.

Finally, there are frequently identified reasons for which breastfeeding is ended among Montana WIC participants and mothers across Montana in this section. This information may provide direction to the areas necessary to increase breastfeeding education and support among agency staff and participants.

Rates of breastfeeding initiation and exclusive breastfeeding at 3 months in Montana decreased between 2013 and 2017. Nationally, breastfeeding initiation and exclusivity at both 3 and 6 months increased throughout this time.

BREASTFEEDING INITIATION AND EXCLUSIVITY AT 3 AND 6 MONTHS, MONTANA VS NATIONAL, 2013–2017

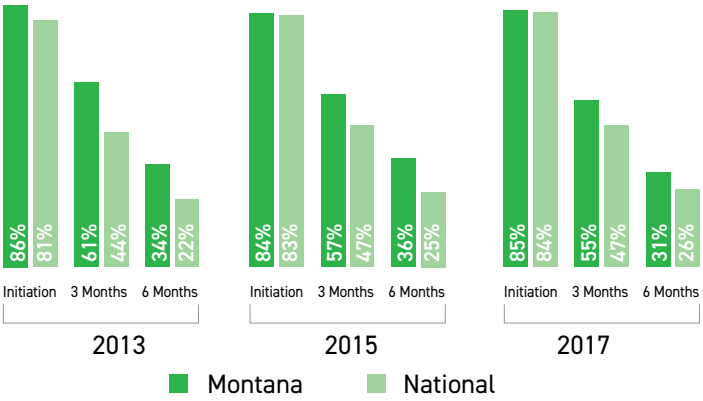


Figure 42: Breastfeeding Initiation and Exclusivity at 3 and 6 Months, Montana vs. National, 2013–2017. CDC Breastfeeding Report Card 2016 & 2018 & 2020

Rates of any breastfeeding increased or remained steady at initiation and 3 months infant age between 2016 and 2018. By contrast, the rate of any breastfeeding decreased for infants aged 6 and 12 months during the period.

WIC BREASTFEEDING INITIATION AND ANY BREASTFEEDING, MONTANA, 2016–2018

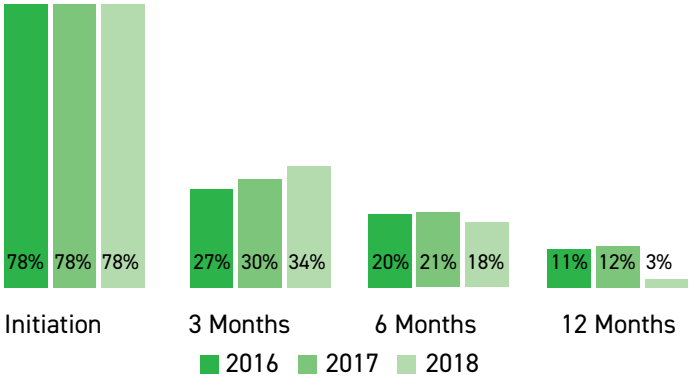


Figure 44: WIC Breastfeeding Initiation and Any Breastfeeding at 3, 6, and 12 Months, Montana, 2016–2018. MT WIC BSFD Report 2020

In Montana, women participating in WIC received full breastfeeding packages at a consistently higher rate from 2016 to 2019 than women in WIC across the nation. However, when comparing total breastfed and fully formula-fed rates, there was little distinction between Montana and the US.

BREASTFEEDING PRACTICES AMONG WIC PARTICIPANTS

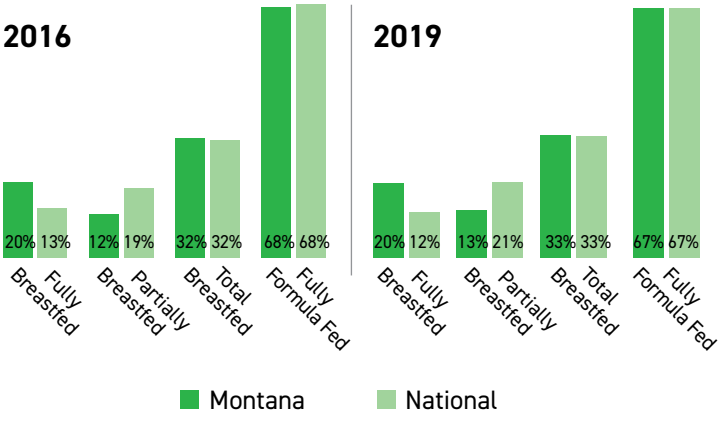


Figure 43: Breastfeeding Practices Among WIC Participants, Montana vs National, 2016–2019. USDA Breastfeeding Local Agency Report 2016 & 2019

More women were provided with a Fully Breastfeeding WIC package at 3 months postpartum in 2018 than in 2016. Though there was an increase from 2016 to 2017, less women with infants aged 6 and 12 months received a Fully Breastfeeding WIC package in 2018 than in 2016.

PARTICIPANTS RECIEVING A FULLY BREASTFEEDING WIC PACKAGE , MONTANA, 2016–2018

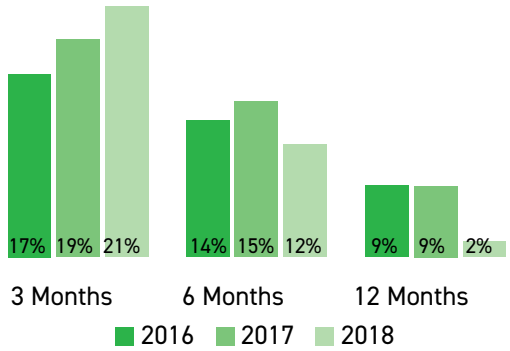


Figure 45: Participants Receiving a Fully Breastfeeding WIC Package by Infant Age, Montana, 2016–2018. MT WIC BSFD Report 2020

When breastfeeding data were aggregated across agencies by size from 2017–2019, large agencies in Montana had higher breastfeeding initiation rates and continued breastfeeding duration at 3 and 6 months compared to small and medium-sized agency categories.

BREASTFEEDING INITIATION AND ANY BREASTFEEDING BY WIC AGENCY SIZE MONTANA, 2017–2019

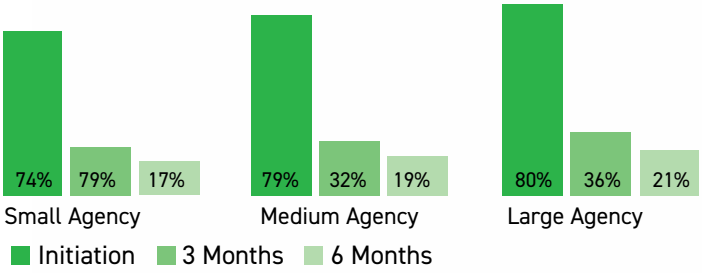


Figure 46: Breastfeeding Initiation and Any Breastfeeding at 3 and 6 Months by WIC Agency Size, Montana, 2017–2019. MT WIC BSFD Data 2017–2019

"BREASTFEEDING MATERIAL HAS DEFINITELY BEEN THE MOST HELPFUL."

-WIC PARTICIPANT

The ten local agencies with the highest breastfeeding initiation rates had rates of 87% and above. Of these ten, two served Native communities (Big Horn, Salish & Kootenai), and three were large agencies (Missoula, Flathead, Gallatin).

The ten local agencies with the highest rates of any breastfeeding at 3 months include three that serve Native communities (Northern Cheyenne, Lake, Salish & Kootenai) and the same three large agencies that had the highest breastfeeding initiation rates.

The ten local agencies with the highest rates of any breastfeeding at 6 months include two serving Native communities (Lake and Northern Cheyenne) and the same three large agencies that had the highest initiation and any breastfeeding rates at 3 months.

BREASTFEEDING INITIATION AND ANY BREASTFEEDING AT 3 AND 6 MONTHS BY LOCAL AGENCY, MONTANA, 2019	Initiation	3 Months	6 Months
Anaconda-Deer Lodge County Public Health Department*	78%	27%	16%
Beaverhead County Public Health Department*	100%	46%	29%
Big Horn Health Department*	92%	33%	8%
Blackfeet Tribal Health	72%	18%	12%
Butte-Silver Bow Health Department*	72%	24%	14%
Cascade County Health Department*	78%	34%	15%
Crow Tribe Health Department	81%	25%	16%
Dawson County Public Health	50%	11%	4%
District 6 Human Resource Development Council (HRDC)	91%	36%	27%
Flathead City-County Health Department*	87%	42%	22%
Fort Belknap Tribal Health Department	74%	19%	9%
Fort Peck Tribal Health Department	56%	14%	8%
Gallatin County Public Health Department*	87%	42%	25%
Hill County Health Department	74%	26%	13%
Lake County Health Department	84%	43%	26%
Lewis & Clark Public Health Department*	78%	32%	19%
Missoula County Health Department*	88%	46%	26%
Northwest Community Health Center	93%	28%	14%
Northern Cheyenne Tribal Board of Health	83%	44%	31%
OneHealth/Custer County Health Department*	85%	39%	21%
Park County Health Department*	93%	55%	38%
Ravalli County Public Health Department*	96%	53%	36%
RiverStone Health*	73%	34%	18%
Rocky Boy Health Center	55%	12%	5%
Salish & Kootenai Tribal Health**	88%	39%	12%
Sanders County Health Department*	83%	31%	28%
Sheridan County Health Department	81%	25%	19%
Teton County Health Department*	81%	39%	18%
Frances Mahone Deaconess Hospital/Valley	65%	29%	19%

**Local agency has a BPCP; **local agency is served by another local agency's BPCP.*

Figure 47: Breastfeeding Initiation and Any Breastfeeding at 3 and 6 Months by local agency, Montana, 2019. MT WIC BSFD Data 2017–2019

Between 2017 and 2019, there was some improvement in racial equity for breastfeeding initiation. As of 2019, there was still a gap of 14% in breastfeeding initiation between White and American Indian/Alaskan Native women participating in WIC.

BREASTFEEDING INITIATION AMONG WIC PARTICIPANTS BY RACE, MONTANA, 2017–2019

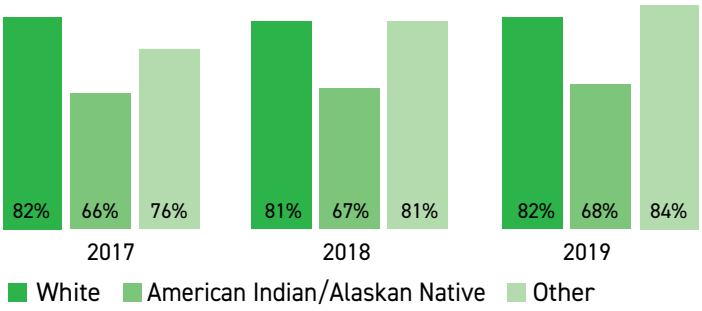


Figure 48: Breastfeeding Initiation Among WIC Participants by Race, Montana, 2017–2019.
MT WIC BSFD Data 2017–2019

When asked the primary reason for ending breastfeeding, 87% of the Montana WIC Program women cited one of the top 6 reasons mentioned in the chart below. These top reasons for ending breastfeeding closely mirror those reported in the PRAMS data on why women stopped breastfeeding. Several of these reasons are often seen as barriers to breastfeeding that are more likely overcome with early breastfeeding initiation and ongoing breastfeeding support and education.

TOP 6 PRIMARY REASON BREASTFEEDING WAS STOPPED, MONTANA WIC, 2020

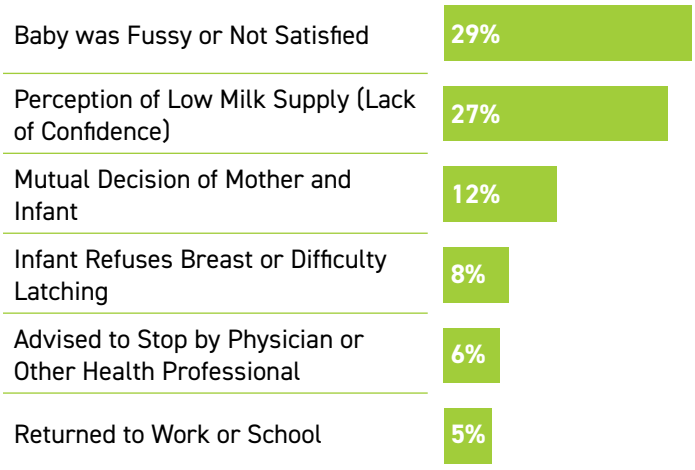


Figure 50: Top 6 Primary Reason Breastfeeding was Stopped, Montana WIC, 2020.
MT WIC—Breastfeeding Data 2021

Over the past five years, more women in Montana WIC initiated breastfeeding overall. Still, that duration lasted less time, with more dyads ending breastfeeding in the 2–5 months age period rather than in the 6–12 months age range. It should be noted that 2020 saw many changes to American life due to the COVID-19 pandemic.

