
Chapter IV

Nutrition Services



Chapter IV. Nutrition Services

I. Introduction

This chapter describes and assesses nutrition services provided by WIC local agencies, based on both Local Agency Survey data and case study information. The assessment is based, in part, upon nutrition services standards jointly developed by the Food and Consumer Service (FCS) and the National Association of WIC Directors (NAWD) as part of the "Focus on Management" (FOM) initiative. In addition, our assessment considers the impact of growth on the delivery and quality of nutrition services. The FOM Nutrition Services Standards apply to the following nutrition services components:

- Nutrition/Health Assessment
- Nutrition Services Plan
- Nutrition Education
- Qualifications and Roles of Nutritionists
- Nutrition Staff Training
- Food Packages.

Each of these areas is addressed below, within the context of local agency operations. For example, preparation of a nutrition services plan, primarily a State activity, is discussed in the context of local agency evaluation activities.

II. Assessment and Care Plan

Nutrition assessment is technically part of both the certification process and the nutrition education process. The participants' nutritional risk must be determined before certification can take place. In most cases, eligibility is determined at the time of application, but all applicants must be notified of their eligibility within 20 days. Development of a care plan is based upon the nutrition/health assessment.

Nutrition/Health Assessment. The WIC eligibility process requires certification of nutritional risk. The participants' nutritional status is determined through an assessment of medical/health history, diet, anthropometric status, and blood work status.¹ Blood tests to determine iron levels are administered, height and weight measurements are taken, and a dietary assessment is completed. Using this information, the nutritionist or nutrition staff member determines whether the participant has any nutritional risks.

¹Young infants are exempted from blood work requirement.

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As indicated in Exhibit IV-1, 18 of the 22 case study sites had registered dietitians or licensed nutritionists conducting the nutrition assessments. Other staff completing this function include other professional nutritionists, paraprofessionals, and nurses.

The dietary assessment process often begins with the participant providing a diet history or 24-hour recall form on the food eaten by the participating family member. All of the case study sites used the 24-hour recall instrument as the method for assessing the participant's dietary status.

Exhibit IV-1

WIC Nutrition Services by Type of Staff
(Number of Case Study Sites)

Service/Activity	Staff Category—WIC Staff or Consultants							
	RD or Licensed Nutritionist	Other Nutritionist	Paraprof. Bachelor's Level	Other Paraprof.	Clerk	Nurse	Lactation Consultant	Other
Income Eligibility Determination	4	1	2	9	15	0	0	0
Measure Height/Weight	9	4	2	6	1	4	1	0
Perform Blood Testing for Anemia	7	3	2	5	0	5	1	0
Nutrition Risk Determination	18	10	3	7	0	2	0	0
Develop Indiv. Care Plan	16	8	2	2	0	2	0	0
Provide Indiv. Nutrition Education	18	11	5	8	2	2	0	0
Conduct Group Nutrition Education	14	8	4	5	1	1	0	0
Instruct on Use of Vouchers	10	4	3	8	16	0	0	1
Issue Voucher	7	4	2	9	14	1	0	1
Breastfeeding Promotion/Support	17	9	4	9	1	2	9	2

Source: 22 case studies, WIC Dynamics, 1993.

In general, the nutrition assessment provides the basis for the particular nutrition education needs of each participant. As part of the nutrition education session, participants are often asked to complete a food frequency form, checking the frequency with which each specific food is eaten. Fourteen of the 22 case study sites used this as part of the dietary assessments. Using this tool, nutrition staff can determine the patterns of eating rather than relying exclusively on the previous day's recall for a measure of how a person usually eats. Nutritionists then talk to participants about their intake and will suggest ways in which a participant may vary her/his diet so as to reduce nutritional risk.

Individual Care Plan. The development of an individual care plan (ICP) follows the assessment process. This plan is most often written as medical notes—Subjective, Objective, Assessment, and Plan (SOAP) format. The purpose of the plan is to describe the participant's condition and suggest actions that might improve that condition. For the most part, an ICP is developed only for high-risk participants. Eighteen of the case study sites developed ICPs for their high-risk participants. The ICP is most often documented in the participant's record. Optimally, the ICP would be developed with the participant's input and would be given to the participant as a learning aid. This was observed at some of the case study sites. For example, in York, PA, the nutritionist explains the purpose of the individual care plan and the need for more extensive nutrition education to the client. In Portage-Columbiana, OH, clients work with the dietitian or nutritionist to develop their own goals for the individual care plan. These goals are written on the folder provided to the client and discussed at the next visit. However, according to one nutritionist in a New York City site, there may be little followup on the ICP on subsequent visits to the WIC clinic if participants see different staff members at each visit. Although the plan is in the participant's record, it is not necessarily referred to during subsequent visits.