AGE AT WHICH BREASTFEEDING ENDED MONTANA WIC, 2016–2020

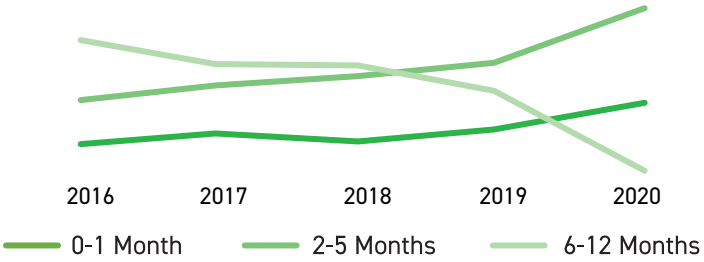


Figure 49: Age at Which Breastfeeding Ended, Montana WIC, 2016–2020.
MT WIC Vital Stats—Breastfeeding Data 2021

When interviewed for the PRAMS, women across Montana were prompted to list the reasons they ended breastfeeding rather than the primary reason. Due to the change in the way the question was asked, this data better conveys the fact that women often end breastfeeding for a myriad of reasons. Many women across Montana have the same barriers to breastfeeding duration as do women in the Montana WIC Program.

REPORTED REASON BREASTFEEDING WAS STOPPED MONTANA, 2017 & 2018

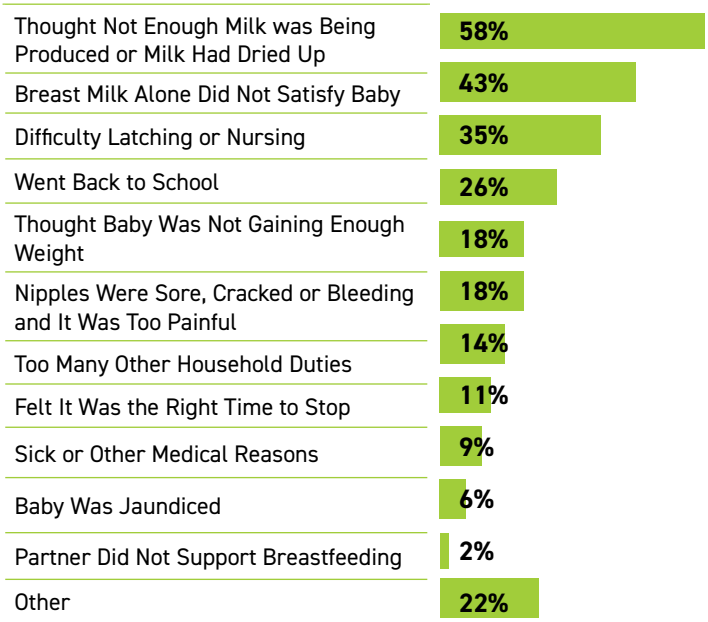
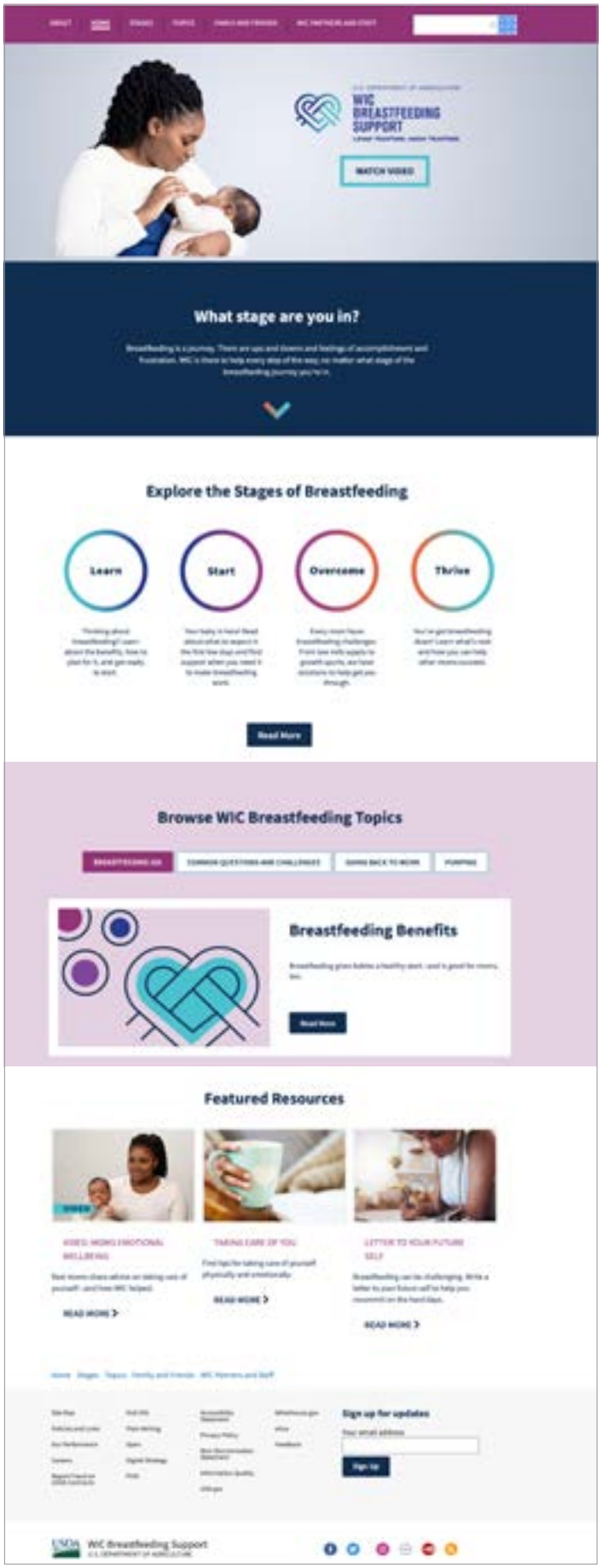


Figure 51: Reported Reason Breastfeeding Was Stopped, Montana, 2017 & 2018
MT WIC Prams Breastfeeding Data 2021

BREASTFEEDING SERVICES

Breastfeeding services vary dramatically between local agencies across Montana. The purpose of these services is to improve breastfeeding initiation and duration among WIC participants. At a minimum, all local agencies employ a staff training and curriculum that they can use to provide support to women considering breastfeeding prenatally, and to mothers as they navigate the basic difficulties of breastfeeding. In local agencies with more robust breastfeeding support, further services are provided that may include staff members who are Certified Lactation Counselors (CLCs), International Board-Certified Lactation Consultants (IBCLCs), or have staff that implement Breastfeeding Peer Counselor Programs (BPCPs).

In 2018, the "WIC Breastfeeding Support - Learn Together. Grow Together." campaign was launched and replaced the "Grow and Glow in WIC" and the "Loving Support" breastfeeding education curriculums. The new campaign is still in the process of being implemented. The updated campaign includes new education modules for local agencies to use when supporting breastfeeding mothers and families. It harnesses the good reputation of WIC information and takes into account new ways of life such as access to technology, mobile apps, social media, critical periods of time in which breastfeeding may pose special challenges, and being realistic with women about the difficulties that are associated with breastfeeding (USDA WIC Breastfeeding Support 2021).



Concurrent with the rollout of the new breastfeeding materials nationally was a growing demand for the Baby-Friendly Hospital Initiative (BFHI), which is known for improving breastfeeding education prenatally and initiation support within the hospital environment. Except for Anaconda Community Hospital's BFHI designation in 2003, 10 of the 29 birthing facilities in Montana that have BFHI status were designated between 2014 and 2019 (Baby-Friendly Facilities by State 2021). One of the pre-eminent prenatal breastfeeding education curriculums associated with BFHI is the "Ready, Set, BABY" (RSB) curriculum developed by the Carolina Global Breastfeeding Institute (CGBI) at the University of North Carolina at Chapel Hill (Carolina Ready, Set, BABY 2021). Due to its excellence in diversity, accessibility, and utility, many of the Montana WIC Program local agencies began using this curriculum with WIC participants in conjunction with WIC-developed breastfeeding education.

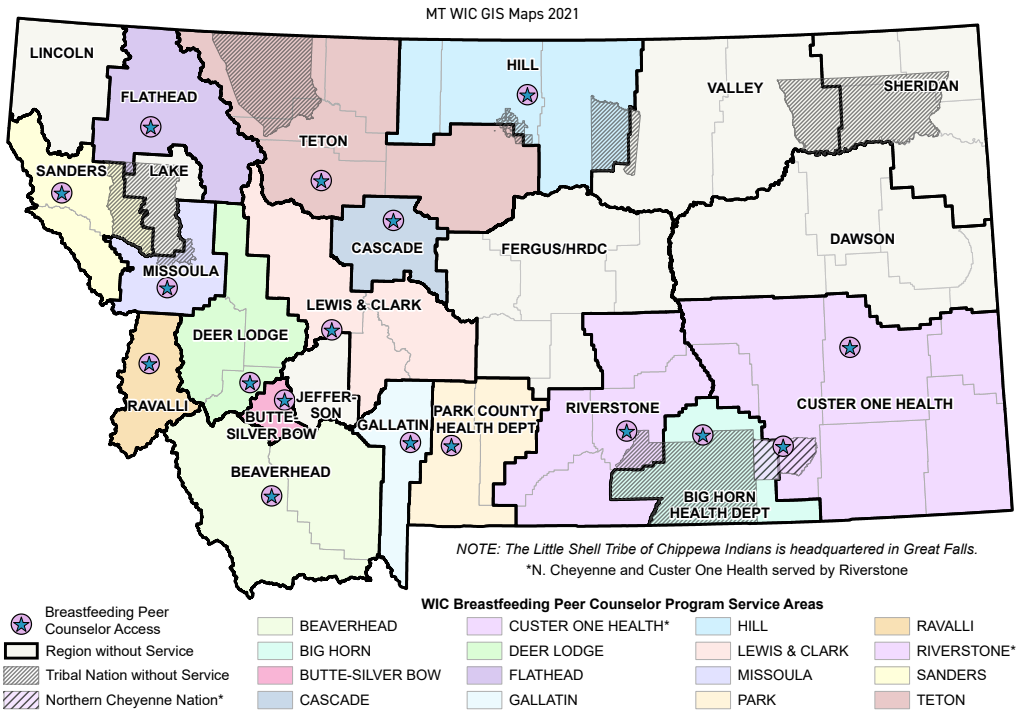
Both the "WIC Breastfeeding Support - Learn Together. Grow Together." and "Ready, Set, BABY" programs are being used by local agencies across Montana at varying degrees of fidelity.

Breastfeeding Peer Counselor Programs in Montana WIC

The Breastfeeding Peer Counselor Program was initiated in 2004 through USDA to provide peer level breastfeeding support to women participating in WIC. Fourteen local agencies across Montana have implemented Breastfeeding Peer Counselor Programs

(BPCP). These programs identify, hire, and train a woman who has breastfed (or is breastfeeding), from the WIC target population, who is supportive and enthusiastic about breastfeeding and helping peers throughout their breastfeeding journey. This woman serves as the local agency's Breastfeeding Peer Counselor (BPC) and works with mothers in the WIC program to navigate and overcome barriers to, and celebrate successes in, breastfeeding. This program has been associated with an increased breastfeeding initiation and duration rate in Montana WIC local agencies that offer them.

Despite evidence of their effectiveness, only two local agencies serving primarily Native communities



have access to these services. In both cases, the BPCPs are available through nearby non-Native local agencies. While an encouraging first step in providing this important service to Native communities, these programs will likely be more effective when the BPCs are members of the Native communities they are serving. Currently, the State WIC Program makes available small grants to all local agencies that are interested in running a BPCP. However, a limited cost-to-benefit ratio for these programs is the primary reason that local agencies do not implement them. Many local agencies are too small to afford the cost of implementing a BPCP, and frequently have difficulty recruiting and managing the necessary staff to conduct the program. The State is actively working to expand the BPCP to more agencies. One method of expansion includes enabling larger agencies to cover smaller agencies with their BPCP. This method is currently being used by Missoula County WIC, which provides BPCP services to the Confederated Salish and Kootenai Tribes, and RiverStone Health, which provides BPCP services to the Northern Cheyenne Nation and Custer-One Health WIC Programs.

Breast Pump Assistance

Historically, the WIC Program has been essential in making breast pumps available to participants who need them. With the expansion of Montana Medicaid and the approval to provide breast pumps to mothers they cover, the use of WIC for accessing breast pumps has steeply declined since 2018. Most Montana WIC local agencies have access to both single-user pumps and high-quality multi-user, hospital-grade pumps that can be loaned out to participants as needed. While training is provided to all local agencies on the use of breast pumps, there are varying levels of staff confidence and comfort in providing this education.

There are 17 local agency regions with Breastfeeding Peer Counselor Program (BPCP) access in Montana as of Spring 2021. Fourteen of these programs have individual contracts with the State WIC Program. Of these 14 local agencies, two provide BPCP to three other regions, bringing the total agencies with BPCP to 17.

Of the 14 Breastfeeding Peer Counselor Programs (BPCP) across the state, two serve Native communities through satellite programs from larger local agencies (Missoula serves Confederated Salish and Kootenai Tribes; Riverstone serves Northern Cheyenne and Custer). There are no BPCPs in northeast Montana, and most of the BPCPs are in western Montana.

78.2% of WIC participants

have access to Breastfeeding Peer Counselor Programs

Figure 52: Density of and Access to WIC Breastfeeding Peer Counselor Programs, Montana, 2020. WIC Staff Density 2021

All six of the large-sized local agencies administer BPCPs. Four of the five medium-sized local agencies administer BPCPs. Five of the 18 small-sized local agencies administer BPCPs.

Among participants who visited a medium-sized clinic between 2016–2018, fully breastfeeding packages were provided at a significantly higher rate to participants at initiation, 3, 6, and 12 months of infant age for agencies with a peer counselor program compared to agencies without a program (all p-values < 0.0001). The greatest differences were seen with initiation (85% versus 72%, respectively).

BREASTFEEDING INITIATION AND FULLY BREASTFEEDING WIC PARTICIPANTS BY PRESENCE OF BREASTFEEDING PEER COUNSELORS IN MEDIUM-SIZED LOCAL AGENCIES

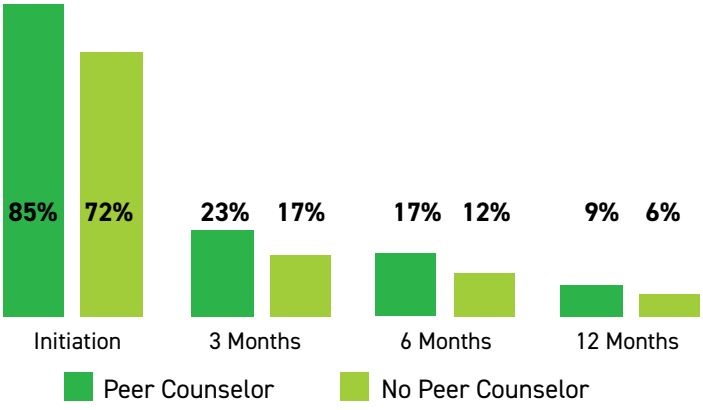


Figure 53: Breastfeeding Initiation and Fully Breastfeeding WIC Participants by Presence of Breastfeeding Peer Counselors in Medium-Sized Local Agencies, Montana, 2016–2018. MT WIC BSFD Report 2020

Most WIC staff that completed the WIC Needs Assessment Survey 2021 and found that the training was applicable to their job duties, indicated a wide range of confidence in providing RSB materials to clients. Almost identical numbers of staff rated their confidence as a 1 on a 5-point Likert scale as the number who ranked their confidence a 5 on the same scale.

WHAT IS YOUR CONFIDENCE LEVEL IN PROVIDING READY, SET, BABY MATERIALS TO CLIENTS?

ON A SCALE OF 1 TO 5, WITH 1 BEING LOW AND 5 BEING HIGH

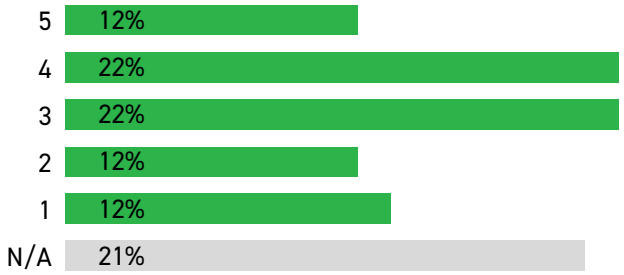


Figure 54: WIC Staff Confidence in Providing Ready, Set, BABY, Montana, 2021. MT WIC Needs Assessment Survey 2021

Of those who perceive the Ready, Set, BABY materials applicable to their work, almost the same number of WIC staff report they use RSB materials Often or Sometimes as those numbers who report using it Rarely or Never.

HOW OFTEN DO YOU USE READY SET, BABY MATERIALS

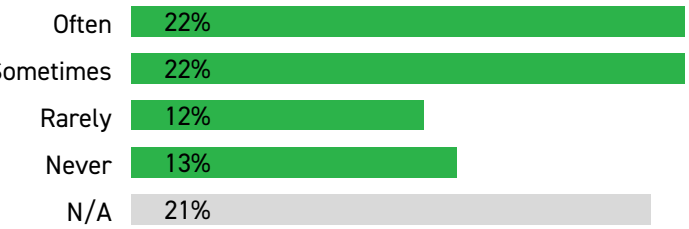


Figure 55: Frequency of WIC Staff Using Ready, Set, BABY, Montana, 2021. MT WIC Needs Assessment Survey 2021

According to the MT WIC Needs Assessment Survey 2021, just under one in five staff report having been trained in RSB, with almost just as many indicating that they are unsure if they've been trained on the materials. The majority, 64%, indicate that they have not been trained.

HAVE YOU BEEN TRAINED IN READY, SET, BABY?

Figure 56: WIC Staff Trained in Ready, Set, BABY, Montana, 2021. MT WIC Needs Assessment Survey 2021

NUTRITION

Improving the nutrition status of WIC participants is the cornerstone of the WIC Program. Covered in this Nutrition Section are three aspects that provide insight into the program's work to improve the nutrition and health status of participants: Nutrition Health Indicators, Food Insecurity, and Nutrition Services. Breastfeeding, as an aspect of infant nutrition, is covered in the Breastfeeding Section of this document.

- **Nutrition Health Indicators:** Provides information about the different types of nutrition risks facing Montana WIC participants, broken down into the following broader categories: anthropometric; biochemical; clinical, health, and medical; and dietary. These are stratified by infants, children, pregnant, postpartum, and breastfeeding women to identify risks specific to each participant category.
- **Food Insecurity:** As an issue that deeply affects the nutrition status of the population, and is particularly acute among low-income households, this section provides more insight into the roles that food insecurity and the Montana WIC Program play in the lives of WIC participants.
- **Nutrition Services**: At the center of the WIC Program are the services provided to participants in the forms of direct nutritious food assistance and nutrition education. In this section of the Assessment, data has been collected to show aspects of the program such as the types of foods that are most redeemed by participants and the percentage of food benefits that are actually procured by the participants, stratified by local agency. It also includes information from participants regarding their perception of the most important nutrition services, their experiences in stores when redeeming WIC benefits, and other aspects of nutrition service delivery.

Overall, data indicates that Montana WIC Program participants have a wide range of complex and impactful nutrition risks that can continue to be addressed through more robust participation in the available nutrition services offered by WIC. These services appear to be routinely underutilized, as shown through benefit utilization rates of just above 50%. More work could be done to determine the reasons behind the underutilization of benefits and which interventions, or programmatic changes may be needed to improve participants' utilization and health status.

Nutrition Health Indicators

Unsurprisingly, the most common nutrition risks seen among Montana WIC participants are similar to nutrition risks seen across the nation, including high weight-for-height, inappropriate feeding practices, and not meeting the recommendations for intake according to the Dietary Guidelines for Americans (DGA) (Duffy, Kay, & Jacquier 2019) (CDC Childhood Obesity 2018) (Barrera, Hamner, Perrine, & Scanlon 2018). Inappropriate nutrition practices include substituting animal milk for breastmilk, using feeding practices that disregard the developmental needs or stage of the infant, or feeding foods to a child that could be contaminated with harmful microorganisms. The DGA are standard guidelines on how many servings of the different food groups—such as fruits, vegetables, starches, and proteins—should be consumed in a typical day.

Infant and children participants of WIC face a myriad of other nutritional risks. In 2018, 17% of infants were born with a low birth weight or prematurely, 4.7% of infants and 4% of children were underweight, while 11% of infants and 8% of children were found to have short stature, and 9% of children to have a low hemoglobin, all of which can be indicators of poor nutrition and areas where accurate food labeling and effective nutrition education and support can improve participants' health status.

Among women utilizing the Montana WIC Program in 2016 and 2018, more than 80% had risk codes indicating inappropriate weight gain patterns during pregnancy. Close to one-third of postpartum women had substance abuse risk codes. In 2016, 30% of postpartum women had low hemoglobin or hematocrit levels, indicating risk for iron-deficiency anemia. Approximately 15% of women in the Montana WIC Program during these years had experienced (history of) stillborn or fetal deaths, and more than 15% of postpartum women reported pregnancy-induced health complications. The constellation of risks experienced by women on the WIC Program only serves to underline the importance of high-quality perinatal education and support by Program staff.

At certification, WIC participants are assessed and assigned nutritional risk codes. The most common risk categories are anthropometric and dietary risks. See the subsequent tables in this section for more information on which nutritional risk codes are included in each broad risk category according to participant category.

MONTANA WIC PARTICIPANTS REPORTING NUTRITIONAL RISK CATEGORIES 2016 & 2018

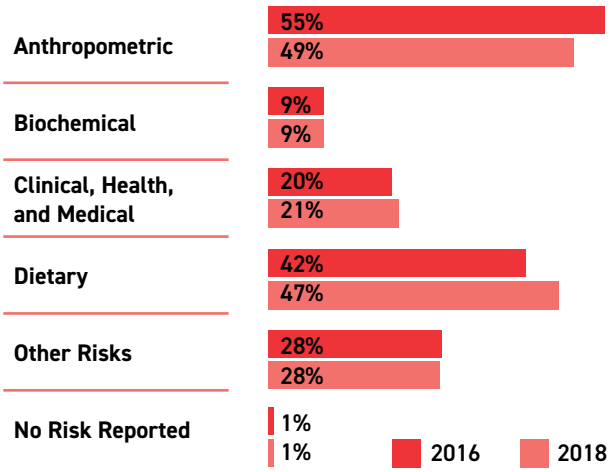
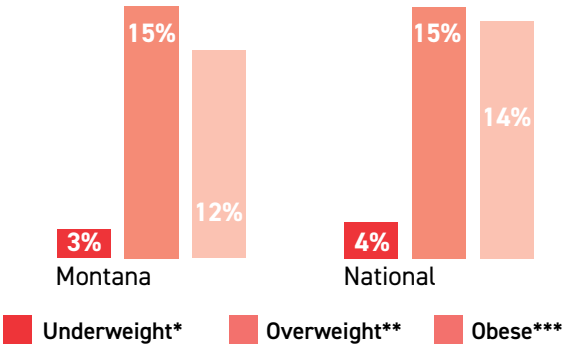


Table 57: WIC Participants Reporting Nutritional Risk Categories, Montana, 2016 & 2018. USDA MT WIC Data 2016 & 2018

In both Montana and the US, fewer than a third of children age 2–4 participating in WIC are assigned a nutrition risk code for weight.

CHILDREN 2 -4 PARTICIPATING IN WIC WITH ASSIGNED NUTRITION RISK CODE FOR WEIGHT, MONTANA, 2018



* Children aged 2 and older who fall at or below the 5th percentile (developed by the WHO) for BMI are considered underweight.

** Children 2 and older who fall at or above the 85th percentile (WHO) and less than the 95th percentile are considered overweight.

*** Children aged 2 and older who fall at or above the 95th percentile (WHO) are considered obese.

Table 59: Children 2–4 Years of Age Participating in WIC Meeting FNS-Issued Nutritional Risk Criteria for Weight, Montana vs. National, 2016 & 2018. USDA MT WIC Data 2016 & 2018, USDA PC Data 2016 & 2018

In Montana, infants and children participating in WIC are twice as likely to be assigned high weight for height/length than low weight for height/length. In 2016, children were more likely than infants to screen positive for anemia. In 2016 and 2018, nearly a quarter of infants participating in WIC were reported to have inappropriate nutrition practices. The number of children with inappropriate nutrition practice codes was higher at 37.9% and 45% in 2016 and 2018, respectively.

MONTANA WIC PARTICIPATING INFANTS AND CHILDREN ACROSS BROAD NUTRITIONAL RISK CATEGORIES, 2016 & 2018

	2016		2018	
	Infants	Children	Infants	Children
Anthropometric				
High Weight-for-Height/ Length [a]	23.4%	23.4%	23%	22.8%
Low Birth Weight/ Premature Birth	13.8%	5.5%	16.6%	5%
Short Stature	10.1%	8.2%	10.6%	8%
Inappropriate Growth or Weight Gain Pattern	10.9%	12.70%	--	--
Low Weight-for-Height/ Length	4.7%	3.6%	4.7%	4%
Biochemical				
Hematocrit / Hemoglobin below FNS Criteria [b]	2.6%	10.9%	--	--
Clinical, Health, and Medical				
Nutrition-Related Risk Conditions	4.4%	5.2%	--	7.3%
Other Health Risks	--	2.7%	--	3.4%
Dietary				
Inappropriate Nutrition Practices	22.9%	37.9%	24.7%	45%
Failure to meet Dietary Guidelines for Americans (DGA)	--	24.3%	--	23.2%

--Denotes data that does not meet disclosure requirements or was not collected.

[a] The criteria for the risk for high weight-for-height/length are as follows: obese (children aged 2–5); overweight or at risk of being overweight (infants and children); and high weight-for-length (infants and children younger than 2).

[b] WIC regulations permit State and local agencies to dispense with hematological testing for infants younger than 9 months as well as for children whose test results are found to be within normal ranges at the last certification if age 2 or older. However, blood tests should be performed on such children at least once in every 12-month period. Criteria are set by USDA's Food and Nutrition Services.

Table 58: WIC Participating Infants and Children Across Broad Nutritional Risk Categories, Montana, 2016 & 2018. USDA MT WIC Data 2016 & 2018

More than half of women participating in WIC in Montana in 2016 and 2018 had high BMIs. In 2016, postpartum women were more likely to be at risk for iron-deficiency anemia than those women who were pregnant or breastfeeding. General obstetrical risks across all categories for women in WIC decreased from 2016 to 2018. Among women assigned a substance abuse risk code, breastfeeding women were assigned the risk code least frequently. In 2016 and 2018, postpartum women were more likely to have nutrition-related risk conditions than breastfeeding women.