The final activity in a nutritional assessment is documentation in the participant's record. A record review at the 22 case study sites revealed that the records do contain a great deal of information, as presented in Exhibit IV-2. As is evident from this exhibit, the only item included by less than half of the sites is followup on referrals. Note that 19 of the 22 sites document the referrals that are made to other programs. Interviews with WIC staff revealed that they perceive the documentation process to be a major time consumer.

III. Nutrition Education

This section describes the delivery of nutrition education and counseling services in WIC, including qualifications and roles of WIC staff, types of education sessions offered, frequency and length of sessions, and breastfeeding promotion activities. Factors which affect the delivery and quality of nutrition education, and local agency perceptions of the quality of nutrition education are also presented in this section.

Exhibit IV-2

Case Studies

Record Review Summary

Record Characteristics/Feature	Number of Sites
Content:	
WIC Only	13
Integrated with Other Health Records	5
Items Contained in Record	
Date of Enrollment	21
Participant Category	21
Height and Weight	22
Date of Birth	22
Data Plotted on Growth Chart	22
Dietary Intake/Food Frequency	22
Dietary Assessment	21
Medical Risks	22
Reasons for Certification	22
Income	21
WIC Priority Group	21
Current Food Package	22
Reasons for Tailoring or Substitutions	15
Referral to Other Programs Outside of WIC	19
Followup of Referrals	10
Source of Referral to WIC	12
Source of Health Care	19
Name of Physician	21
Nutrition Education Topics and Dates	22
Date of Next Certification	22
Individualized Care Plan	17
Notes on Medical Background	17
Notes on Social Background	17

Source: 22 case studies, WIC Dynamics, 1993.

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Qualifications and Roles of Nutrition Education Staff. Nutrition education is conducted by nutritionists, dietitians, diet technicians, paraprofessionals, and other health professionals. Nutritionists may or may not be licensed or registered, depending on the State licensure requirements. Some States require all people using the title "nutritionist" to meet licensing requirements, while others require licensing for nutritionists providing therapeutic services (not including weight loss, for example). Many clinics and hospitals require nutrition staff to be either licensed or to be a registered dietitian. Whether or not a person is licensed does not reflect the type of educational degree they have; nutritionists can have either a bachelor's or a master's degree. As presented in Exhibit IV-3, survey data indicate that approximately 25 percent of all agencies have no licensed or registered nutrition education staff; another 25 percent have 25-50 percent of their nutrition staff licensed or registered; and 22 percent of the agencies have over three-fourths of their nutrition education staff licensed or registered. In the case study sites, 18 of the agencies had a licensed, registered, or certified nutrition professional providing nutrition education to participants (see Exhibit IV-1).

Exhibit IV-3

Percent of Local Agencies Whose Total Nutrition Staff Are Licensed/Registered Staff, Paraprofessional Staff, and Others

Percent of Total Nutrition Staff	Percent of Local Agencies Whose Total Nutrition Staff Is:		
	Licensed (%)	Paraprofessional (%)	Other Professionals (%)
None	25	67	32
1% to 10%	2	2	2
11% to 25%	17	6	7
26% to 50%	26	12	25
51% to 75%	8	11	12
76% to 100%	22	3	22
Total	100	100	100

Source: Based on estimates for 1,777 local agencies. Local Agency Survey, WIC Dynamics, 1993.

The majority of case study sites used nutritionists to provide nutrition education, although paraprofessionals also played a role in some sites. Data from the case studies indicate that 5 out of 22 (23%) of the sites used paraprofessionals with a bachelor's degree and 8 sites (36%) used some other paraprofessionals to provide nutrition education. Note that the data collected from the case studies does not refer to exclusive use of a professional or paraprofessional. Sites often used a mix of professionals and paraprofessionals as their nutrition team. Data from the Local

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Agency Survey indicate that one-third of agencies use paraprofessional staff to provide nutrition education.