WOMEN PARTICIPATING IN WIC BY NUTRITIONAL RISK CATEGORIES, MONTANA, 2016 & 2018

	2016			2018		
	Pregnant	Breastfeeding	Postpartum	Pregnant	Breastfeeding	Postpartum
Anthropometric						
High Weight-for- Height/Length (BMI) [a]	54.7%	56.7%	56.6%	58.1%	57%	57.3%
Inappropriate Growth or Weight Gain Pattern	82.2%	48.3%	47.80%	83.1%	45.9%	47.5%
Low Weight- for-Height/Length	2.9%	4.4%	4.80%	3.7%	2.8%	5.2%
Biochemical						
Hematocrit or Hemoglobin below FNS Criteria	6.5%	9%	19.8%	--	--	--
Clinical, Health, and Medical						
General Obstetrical Risks	36.2%	28.3%	28%	17.1%	15.2%	16.5%
Substance Abuse	24.6%	11.3%	31.2%	22.2%	12%	31%
Nutrition-Related Risk Conditions	11.2%	18.6%	21.4%	--	27.7%	33.6%
Prior Stillbirth / Fetal / Neonatal Death	16.%	3.%	3.1%	14.4%	--	--
Delivery of Low-Birthweight / Premature Infant	9.3%	9.1%	11.4%	8.2%	11%	14.8%
Pregnancy-Induced Conditions	10.1%	14.%	15.6%	10.4%	15.%	17.6%
Other Health Risks	5.1%	3.5%	4.5%	--	--	--
Dietary						
Failure to Meet Dietary Guidelines for Americans (DGA)	8.4%	7.5%	11.2%	8.4%	7.6%	6.3%
Inappropriate Nutrition Practices	6.7%	6.5%	9.3%	6.5%	9.9%	11.5%

[a] 2018 Criteria Revision lowered the pre-pregnancy BMI cutoff value for pregnant women to be assigned the risk of low weight-for-height (based on the underweight risk criterion) from less than 19.8 to less than 18.5. This revision also lowered the pre-pregnancy BMI cut-off value for pregnant women to be assigned the risk for high weight-for-height/length (based on the overweight risk criterion) from less than or equal to 26.1 to less than or equal to 25.0. The criteria for the risk for high weight-for-height/length are as follows: overweight (women); obese (children aged 2–5); overweight or at risk of being overweight (infants and children); and high weight-for-length (infants and children younger than 2).

Figure 60: Women Participating in WIC by Nutritional Risk Categories, Montana, 2016 & 2018. USDA MT WIC Data 2016 & 2018

For both Montana and the United States, the percentage of women (breastfeeding and postpartum) that were classified as overweight increased between 2016 and 2018. Breastfeeding women were less likely to be overweight in both years when compared to their postpartum (non-breastfeeding) counterparts.

PERCENTAGE OF WOMEN (BREASTFEEDING AND POSTPARTUM) CLASSIFIED AS OVERWEIGHT, 2018

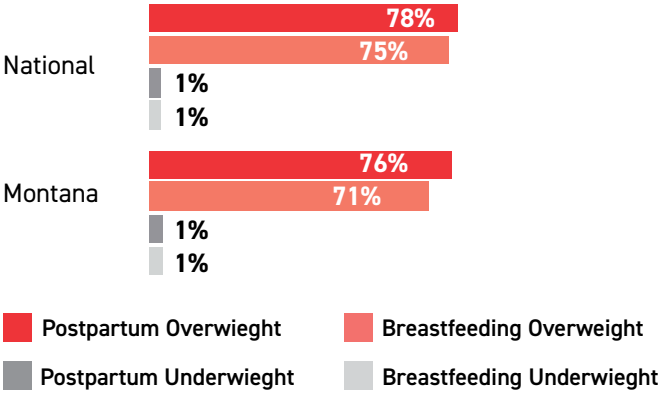


Figure 61: Postpartum Women Participating in WIC Meeting FNS-Issued Nutritional Risk Criteria for Weight, Montana vs. National, 2016 & 2018. USDA MT WIC Data 2016 & 2018, USDA PC Data 2016 & 2018

In 2018, Montana reported higher rates of risk for iron-deficiency anemia among children and women in Montana WIC compared to WIC nationally.

WIC PARTICIPANTS MEETING FNS-ISSUED RISK CRITERIA FOR HEMOGLOBIN LEVELS, MONTANA VS. NATIONAL, 2018 USDA MT WIC DATA 2018

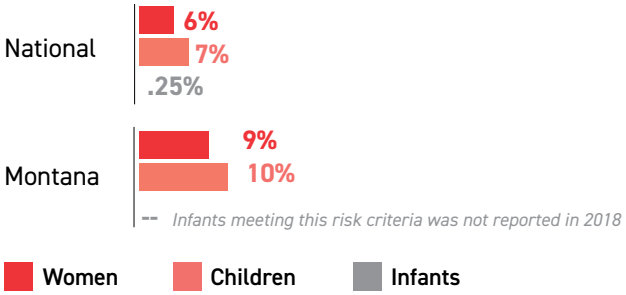


Figure 62: WIC Participants Meeting FNS-Issued Risk Criteria for Hemoglobin Levels, Montana vs. National, 2018. USDA MT WIC Data 2018, USDA PC Data 2018

Food Security

Food security is defined by the USDA as "access by all people at all times to enough food for an active, healthy life" (USDA ERS Food Security 2021). A lack of food security can lead to unhealthy nutrition practices, hunger, and lasting physical and mental health issues (Hunger in Montana Report 2018). While the WIC Program is a supplemental program and was never intended to fully eliminate food insecurity, its direct food benefits provide some measure of food security for participants.

Much work has been done by Lacy Little, MPH, RDN at the Montana WIC Program regarding food insecurity in Montana. Her report "Food Insecurity in Montana and How WIC Helps" explains the presence of widespread food insecurity and provides insights into the scope, severity, and patterns of food insecurity among WIC participants (Food Insecurity MT Little 2020). This data will inform the program and in turn, allow Montana WIC to better serve and support those food-insecure participants.

As highlighted in Little's report, the Montana Food Bank's "Hunger in Montana" report (Hunger in Montana Report 2018), and as reinforced in this Needs Assessment, underutilization of services like WIC is a contributing factor to food insecurity alongside larger, more systemic issues in Montana such as food deserts, insufficient living wages, and high medical and childcare costs.

Close to one in five participants self-identify as "food insecure" or "sometimes food insecure" when first entering the Montana WIC Program. A lower percentage of participants identify as "food insecure" or "sometimes food insecure" at subsequent certifications than during the initial certification. However, far fewer participants return for certification at each subsequent certification.

WIC PARTICIPANTS IN FOOD INSECURE HOUSEHOLDS MONTANA, 2017–2020

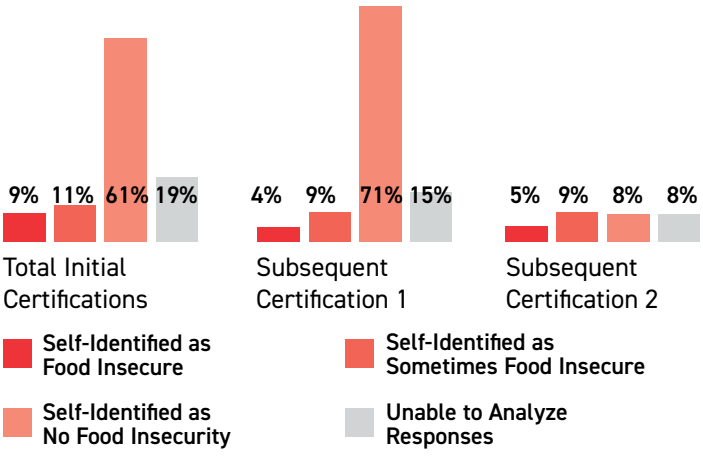


Figure 63: WIC Participants in Food Insecure Households, Montana, 2017–2020.
Food Insecurity MT Little 2020

USDA ERS Food Access Atlas 2021

Using the USDA's Economic Research Service's (ERS) interactive mapping tool, Little was able to identify food deserts across Montana. The areas of green in the map above show places in the state where people meet the ERS definition of low-income Census tracts and live more than 1 mile from a grocery store in urban areas or more than 10 miles from a grocery store in areas considered to be rural. In her research, Little was able to use the map to identify that six of the eight Montana counties without Montana Food Bank Network services or partners lie in areas that were determined to be food deserts.

Nutrition Services

The food package provided to participants varies according to the category in which they participate in the WIC Program (fully formula-feeding infant, fully or mostly breastfeeding infant, child, pregnant woman, breastfeeding woman, postpartum/non-breastfeeding woman). In addition, participant food packages change as they are certified into different categories throughout their participation in WIC. To learn more about the types and amounts of foods in each kind of food package, you can visit the WIC website, "WIC Food Packages - Maximum Monthly Allowances": https://www.fns.usda.gov/wic/wic-food-packages-maximum-monthly-allowances

When the USDA updated the WIC Program food packages in 2010, it aligned the packages more directly with the 2005 Dietary Guidelines for Americans (DGA), provided cash benefits for participants to purchase fresh fruits and vegetables, and also allowed states to exert more flexibility over the types of foods offered in the packages to accommodate their participants' cultural and ethnic food preferences.

In addition to food packages, WIC participants in Montana also have access to the Farmers Market Nutrition Program (FMNP). FMNPs "were established...to provide fresh, unprepared, locally grown fruits and vegetables to WIC participants, and to expand the awareness, use of, and sales at farmers' markets." With an FMNP "eligible WIC participants are issued FMNP coupons in addition to their regular WIC benefits. These coupons can be used to buy eligible foods from farmers, farmers' markets, or roadside stands that have been approved by the state agency to accept FMNP coupons" (USDA WIC Farmers Market Programs 2021).

In Montana, after a person has been certified and determined eligible as a participant in the WIC Program, the food package benefits that are provided to them are loaded onto an Electronic Benefits Transfer (EBT) card, and the participant has the ability to purchase the items of their food package at any participating store within the state of Montana. There are specific rules that govern the types of foods allowable for purchase on the WIC Food List and are assigned to each participant on their food package. Often brands, package size, unit

quantities, and certain nutrition criteria (such as fat level or iron fortification), as well as availability and cost, factor into these determinations. These stipulations can make it challenging for some participants to accurately identify the correct foods in the store. According to the Montana Participation Satisfaction Survey 2020, only 32.4% indicated that they understood which foods were eligible as part of their benefits "all of the time." Some participants have indicated that there is a stigma associated with participating in WIC at the store level, but 55.7% of participants indicate that they never feel unwelcome or uncomfortable in stores using their WIC benefits. The Montana Participation Satisfaction Survey is conducted annually and aims to gain an understanding of participants' perceptions of various components of the Montana WIC Program.

Additionally, data was collected from the M-SPIRIT system that tracks Montana WIC participants' benefit utilization to better understand patterns of food package redemption, or foods (according to unit) purchased using WIC EBT. Each food in the food package has a specific unit by which it is redeemable. For example, eggs are redeemable by the dozen, and so must be purchased by the dozen to qualify for purchase with WIC EBT. Through this data, trends can be seen in the types of foods participants are most likely to redeem, the average amount of benefits redeemed across the Montana WIC Program and, more specifically, across local agencies.

Overall, this section of the Needs Assessment provides insight into the scope and ways in which the Montana WIC Program is underutilized by participants and some of the aspects of the program that are most valuable to participants.

From 2018 to 2020, there was a marked decline in the rate of food redemption for most of the categories listed, especially rates from 2018 to 2019. Food categories that experienced the greatest decrease in rate of redemption from 2018-2020 were infant cereal (45.0% change), infant meat (42.9% change), fish (38.6% change), legumes (37.7% change), and whole grains (35.5% change). Utilization of the fruit and vegetable cash benefits, formula, infant fruit and vegetable, and milk remained similar over the three-year period.

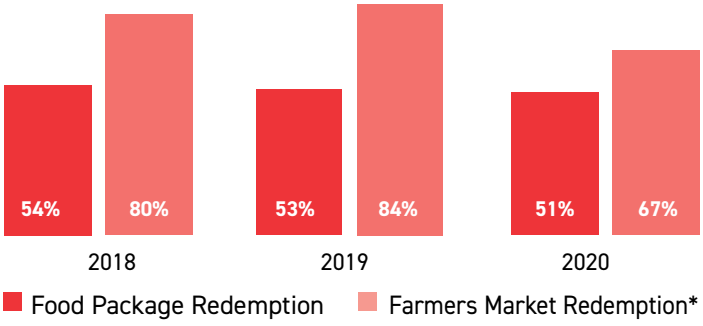
AVERAGE RATES OF REDEMPTION FOR SPECIFIC FOODS BY CATEGORY, MONTANA, 2018 - 2020

FOOD CATEGORY	2018	2019	2020
Eggs (dozen)	80%	69%	61%
Cheese (pounds)	72%	67%	61%
Fruit and Vegetable Cash Benefit (dollars)	52%	51%	50%
Formula (cans)	45%	46%	45%
Juice (containers)	70%	52%	47%
Cereal (ounces)	66%	52%	46%
Legumes (Beans/Peanut Butter) (cans/jars)	67%	46%	42%
Whole Grains (ounces)	67%	50%	43%
Fish (ounces)	69%	48%	42%
Infant Fruit/Vegetable (ounces)	41%	37%	36%
Milk (gallons)	40%	36%	35%
Infant Cereal (ounces)	63%	38%	35%
Infant Meat (ounces)	32%	20%	18%
STATE OVERALL	**52%**	**46%**	**42%**

Figure 64: Average Rates of Redemption for Specific Foods by Category, Montana, 2018 - 2020
MT WIC M-SPIRIT Food Package Redemption Data 2021

Redemption of both Food Package and Farmers Market Cash Value benefits decreased in 2020 compared to the two previous years, with Farmer's Market benefits being utilized at a higher rate than Food Package benefits. COVID-19 affected many farmers markets in 2020, which affected participants' ability to redeem Farmer's Market benefits. It should be noted that Farmers Market cash value benefit redemption percentages are in relation to the amount of grant monies available to the program rather than benefits issued. As can be seen in the map below, there are seven Farmers Market Nutrition Programs (FMNP) in Montana, the majority of which are centralized around the western half of the state, except for the RiverStone region.

PERCENTAGE OF FOOD PACKAGE AND FARMER'S MARKET BENEFITS REDEEMED BY UNIT MONTANA WIC, 2018–2020



**Cash value benefit redeemed according to amount granted, not amount issued to participants*

Figure 65: Percentage of Food Package and Farmer's Market Benefits Redeemed by Unit, Montana WIC, 2018–2020. MT WIC FMNP Data 2021, MT WIC M-SPIRIT Benefit Package Data 2021

MONTANA WIC CLINICS PROVIDING FARMERS MARKET NUTRITION PROGRAM (FMNP) BENEFITS

MT WIC GIS Maps 2021

As can be seen in the map above, only 7 of the 29 WIC agencies offer a FMNP. None of the Tribal Nations has their own FMNP.

Among WIC participants who responded to the Participant Satisfaction Survey in 2020, nearly all rated food benefits as important when ranking the importance of WIC benefits. Breastfeeding information ranked the lowest. Rankings did not differ significantly between 2019 and 2020.

"THE WIC SHOPPER APP IS PERFECT! NOTHING ELSE IS NEEDED."

-WIC PARTICIPANT

IMPORTANCE OF WIC BENEFITS TO WIC PARTICIPANTS MONTANA, 2020

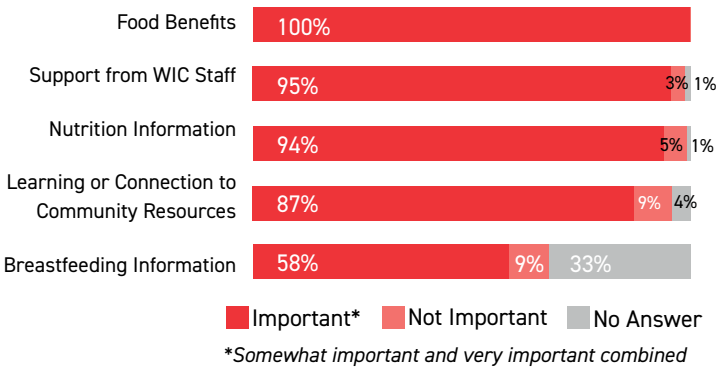


Figure 66: Importance of WIC Benefits to WIC Participants, Montana, 2020.
MT Participant Satisfaction Survey 2020

Participant Satisfaction survey results highlight the confidence and competency of participants in utilizing WIC benefits in stores. Nearly 90% of WIC participants state that it is easy for them to find a store to use WIC benefits all or most of the time. More than half say they never feel unwelcome when using their benefits in a store, while a third say they only feel unwelcome some of the time. Most participants say their overall store experience is positive most of the time or all the time.

WIC STORE EXPERIENCE RANKED, MONTANA, 2020

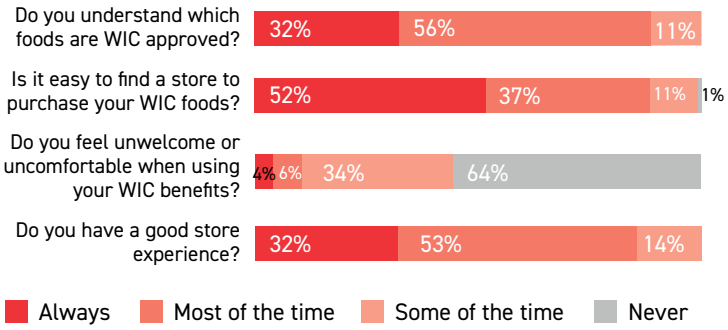


Figure 67: WIC Store Experience Ranked, Montana, 2020. MT Participant Satisfaction Survey 2020

The majority of WIC staff who completed the WIC Needs Assessment Survey 2021 and found that the training was applicable to their job duties, indicated high confidence in providing nutrition education to participants, as 78.2% of staff ranked their comfort as a 4 or 5 on a 5-point Likert scale with 5 being high.

WIC LOCAL AGENCIES AND STAFF TRAINED IN PROVIDING NUTRITION EDUCATION, MONTANA, WIC 2021

On a scale of 1 to 5, with 1 being low and 5 being high, what is your confidence level in providing nutrition education?

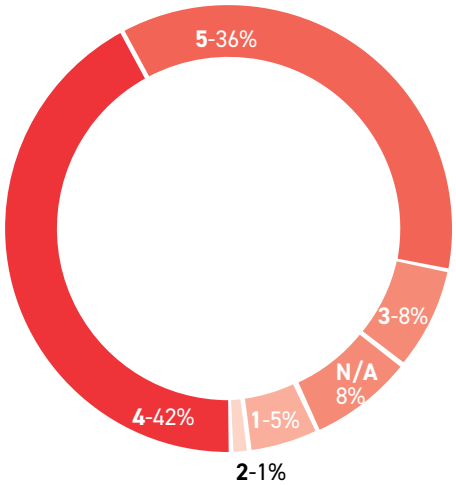


Figure 68: Number of WIC Local Agencies and Staff Trained in Providing Nutrition Education, Montana, WIC 2021. MT WIC Needs Assessment Survey 2021

One-on-one nutrition education in the clinic setting rose to the top as the preferred method for WIC education, followed by online education. The least preferred education method was group classes. This distribution highlights that WIC participants benefit from direct instruction but prefer it to be completed privately rather than in groups.

PREFERRED WIC EDUCATION METHODS, MONTANA, 2020

On a scale of 1 to 5, with 1 being low and 5 being high, what is your confidence level in providing nutrition education?

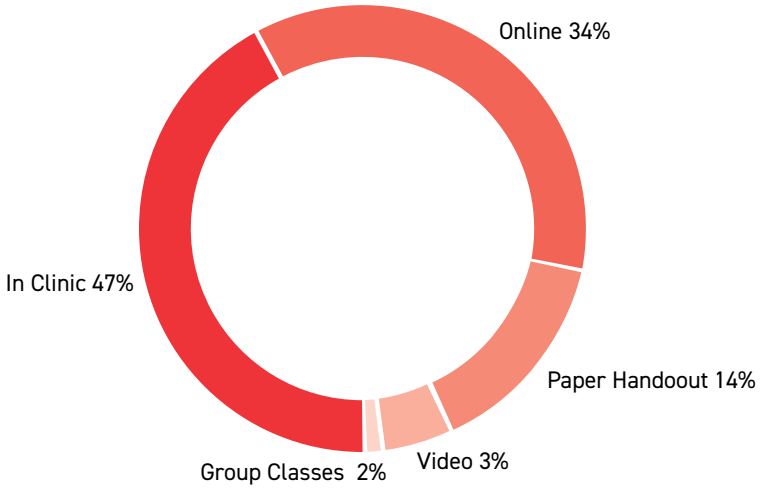


Figure 69: Preferred WIC Education Methods, Montana, 2020. MT Participant Satisfaction Survey 2020

REFERRALS

Referrals are an important aspect of WIC Program recruitment and services. The Montana WIC Program both receives and sends referrals from and to a variety of organizations to better meet the wide range of participants' needs. As part of the wider network of social services available to residents in Montana, the Montana WIC Program must maintain relationships with a variety of organizations across the state. The State of Montana has recognized the importance of interagency referrals and the need to increase efficient referrals across the State. To this end, the State supported the development of an electronic referral system named CONNECT in 2009, with a significant refurbishment and roll out in 2019. WIC began utilizing CONNECT in 2020 and is in the process of increasing the utilization of the system across all local agencies.

This section covers referrals into the Montana WIC Program and utilization of CONNECT.

Over a five-year timespan from 2016–2020, nearly two-thirds of the Montana WIC Program referrals came from family members or friends. The second most frequent referral source came from healthcare providers, whose referrals to WIC increased slightly over that same four-year period. A consistent but small portion of referrals come from other social service programs such as SNAP, TANF, or OPA. The remainder of referral sources provide nearly negligible referrals to the Montana WIC Program.

REFERRALS INTO LOCAL MONTANA WIC AGENCIES FROM OTHER COMMUNITY RESOURCES, 2016–2020

	2016	2017	2018	2019	2020
Health Care Provider	2,000 (13%)	1,988 (14%)	1,936 (14%)	1,951 (15%)	1,945 (17%)
Family Member or Friend	10,798 (69%)	10,036 (69%)	9,515 (67%)	8,649 (65%)	7.504 (64%)
SNAP, TANF or OPA	1,145 (7%)	1,053 (7%)	960 (7%)	960 (7%)	854 (7%)
Poster, Flyer, or Pamphlet	48 (.3%)	54 (.4%)	52 (.4%)	47 (.4%)	39 (.3%)
Head Start Program	30 (.2%)	36 (.3%)	39 (.3%)	35 (.3%)	23 (.2%)
School or Educational Facility	38 (.2%)	31 (.2%)	28 (.2%)	37 (.3%)	37 (.3%)
Advertisement via Billboard, Text Message, Newspaper, or Radio	53 (.3%)	47 (.3%)	83 (.6%)	123 (1%)	101 (1%)
Converted from Old System	46 (.3%)	43 (.3%)	33 (.2%)	26 (.2%)	25 (.2%)
Other	1,422 (9%)	1,331 (9%)	1,457 (10%)	1,468 (11%)	1,257 (11%)

Figure 70: Referrals Into Local Montana WIC Agencies from Other Community Resources, 2016–2020. MT WIC M-SPIRIT Participant Referral Data 2021

Of the staff who participated in the MT WIC Needs Assessment Survey 2021, only 12% indicate that they utilize the CONNECT platform to send referrals all or most of the time. Another 15% of staff use it sometimes, but most staff, 63%, never use the platform. CONNECT is an electronic, bi-directional, secure, referral system that is hosted by MT DPHHS.

HOW OFTEN ARE YOU USING THE "CONNECT PLATFORM" TO SEND AND RECIEVE REFERRALS?

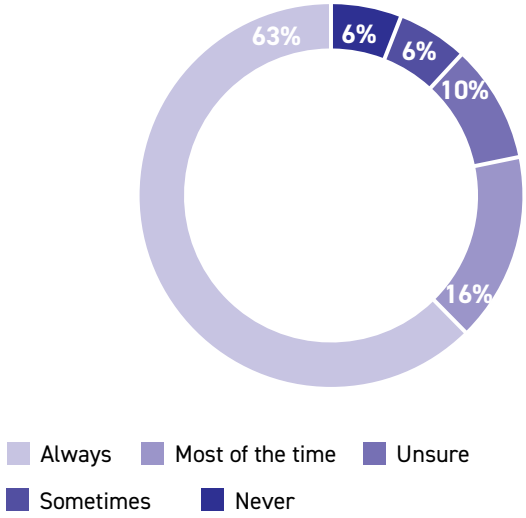


Figure 71: WIC Staff Utilization of CONNECT, Montana, 2021. MT WIC Needs Assessment Survey 2021

The most perceived unmet need among WIC participants, as reported by WIC staff in 2021, was lack of income, with 17.7% of staff indicating that this was an unmet need of the participants they serve. Next in line as top unmet needs were lack of transportation, childcare and housing. These needs can guide the Montana WIC program in determining which additional services or partnerships may be most beneficial to participants.

UNMET NEEDS OF PARTICIPANTS AS REPORTED BY WIC STAFF, MONTANA, 2021

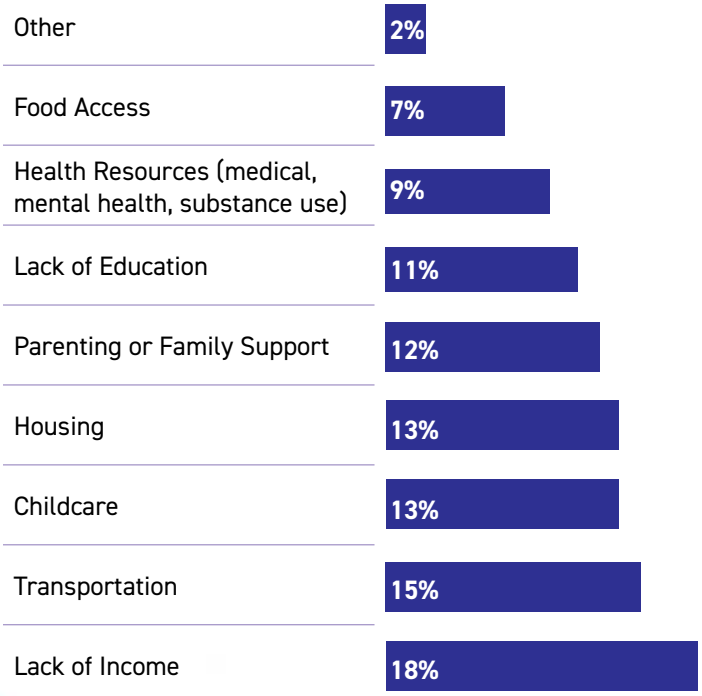


Figure 72: Unmet Needs of Participants as Reported by WIC Staff, Montana, 2021
MT WIC Needs Assessment Survey 2021

QUALITY ASSURANCE & IMPROVEMENT

Across the Montana WIC Program, there are systems in place to ensure that local agencies are delivering WIC services to the fidelity required for meeting federal requirements and the needs of local participants. Quality assurance and improvement is additionally underpinned using robust data systems and the implementation of periodic programmatic changes. Quality improvement efforts are led by the WIC Outreach Coordinator and Quality Improvement State staff position.