Type of Session—Individual or Group. Data from the Local Agency Survey indicate that 98 percent of all agencies offer individual nutrition education sessions (Exhibit IV-4). In addition, 57 percent offer small groups (2-9 people); 47 percent offer medium groups (10-19 people); 21 percent offer large groups (20-29 people); and 10 percent offer very large groups (30 people or more). When analyzed by the number of participants in these various sites, almost 50 percent of participants are in agencies offering large groups and 18 percent are in agencies offering very large groups. Among the 22 case study sites, five offered only individual sessions, five sites had small groups, nine offered medium groups, one offered large groups, and three offered very large groups. The study did not investigate the relationship between group and individual sessions.

Exhibit IV-4

Group Size for Providing Nutrition Education

Group Size	Agency (%)	Participant (%)
Individual	98	98
Small Group (2-9)	57	64
Medium Group (10-19)	47	62
Large Group (20-29)	21	47
Very Large Group (30+)	9	18

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

Since 1988, over half (57%) of the agencies have increased their use of group education sessions (Exhibit IV-5). However, equal proportions of agencies (slightly more than 25%) reported switching from one type of session to the other, that is, either offering more group and less individual sessions, or more individual and less group sessions. Regardless of any changes in session format, more agencies are offering group sessions. Since 1988, 40 percent of agencies have increased their class size and 56 percent increased their use of handouts and pamphlets.

Exhibit IV-5

Changes in Nutrition Education Practices Since 1988

Specific Changes in Nutrition Education Operations	Implemented Changes	
	Agency (%)	Participant (%)
Increased group nutrition education	57	66
More group nutrition, fewer individual sessions	26	43
More individual nutrition, fewer group sessions	27	22
Placed more emphasis on breastfeeding	97	98
More staff time per participant for nutrition education	33	33
Less staff time per participant for nutrition education	35	45
Paraprofessionals deliver nutrition education	38	47
More handouts and pamphlets	56	61
Increased class size	41	59
Decreased class size	7	10
Other	3	8

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

Frequency and Length of Sessions. As stated above, Federal regulation requires WIC agencies to offer nutrition contacts to each participant twice per certification period. The majority of agencies report offering nutrition education at least this frequently, and it appears that nutrition education contacts are made at varying degrees of frequency. Eleven percent reported only one nutrition education contact for high-risk participants, and 29 percent reported this infrequent contact with non-high-risk participants. Further analysis of this data revealed that all but 3 of the 11 percent and 20 of the 29 percent also reported contacts at another frequency (e.g., twice per certification period). We contacted some respondents who indicated that they made only one contact. The consistent explanations given indicated that they did not count the nutrition education provided as part of initial certification as one of the two contacts, so they reported only one. Therefore, it appears that local agencies are in compliance, but that about 30 percent of them classify the nutrition education that occurs during certification as a certification activity, rather than solely a nutrition education contact. However, nutrition education and counseling does take place during this initial visit.

Exhibit IV-6

Frequency of Nutrition Education Contacts

Frequency	High-Risk Participant		Non-High-Risk Participant	
	Agency (%)	Participant (%)	Agency (%)	Participant (%)
Once Per Certification Period*	11	8	29	21
Twice Per Certification Period	43	46	54	56
Monthly	42	35	10	9
Bimonthly	38	41	23	31
Other	8	16	3	4
Don't Know	0	0	0.9	1

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

Note: Percents add to greater than 100 percent because local agencies provided contacts at more than one frequency.

*Follow-up calls revealed that some local agencies do not characterize the initial visit as a nutrition education contact, but rather as a certification. However, nutrition education and counseling do take place during this initial certification visit.

Local agencies reported that the length of time spent waiting for and participating in nutrition education sessions also varies widely. Typically, agencies have less than a 10-minute waiting time for nutrition education (Exhibit IV-7). Sixty-eight percent of agencies have a waiting time of 10 minutes or less for individual sessions, and 73 percent have the same wait for group sessions.