Annually, each local agency is asked to review their local data and set goals for quality improvement in the areas of nutrition and breastfeeding according to seven standardized metrics or metrics from the Affirmative Action Plan. These goals help inform each local agency's nutrition education and breastfeeding plan, which are evaluated annually by the local agency and then approved or denied by the State Office.

The WIC Work Group (WWG) is another route through which the State Agency works on quality improvement projects. Established in 2016, the WWG is made up of 8 members who are employees of local agencies across Montana. They are recruited and appointed by the Montana Association of WIC Agencies (MAWA) with the purpose of informing quality improvement projects at the clinic and state levels. Typically, the WWG meets 3-4 times per year for 1-2 days at a time to review issues and assist with intervention development.

In 2019, the percentage of LA Staff that reported that the State Office identifies issues and enforces findings fairly in monitoring, by choosing "strongly agree" or "agree" was 84%. That same group in 2020 was 85% of the respondents.

EXTENT TO WHICH THE STATE OFFICE IDENTIFIES ISSUES THAT CAN BE FIXED ONSITE AND ENFORCES FINDINGS FAIRLY, 2019-2020

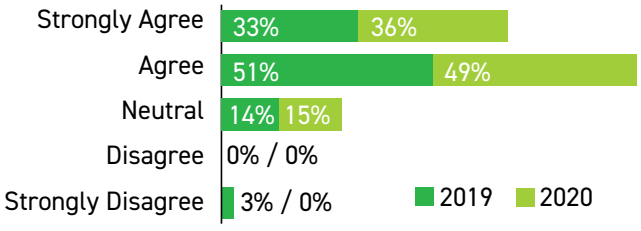


Figure 73. Extent to Which The State Office Identifies and Enforces Findings Fairly, 2019-2020. MT WIC Customer Service Survey 2017-2020

Data Systems

Montana Successful Partners in Reaching Innovative Technology (M-SPIRIT): As the primary system for directly documenting individual participant data, the M-SPIRIT system is the most robust collection tool available to the Montana WIC Program for population-level data. Data quality issues can arise from user and system errors that are difficult to address through data analysis alone. Several indicators of interest through M-SPIRIT could not be used for this Needs Assessment, as there were concerns regarding data quality, including data entry errors on the part of WIC staff, self-reporting by WIC participants, and differences in data collection points of time or frequency.

Tableau: Tableau is a data visualization platform that receives data from M-SPIRIT, making population level data more easily available to both local and state agency staff. All local agencies have access to and have received training in the use of Tableau.

The following data in this section provides insight into the existing data challenges and strengths that currently exist in the Montana WIC Program.

In 2017, the percentage of LA Staff that reported that data provided by the State Office was helpful and understandable, by choosing "strongly agree" or "agree" was 75%. That same group in 2020 was 90% of the respondents.

HOW MUCH DO YOU VALUE TABLEAU

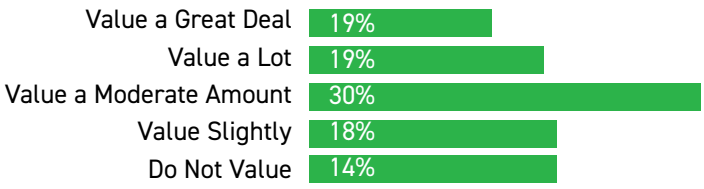


Figure 74. Value of Tableau, 2020. MT WIC Customer Service Survey 2017-2020

Tableau is a relatively new software that is used by the State Office to organize and distribute participant data and other data to the LA Staff. The 2020 survey was the first time they were asked about the software program.

DEGREE TO WHICH DATA PROVIDED BY THE STATE OFFICE IS HELPFUL AND UNDERSTANDABLE, 2017-2020

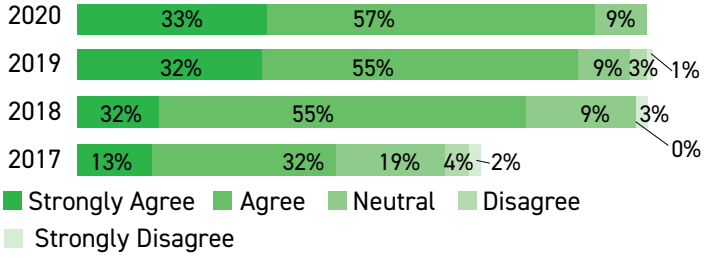


Figure 75. Degree to Which Data Provided by the State Office is Helpful and Understandable, 2017-2020. MT WIC Customer Service Survey 2017-2020

RECOMMENDATIONS

Major recommendations resulting from this assessment center around increasing participation, service improvement, including streamlining services and increasing ease of access to services, expansion, staffing improvements, data and quality developments, continuing efforts to engage and serve Native and other special populations equitably and in a culturally appropriate manner, and funding priorities. The next steps to address these recommendations are extrapolated upon in the conclusion.

Increasing Participation

Over the past several years, participation among those eligible for WIC services in Montana has fallen steeply, which mirrors the falling participation rate across WIC nationally (USDA WIC Participation Decline 2016). As federal funding is based on participation rates, reduced participation reduces state funding and thereby the ability to serve people who could benefit from the Montana WIC Program. It is critical that the Montana WIC Program focuses on maximizing participation across the State. There are five main areas where the declining participation rates may be addressed: recruitment, retention, referrals, utilization, and expanded eligibility.

There are likely many reasons why fewer caregivers choose to enroll themselves, their children, or both in WIC. At the federal level, experts cite an improvement in the economy and a decline in births as reasons for fewer people being eligible for the WIC Program (USDA WIC Participation Decline 2016). While it is also true that the percent of the population in Montana eligible for WIC has fallen, the participation of those who are eligible has also declined. Possible reasons for the decrease in participation could include: delays in reproduction, increasing education of the general population, the stigma around receiving social support services, improvements in economic stability at the family level due to increased SNAP, TANF, and other benefits, or a lack of awareness of available services. The data from this Needs Assessment show that the most significant gaps in eligibility and subsequent participation are found among those who are White, married, educated, and employed. Recruitment efforts should be tailored to reach these populations. However, these efforts should not neglect other relevant populations currently participating at a higher rate, as they could still be participating at a much higher rate. Understanding the reasons why people choose not to participate in WIC is imperative to design targeted initiatives to adequately adjust recruitment and retention efforts.

Increased participation could occur through an improved referral system to the Montana WIC Program. At this time, almost all referrals into WIC come from friends or family rather than professional sources. The rate of referrals from mechanisms such as advertising is minimal, though marketing may play a role in how people trust the WIC program and whether they feel comfortable participating. Funds and staff time should be directed to referral avenues that provide maximum effectiveness. Increasing the utilization of the CONNECT electronic referral system across the state of Montana will likely improve the receipt of referrals from other professional organizations. CONNECT, if utilized robustly, will also provide a centralized location from which providers can discover what local resources are available and thereby use those resources more regularly. Similarly, two additional ways to increase entry into WIC could be to: (1) increase the number of women entering WIC in their first trimester of pregnancy, and (2) increase the number of infants who are certified for WIC while still at the hospital. This would be a large expansion for WIC and would necessitate increased partnerships with prenatal care providers and birthing facilities across the State.

Another area of focus for improving participation overall could be around improving retention by increasing utilization of the eligible certification period. Of note, participation decreases at 6–11 months of age, which may be a key target for retention in the future. While most participants engage in WIC for three years or more, there is still significant attrition throughout the timespan that participants are eligible for services. Further understanding the reasons participants have for withdrawing from WIC services will allow interventions that can preempt issues and improve retention. Potential reasons for attrition may include the frequency with which participants need to contact WIC (at least once every three months), the difficulty of accessing WIC services in rural areas, or the perceived value of the WIC benefits. As reported by WIC staff in the 2021 WIC Needs Assessment Survey, the largest perceived barrier to participation among participants was the time required to take off from work, school, or other commitments. This barrier could be addressed through extending hours or continuing or expanding the availability of remote services. Some counties do not have a WIC clinic in their county, and participants must travel to an adjacent county to receive services. Additionally, some rural communities may have limited access to stores that accept WIC EBT. Technology and a simplification of the process for receiving benefits could address some of these issues.

Increasing the use of available benefits by participants while they are in the WIC program may be a way to improve retention and diet quality. Nutrition benefits appear to be routinely unredeemed, as shown through benefit utilization rates of just above 50%. It may be helpful to determine the reasons behind the underutilization of benefits and which interventions or programmatic changes may be needed to improve utilization and health status of participants.

Finally, a more wide-reaching option to increase participation in the Montana WIC Program may be to expand and simplify eligibility to include a wider demographic for some or all the program benefits. While this would likely require a systematic change at the federal level for some benefits, it is possible that some services such as access to Registered Dietitian Nutritionists and breastfeeding support experts to all pregnant, postpartum, and young children in Montana may be an expansion consideration if WIC services were more closely integrated into primary care settings, and those services made billable. Overall, it will be important to investigate qualitatively why participants are ending participation, who is stopping, and when.

Service Improvement and Expansion

While increasing program participation must be a key focus, improving and expanding services can aid in drawing and keeping more participants while increasing the impact of those services for current participants in the Montana WIC Program. Some suggestions for the improvement and expansion of services include bolstering staff training, expanding Breastfeeding Peer Counselor Programs (BPCP), providing more individualized nutrition education, integration of WIC services into primary care settings, and maintaining the flexibility to allow for remote certifications and education appointments with WIC staff that were necessary to accommodate COVID-19 safety protocols.

Peer counseling programs have found great success in many areas, including breastfeeding (WIC BPC Success 2019). As can be seen in Tables 52 and 53, BPCP significantly increases the rate of breastfeeding among MT WIC participants. Additionally, MT WIC staff clearly

indicated in the MT WIC Needs Assessment Survey 2021 that Breastfeeding Peer Counseling was an area of WIC programming that needed improvement. With all the known benefits of breastfeeding, for both mother and baby, expansion of BCPC across Montana should be prioritized. Specifically, there should be targeted expansion to small agencies, agencies in Northeast Montana, and Tribal agencies or agencies serving Tribal communities. Currently, very few small agencies, no agencies in Northeastern Montana, and just two Tribal communities have access to BPCPs. There are currently efforts to expand BPCP to more local agencies. Additionally, heightened emphasis will be placed on ensuring all necessary staff are appropriately trained as certified lactation counselors (CLCs).

Participant surveys reveal that participants significantly benefit in the nutrition education they receive through the Montana WIC Program. The staff of the MT WIC local agencies indicated both confidence in providing nutrition education and a strong desire for more time to provide this service and develop innovative and meaningful ways to provide this service to participants. Continuing to enhance and refine nutrition education so that it is individualized and constantly relevant to participants' contemporary nutrition needs and concerns will continue to improve participant diet quality and confidence in the Program. Nutrition services may also be improved by implementing evidence-based, culturally relevant nutrition curricula across all local agencies, as well as improved access to RDNs for higher-risk clientele.

As was shown in the WIC Needs Assessment Survey 2021, WIC clinic and primary care integration is limited. Further integration between these two key health services may lead to more consistent access to RDNs and qualified staff as CPAs, increased participant access, savings to funds spent on space, improved program coordination, and other benefits associated with integrated care.

The COVID-19 pandemic highlighted the importance of keeping pace with technological updates. Many organizations, healthcare providers, and social service programs, like WIC, were forced to adapt to virtual service provision to keep their participants and staff safe. While many Montana WIC Programs were able to make this adjustment, it was not without considerable challenges. It is important that Montana learns from this experience and continues to stay at the forefront of technological innovations for service delivery. Many of the staff who participated in the MT WIC Needs Assessment cited the availability of remote appointments with participants as a benefit to both the staff and some participants and expressed the desire to maintain remote visits as an option after COVID-19 safety concerns are resolved.

Staffing

Prior to the completion of this Assessment, the State WIC Program had identified several staffing needs that are also reflected in the findings of this Assessment. These needs include identifying appropriate staffing levels for CPAs and RDNs, appropriate ways to increase eligibility for CPA positions in rural areas without compromising service delivery, and an increase in available Registered Dietitian Nutritionists (RDNs) and Native Breastfeeding Peer Counselors (BPCs).

Due to the wide variation in area of coverage, participant population, and rurality, it is difficult to determine appropriate "one-size-fits-all" staffing level recommendations for each local agency and clinic. This Assessment provides some additional insight into determining these levels, with the calculation of staff to participant ratios and specific staffing questions aimed at directors in the WIC Needs Assessment Survey 2021. Both sources indicated that there are likely specific areas where staffing levels need to be addressed, with reasons and issues differing in rural, Tribal, and urban areas.

Montana's strained workforce capacity makes finding adequately educated staff a chronic challenge (High

Country News 2018, Montana Labor Day Report 2019). Further investigation needs to be conducted into determining adequate standard staffing levels for the Montana WIC Program that account for the variation in needs across local agencies in conjunction with increased efforts to address the workforce shortage. Specifically, there are dramatic shortfalls in the availability of RDNs and Native BPCs. While each local agency has access to an RDN, many are contracted out from other agencies or are not directly employed by WIC. Improving the proportion of RDNs to WIC participants will provide a higher quality of service delivery and value to WIC participants. Of the 14 BPCPs, only two serve Native communities, and there is only one Native BPC. Peer counselors should ideally be from and representative of the community they are serving. In conjunction with the previous recommendation to expand BPCPs, the Montana WIC Program should increase efforts towards recruiting and hiring BPCs from the various Native communities in Montana to serve their communities.

WIC staffing models at both the State and local levels already receive job training aligned with federal requirements. However, the Needs Assessment process identified a few areas where additional training may be helpful. These areas include referring participants to relevant community services (specifically using the CONNECT platform to accommodate this), breastfeeding support and education, general education counseling skills, and better training in mental health and substance use issues and specifically how to create WIC environments supportive of these conditions.

Native Populations

Throughout this Assessment, an emphasis was placed on ensuring that the needs and services provided to Native communities was consistently reviewed so that further work can support putting resources into these communities that have historically experienced higher rates of health inequities than their White counterparts. The Montana WIC Program is excelling at recruiting and retaining Native participants and has seen an increase in participation from other non-White groups as well. Despite this, there are service disparities in Breastfeeding Peer Counseling Programs among Tribal WIC agencies (there are no BPCP which are directly provided through Tribal WIC agencies) and lower breastfeeding rates at initiation and over time among Native women utilizing the Montana WIC Program.

More should be done to understand the specialized

needs of Tribal communities, such as culturally relevant nutrition education, foods, and traditional ways of knowing. Additionally, more could be done to specifically ensure that Tribal WIC clinics have the funding, staffing, training, and resources necessary to support culturally responsive and supportive service delivery for their communities and ultimately improve racial health equity among participants.

Additional weight should be given to continuing to address the unique needs of Montana's other special populations, which may include Black and Hispanic communities, refugee populations, people with disabilities, foster families, and others to ensure the continuity of equity of WIC service provision.

Data Use and Quality

The Montana WIC Program collects an extensive amount of data through various outlets including the M-SPIRIT system, annual surveys of participants and staff, DPHHS epidemiologists, the USDA, CDC, and other secondary sources. While this Needs Assessment is a sufficient starting point for utilization of this data, applicability and usability of data collected should be considered in the future so that specific pieces of data are tied to specific programmatic goals and assessment. This will streamline data collection and use and prevent survey fatigue, inefficient use of staff time, and other redundancies.

Using data to identify areas of need and measure change in a program are not new concepts to the Montana WIC Program. The Program currently relies on a robust integration of the M-SPIRIT data with the data

visualization benefits of Tableau to assist staff at the State and local levels to understand their participants' needs, utilization patterns, and other programmatic markers. Additionally, the Program has access to large data sets through MT PRAMS, MT hospital discharge data, MT Medicaid, and other statewide benefit programs that can be compared to and stratified by WIC participants. Many of these sources require the expertise and talents of the DPHHS epidemiology department staff to analyze. Planning for the exact data that would be helpful to drive the entire Program, or specific initiatives, forward may be a worthwhile endeavor to ensure that data from these sources are collected in a way that ensures they are available when needed and enables comparison with State and National data sources. This may necessitate considerations regarding timespan, frequency of data collection, method of data collection, variable definitions, and more. One such recommendation for variable definitions is the removal of local agency size categorization. Defining agencies as small, medium, or large is becoming irrelevant due to the consistent decline in participation and therefore consistent reduction in agency size. It may also be necessary to integrate additional validated screeners for food security, nutrition quality, behavioral health, and other areas to collect more reliable information on participants to compare and track program progress. Additionally, improvements in retention data calculations should be considered to ensure the most meaningful and useful data are extracted on this important topic. It may be helpful to learn from what other states have used when determining retention. However, the functionality and usability of Tableau (the main aggregated data access platform for WIC staff) has been insufficient for the needs of the local agency staff. The Montana WIC Program may consider providing local agencies with monthly static reports, additional trainings, or even a comprehensive data quality assessment to increase the usability of data collected through the M-SPIRIT system or the utilization of another system. One way to adequately address many of these data use and quality concerns would be to hire an epidemiologist exclusively for the WIC program.

Data use and quality is an ever-present and often intransigent issue that becomes increasingly complex when considering a federal program implemented at state and local levels. While the Montana WIC Program uses an incredible amount of high-quality data to make decisions, a few key data use and quality issues could be addressed to ensure more reliable data is informing the monitoring and evaluation of the program going forward.

Funding

WIC programs are funded through federal budget determinations, which can be limiting and unpredictable. However, State WIC Programs can request additional funding at the federal level and apply for separate funding through grants, and local agencies may request additional funding as needs are identified. When surveyed, 21% of Montana local agencies believed they received insufficient funding to meet their staffing, clinic hours, and service provision needs. Others stated that funding received could not meet their supply, travel, or training needs. Because funding received from the federal government is directly related to participation count, the decrease in participation seen over the last several years has led to a decrease in funding across all local agencies. The decline in funding often leads to a decrease in the services local agencies can provide, which may in turn decrease participation. The State is aware of this issue and is working to evaluate equity in their funding to local agencies, as well as considering various adjustments based on Affirmative Action plans and cost of living. It is recommended that alternative funding sources, including efforts to increase billable services, be considered to address funding shortfalls. All the previous recommendations mentioned thus far will be aided by an increase in funding, including additional research into data quality and staffing needs, an increase in staffing, creative solutions to increase participation and benefit utilization, and expansion of BPCPs.

NEXT STEPS

The Montana WIC Program is a cornerstone in providing support to the women, infants, and children of Montana. This program's nutrition and breastfeeding services are invaluable to thousands of families across the state each year. As the program continues to adjust to the ever-changing political and socio-economic environment, several next steps will assist the Program in making plans to address the above recommendations.

1. Comprehensive Nutrition Services Standards Self-Assessment - This will serve to provide detailed information from each local agency on their ability to meet the 16 NSS and thereby identify specifically where improvements need to be made.

2. Comprehensive State Nutrition Services Plan - While Montana has had a basic Nutrition Services Plan in the past, the comprehensive plan will be based off of this Assessment and the results of the NSS Self-Assessment and will therefore be evidence-based in order to most effectively improve WIC services across the State. A key part of this plan could review all local agencies' nutrition and breastfeeding plans to determine current focus areas and align all local agencies' nutrition and breastfeeding services plans with the State plan, ensuring that each agency is working towards the same overarching goals as the State. This alignment will also aid the State in the ongoing monitoring and evaluation of local agencies and clinics.

3. Feasibility Study for the Expansion and Integration of Services - A feasibility study could determine the viability of expanding WIC services to a wider population through integration into primary care settings, including comprehensive budget reviews, staffing considerations, and technological capacities this would entail.

4. Participation Recruitment and Retention Plan - Due to the imperative nature of improving participation in the Montana WIC Program, a plan around participant recruitment and retention may be necessary to conduct outside of the Comprehensive State Nutrition Services Plan. This plan could consider and target efforts to mitigate the decline in participation by specifically targeting the demographics that are participating at lower rates while ensuring that populations with historically disparaging health inequities are consistently recruited and retained.

5. Comprehensive WIC Data Quality Review and Plan - This plan would ideally involve a comprehensive look at all data needs across the State level and local agencies to identify specific data needs, collection methods, alignment with collection at the state and national levels, responsible party for collecting and disseminating the data elements, and timelines for collection. This process would support future iterations of WIC Needs Assessments, quality improvement efforts, and more accurately determine which areas are ripe for improvement.

CONCLUSION

The Montana WIC Program consistently strives to provide high-quality services to its participants. With the completion of this Montana WIC Needs Assessment, it is poised to implement evidence-based and data-driven improvements in a more pointed way than ever before. These improvements will widely benefit families across Montana and staff who dedicate their professional talents to the Program.

Specifically, Montana WIC is not alone in its experience of declining eligibility and participation in the WIC Program. Still, the Program is hopeful that with innovative and data-driven responses, Montana can interrupt these trends. The rural nature of Montana also provides unique challenges to service provision that aren't necessarily seen in most of the United States. Addressing these challenges with creative solutions will improve participation and quality of services in the State, including experimenting with more integration of WIC services into primary care. Expanding Breastfeeding Peer Counseling Services and Registered Dietitian Nutritionist services are clearly desired by participants and staff and ripe for expansion. Still, these too will require creative implementation due to the State's rural nature. Staffing, data, equitable health service provision, and funding considerations will play a role in all aspects of further innovations and improvements.

Continuing to study trends and create targeted plans that align local, state, and federal goals will lay the foundation for a more equitable, responsive, and relevant Montana WIC Program for years to come.

REFERENCES

CITATION CODE	CITATION	DATA YEARS
ACS 2018 1YR Estm Dat	U.S. Census Bureau. 2018. Hispanic or Latino Origin by Race in Montana. American Community Survey 1-year estimates. Retrieved from: https://data.census.gov/cedsci/table?q=race%20and%20ethnicity&g=0400000US30&tid=ACSDP1Y2018.DP05&hidePreview=true&moe=false	2018
ACS 2019 1YR Estm Det	U.S. Census Bureau. 2019. Racial Makeup of Six Counties in Montana. American Community Survey 1-year estimates. Retrieved from: https://data.census.gov/cedsci/table?t=Race%20and%20Ethnicity&g=0100000US_0400000US30_0500000US30013,30029,30031,30049,30063,30111&tid=ACSDT1Y2019.B02001&hidePreview=false.	2019
Allen, Gillen, & Rixson 2009	Allen, D., Gillen, E., & Rixson, L. 2009. Systematic review of the effectiveness of integrated care pathways: What works, for whom, in which circumstances? International Journal of Evidence-Based Healthcare 7(2), 61–74. doi:10.1111/j.1744-1609.2009.00127.x.	2009
Baby-Friendly Facilities By State 2021	Baby-Friendly USA. 2019. BABY-FRIENDLY Facilities a-z and by state. Retrieved on March 26, 2021 from: https://www.babyfriendlyusa.org/for-parents/baby-friendly-facilities-by-state/.	2021
Barrera, Hamner, Perrine, & Scanlon 2018	Barrera, C. M., Hamner, H. C., Perrine, C. G., & Scanlon, K. S. 2018. Timing of Introduction of Complementary Foods to US Infants. National Health and Nutrition Examination Survey 2009–2014. Journal of the Academy of Nutrition and Dietetics 118(3), 464–470. doi:https://doi.org/10.1016/j.jand.2017.10.020.	2018
Carolina Ready, Set, BABY 2021	UNC Gillings School of Global Public Health. 2020. Ready, Set, BABY. Retrieved on March 26, 2021 from: https://sph.unc.edu/cgbi/ready-set-baby/.	2021
CDC Breastfeeding Report Card 2016	Division of Nutrition, Physical Activity and Obesity. 2016. Breastfeeding Report Card United States, 2016. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from: https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf	2016
CDC Breastfeeding Report Card 2018	Division of Nutrition, Physical Activity and Obesity. 2018. Breastfeeding Report Card United States, 2018. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from: https://www.kdheks.gov/nws-wic/memos/2019/CDC_2018_Breastfeeeding_Report_Card.pdf	2018
CDC Breastfeeding Report Card 2020	Division of Nutrition, Physical Activity and Obesity. 2020. Breastfeeding Report Card United States, 2020. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from: https://www.cdc.gov/breastfeeding/pdf/2020-Breastfeeding-Report-Card-H.pdf.	2020
CDC Childhood Obesity 2018	Centers for Disease Control. 2018. Childhood Overweight and Obesity. Retrieved on March 26, 2021 from: https://www.cdc.gov/obesity/data/childhood.html	2018
CDC NCHS Births 2019	Martin, J. A., Hamilton, B. E., & Osterman, M.J.K. 2020. Births in the United States, 2019. NCHS Data Brief no 387. Hyattsville, MD: National Center for Health Statistics. Retrieved from: https://www.cdc.gov/nchs/data/databriefs/db387-H.pdf	2019
CDC State Birth Delivery Method 2018	United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics, Natality public-use data 2016-2019, on CDC WONDER Online Database, October 2020. Retrieved from: http://wonder.cdc.gov/natality-expanded-current.html	2018
CDC State Low Birthweight Rate 2014–2018	Martin, J. A., Hamilton, B. E., Osterman, M.J.K., & Driscoll, A. K. 2020. Births: Final Data for 2018–Percentage of Babies Born Low Birthweight by State. National Health Statistics Reports 68(13). Hyattsville, MD: National Center for Health Statistics. Retrieved from: https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm	2018

CITATION CODE	CITATION	DATA YEARS
CDC State Teen Birth Rate 2014–2018	Martin, J. A., Hamilton, B. E., Osterman, M.J.K., & Driscoll, A.K. 2018. Births: Final Data for 2018—Teen Birth Rate by State, 2018. National Vital Statistics Reports vol 68, no 13. Hyattsville, MD: National Center for Health Statistics. Retrieved from: https://www.cdc.gov/nchs/pressroom/sosmap/teen-births/teenbirths.htm.	2018
CDC Vital Stat 2018	Martin, J.A., Hamilton, B.E., Osterman, M.J.K, & Driscoll, A.K. 2021. Births: Final Data for 2019. National Vital Statistics Reports vol 68, no.13. Hyattsvill, MD: National Center for Health Statistics. Retrieved from: https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf	2010-2018
CDC Vital Stat 2019	Martin, J.A., Hamilton, B.E., Osterman, M.J.K, & Driscoll, A.K. 2021. Births: Final Data for 2019. National Vital Statistics Reports vol 70, no2. Hyattsville, MD: National Center for Health Statistics. Retrieved from: https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf	2010-2019
CFR 2020	Special Supplemental Nutrition Program for Women, Infants and Children, 7 CFR 246 (2020).	2020
Duffy, Kay, & Jacquier 2019	Duffy, E. W., Kay, M. C., Jacquier, E., Catellier, D., Hampton, J., Anater, A. S., & Story, M. 2019. Trends in Food Consumption Patterns of US Infants and Toddlers from Feeding Infants and Toddlers Studies (FITS) in 2002, 2008, 2016. Nutrients 11(11), 2807. Retrieved from: https://doi.org/10.3390/nu11112807	2019
FNS WIC Nutrition Standards 2013	United States Department of Agriculture Office of Federal Nutrition Services. 2013. WIC Nutrition Services Standards. Retrieved from: https://wicworks.fns.usda.gov/sites/default/files/media/document/WIC_Nutrition_Services_Standards.pdf	2013
Food Insecurity MT Little 2020	Little, L. 2020. Food Insecurity in Montana and How WIC Helps. Unpublished manuscript.	2017–2020
High Country News 2018	Saboe, B., 2018, A majority of Montana counties face primary care shortages: The gap in health care access is particularly acute in rural areas, High Country News, Retrieved March 30, 2021, from https://www.hcn.org/articles/the-montana-gap-a-majority-of-montana-counties-face-primary-care-shortages	2018
Hunger in Montana Report 2018	Montana Food Bank Network. 2018. Hungry in Montana: Factors Leading to Emergency Food Needs. Retrieved from: https://mfbn.org/wp-content/uploads/2019/04/2018-Hungry-in-Montana-Report.pdf.	2018
Johnston, Landers, & Noble 2012	Johnston, M., Landers, S., & Noble, L. 2012. Breastfeeding and the Use of Human Milk. Pediatrics 129(3). doi:10,1542/peds, 2011-3552.	2012
Montana Labor Day Report 2019	Montana Department of Labor and Industry. 2021. Montana Labor Day Report 2019, from: https://news.dli.mt.gov/_docs/LDR-2019.pdf	2019
MT Affirm Action 2014-2018	Montana Department of Public Health and Human Services. 2020. Affirmative Action Table, 2014-2018. Unpublished data.	2014-2018
MT Participant Satisfaction Survey 2020	Montana Department of Public Health and Human Services. 2020. WIC Participant Survey Analysis 2018-2020. Unpublished data.	2018–2020
MT Preg Entry 2017–2019	Montana Department of Public Health and Human Services. 2019. WIC Participant Pregnant Entry Data Tables, 2017–2019. Unpublished data.	2017–2019
MT Vital Stat 2016	Office of Vital Statistics, Montana Department of Public Health and Human Services. 2016. Montana Vital Statistics Report 2016. Retrieved on October 1, 2020 from: Indicator-Based Public Health Information System website: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/VSU/VSU2016AnnualReport.pdf	2016
MT Vital Stat 2017	Office of Vital Statistics, Montana Department of Public Health and Human Services. 2017. Montana Vital Statistics Report 2017. Retrieved on October 1, 2020 from Indicator-Based Public Health Information System website: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/VSU/VSU2017AnnualReport.pdf	2017

CITATION CODE	CITATION	DATA YEARS
MT Vital Stat 2018	Office of Vital Statistics, Montana Department of Public Health and Human Services. 2018. Montana Vital Statistics Report 2018. Retrieved on October 1, 2020 from: Indicator-Based Public Health Information System website: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/VSU/VSU2018AnnualReport.pdf	2018
MT Vital Stat 2019	Office of Vital Statistics, Montana Department of Public Health and Human Services. 2019. Montana Vital Statistics Report 2019. Retrieved on October 1, 2020 from: Indicator-Based Public Health Information System website: https://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/VSU/VSU2019AnnualReport.pdf	2019
MT WIC BSFD Data 2017-2019	Montana Department of Public Health and Human Services. 2020. M-SPIRIT data, "Statewide Breastfeeding Tables" 2019. Unpublished data.	2017-2019
MT WIC BSFD Report 2020	Montana Department of Public Health and Human Services. 2020. Breastfeeding Among WIC Participants 2016-2018. Retrieved from: https://dphhs.mt.gov/Portals/85/publichealth/documents/WIC/Data/BFReport.pdf	2016-2018
MT WIC Certified Infants Data 2021	Montana Department of Public Health and Human Services. 2021. Email communication, 2021. Unpublished data.	2011-2019
MT WIC Customer Service Survey 2017-2020	Montana Department of Public Health and Human Services. 2021. WIC Customer Service Survey Analysis, 2017-2020. Unpublished data.	2017-2020
MT WIC FMNP Data 2021	Montana Department of Public Health and Human Services. 2021. Email communication, 2021. Unpublished data.	2018-2020
MT WIC GIS Maps 2021	Montana Department of Public Health and Human Services. 2021. Montana WIC GIS Maps, 2021. Unpublished GIS Map.	2021
MT WIC M-SPIRIT Benefit Package Data 2021	Montana Department of Public Health and Human Services. 2021. WIC M-SPIRIT, "Percentage of Benefits Redeemed" 2021. Unpublished raw data.	2021
MT WIC M-SPIRIT Food Package Redemption Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Data, "Food Package Redemption" 2021. Unpublished data.	2018-2020
MT WIC M-SPIRIT Participant Authorization Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Data, "Relationship to Participant" 2021. Unpublished data.	2021
MT WIC M-SPIRIT Participant Referral Data 2021	Montana Department of Public Health and Human Services. 2021. WIC M-SPIRIT, "Participant Referral Data" 2021. Unpublished data.	2021
MT WIC M-SPIRIT PHQ-2 Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Data, "PHQ-2 Survey Results" 2021. Unpublished data.	2018–2020
MT WIC M-SPIRIT Retention Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Data, "WIC Retention" 2021. Unpublished data.	2021
MT WIC Needs Assessment Survey 2021	Montana Department of Public Health and Human Services. 2021. MT WIC Needs Assessment Survey. Unpublished data.	2021
MT WIC PedPNSS	Montana Department of Public Health and Human Services. 2019. WIC Pediatric Nutrition Surveillance System (PedPNSS) Data, 2019. Unpublished data.	2019
MT WIC PNSS 2019	Montana Department of Public Health and Human Services. 2019. WIC Pregnancy Nutrition Surveillance System (PNSS) Data, 2019. Unpublished data.	2019

CITATION CODE	CITATION	DATA YEARS
MT WIC Prams Breastfeeding Data 2021	Montana Department of Public Health and Human Services Prams Data, "Breastfeeding Cessation Reasons" 2021. Unpublished data.	2017–2018
MT WIC Prams PHQ-2 Survey Data 2021	Montana Department of Public Health and Human Services. 2021. Prams Data, "PHQ-2 Survey Results" 2021. Unpublished data.	2018–2020
MT WIC Vital Stats—Birth Characteristics Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Vital Statistics and Birth Certificate Data, "WIC Needs Assessment" 2021. Unpublished raw data.	2021
MT WIC Vital Stats—Birth Method Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Vital Statistics and Birth Certificate Data, "WIC Needs Assessment" 2021. Unpublished raw data.	2018
MT WIC Vital Stats—Breastfeeding Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Vital Statistics and Birth Certificate Data, "WIC Needs Assessment" 2021. Unpublished raw data.	2016–2020
MT WIC Vital Stats—Preterm Birth Data 2021	Montana Department of Public Health and Human Services. 2021. M-SPIRIT Vital Statistics and Birth Certificate Data, "WIC Needs Assessment Epi Data" 2021. Unpublished raw data.	2018–2019
MT WIC Vital Stats—Teen Birth Data 2021	Montana Department of Public Health and Human Services. 2021. Vital Statistics and Birth Certificate Data, "WIC Needs Assessment" 2021. Unpublished raw data.	2021
MTLBWPR 2016–2018	Montana Department of Public Health and Human Services. 2018. WIC Participant Low Birth Weight Data Tables, 2016–2018. Unpublished data.	2016–2018
USDA Breastfeeding Local Agency Report 2016	United States Department of Agriculture Supplemental Food Programs Division. 2017. WIC Breastfeeding Data Local Agency Report Fiscal Year 2016. Retrieved from: https://fns-prod.azureedge.net/sites/default/files/wic/FY2016-BFDLA-Report.pdf	2016
USDA Breastfeeding Local Agency Report 2019	United States Department of Agriculture Supplemental Food Programs Division. 2020. WIC Breastfeeding Data Local Agency Report Fiscal Year 2019. Retrieved from: https://fns-prod.azureedge.net/sites/default/files/resource-files/FY2019-BFDLA-Report.pdf	2019
USDA ERS Food Access Atlas 2021	United States Department of Agriculture Economic Research Service. 2021. Food Access Research Atlas. Retrieved from: https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/.	2020
USDA ERS Food Security 2021	United States Department of Agriculture Economic Research Service. 2021. Food Security in the U.S. Retrieved from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/	2021
USDA MT WIC Data 2016	United States Department of Agriculture. 2016. WIC Montana Participant and Program Characteristic Data Tables, 2016. Unpublished data.	2016
USDA MT WIC Data 2018	United States Department of Agriculture. 2018. WIC Montana Participant and Program Characteristic Data Tables, 2018. Unpublished data.	2018
USDA PC Data 2016	Thorn, B., Kline, N., Tadler, C., Budge, E., Wilcox-Cook, E., Michaels, J., Mendelson, M., Patlan, K. L., & Tran, V. 2018. WIC Participant and Program Characteristics 2016. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service. Retrieved from: https://fns-prod.azureedge.net/sites/default/files/ops/WICPC2016.pdf	2016

CITATION CODE	CITATION	DATA YEARS
USDA PC Data 2018	Kline, N., Thorn, B., Bellows, D., Wroblewska, K., & Wilcox-Cook, E. 2020. WIC Participant and Program Characteristics 2018. Alexandria, VA: U.S. Department of Agriculture, Food and Nutrition Service. Retrieved from: https://fns-prod.azureedge.net/sites/default/files/resource-files/WICPC2018.pdf	2018
USDA WIC Breastfeeding Support 2021	United States Department of Agriculture Special Supplemental Nutrition Program. 2021. WIC Breastfeeding Support. Retrieved from: https://wicbreastfeeding.fns.usda.gov/	2021
USDA WIC Eligibility Criteria 2021	United States Department of Agriculture Special Supplemental Nutrition Program. 2021. WIC Eligibility Requirements. Retrieved from: https://www.fns.usda.gov/wic/wic-eligibility-requirements	2021
USDA WIC Farmers Market Programs 2021	United States Department of Agriculture Food and Nutrition Service. 2021. Farmers Market Nutrition Program. Retrieved from: https://www.fns.usda.gov/fmnp/wic-farmers-market-nutrition-program	2021
USDA WIC Participation Decline 2016	United States Department of Agriculture Food and Nutrition Service. 2016. WIC Participation Continues to Decline. Retrieved from: https://www.ers.usda.gov/amber-waves/2017/june/wic-participation-continues-to-decline/	2016
WIC BPC Success 2019	National WIC Association: WIC's Breastfeeding Peer Counselor Program. 2019. Breastfeeding Peer Counselors: A Successful Program That Should Be Expanded [Press release]. Retrieved on March 26, 2021 from: https://thewichub.org/breastfeeding-peer-counselors-a-successful-wic-program-that-should-be-expanded/	2019
WIC MT Agency List 2020	https://dphhs.mt.gov/Portals/85/ecfsd/documents/WIC/2021StatePlan/Attachments/LocalAgencyPhoneList.pdf	2020
WIC MT Elg Census 2013–2018	U.S. Census Bureau. 2020. Profile of WIC Eligibility and Participation in Montana, 2018: Evidence from Administrative Records and the American Community Survey. Retrieved from: https://drive.google.com/file/d/1y67LmYil_3rn9dRRLD97XVGj0XNI2NxU/view?usp=sharing.	2013–2018
WIC Part Count 2016–2020	Montana Department of Public Health and Human Services. 2020. WIC Participant Counts Data, 2020. Unpublished raw data.	2016–2020
WIC Staff Density 2021	Montana Department of Public Health and Human Services. 2021. WIC Staffing Density, 2021. Unpublished raw data.	2021

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