Exhibit IV-7

Typical Number of Minutes Participants Wait for Group and Individual Nutrition Education

Typical Number of Minutes Waiting for Service	Group Nutrition Education		Individual Nutrition Education (%)	
	Agency (%)	Participant (%)	Agency (%)	Participant (%)
0 to 5	49	30	38	24
5 to 10	24	24	30	26
10 to 15	14	24	17	18
15 to 30	7	15	12	22
More than 30	4	5	3	9
Total	100	100	100	100

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

The amount of time local agencies report that participants spend receiving education was generally 15 to 30 minutes for all group sessions. Among agencies providing non-high-risk group education sessions, 51 percent offer 15- to 30-minute sessions; among agencies providing high-risk group sessions, 58 percent offer sessions of that same length (Exhibit IV-8a). High-risk individual education was generally longer than non-high-risk education. Approximately 42 percent of agencies provided between 15- and 30-minute sessions for high-risk participants, compared to 14 percent of agencies providing such lengthy sessions to non-high-risk participants. Thirteen percent of the agencies reported providing non-high-risk individual sessions that last less than 5 minutes. Among the case study sites, more than half (12 of the 22) spend between 10 and 15 minutes providing individual nutrition education (see Exhibit IV-8b).

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Exhibit IV-8a

Typical Number of Minutes Participants Spend Receiving Group and Individual Nutrition Education

Typical Number of Minutes Receiving Service	Group Nutrition Education (not high-risk)		Group Nutrition Education (high-risk)		Individual Nutrition Education (not high-risk)		Individual Nutrition Education (high-risk)	
	Agency (%)	Participant (%)	Agency (%)	Participant (%)	Agency (%)	Participant (%)	Agency (%)	Participant (%)
0 to 5	0.8	2	0	0	13	18	4	4
5 to 10	9	9	11	8	39	35	20	22
10 to 15	23	27	9	15	32	33	28	23
15 to 30	51	54	58	62	14	12	42	42
More than 30	16	9	22	15	2	3	7	10
Total	100	100	100	100	100	100	100	100

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

Exhibit IV-8b

Typical Number of Minutes Participants Spend Receiving Group and Individual Nutrition Education at 22 Case Study Sites

Typical Number of Minutes Waiting for Service	Individual Nutrition Education (# of sites)	Group Nutrition Education (# of sites)
0 to 5	0	0
5 to 10	2	2
10 to 15	12	3
15 to 20	7	3
20 to 25	3	3
25 to 30	0	3
More than 30	1	2

Source: 22 case studies, WIC Dynamics, 1993.

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Topics and Methods of Presentation. From a list of 14 potential nutrition education topics, more than 90 percent of the WIC local agencies said they offered each of the following 13 topics:

- Management of individual nutrition risk
- Importance of nutrition to health status
- Description of basic good diet
- Major nutrients provided by WIC package
- Other sources of particular nutrients
- Importance of diet for fetal growth
- Breastfeeding
- Handling of infant formula
- Solid and table foods
- Importance of nutrition for growth
- Nutritious snacks
- Dental health
- Risks of substance abuse.

Eighty-nine percent said they covered the 14th topic—use of whole cow's milk. In addition, 5 percent of the respondents wrote in topics related to food preparation/shopping/safety, while 8 percent said they covered other additional topics.

During the case study site visit observations, it was found that local agency procedures on the frequency and audience for the sessions differed across sites. Some agencies used a rotating topic schedule and did not direct the topics toward any specific group. Others rotated their topics, but controlled who the audience would be by having different categories of participants receive group education on different days. Others gave a series of topics targeted to a specific group—for example, pregnant and postpartum women generally were taught about the importance of diet on fetal growth, breastfeeding, and infant feeding.

In general, all agencies use a variety of presentation methods in their nutrition education sessions (Exhibit IV-9). For individual sessions, all agencies used verbal discussion and pamphlets. Other popular methods include food models (84%), films or videos (63%), and flip charts (58%). Computer-assisted instruction was used by only 3 percent of the agencies. In presenting group sessions, compared to individual sessions, agencies use less discussion (77%) and pamphlets (80%) in groups. There is a slightly greater use of films or videos (77%) and approximately the same amount of use of flip charts (61%). Food models are used less often (67%), but food demonstrations are more common (51%). Computer-assisted instruction is used by only 2 percent of sites during group instruction. These findings are similar to those from the case studies, which are also described in Exhibit IV-9.

Exhibit IV-9

Use of Nutrition Education Materials and Methods

Materials Used in Instruction	Used in Individual Nutrition Education Sessions (% of agencies)	Used in Group Nutrition Education Sessions (% of agencies)	Used in Individual Nutrition Education Sessions (# of case study sites)	Used in Group Nutrition Education Sessions (# of case study sites)
Verbal Discussion/Counseling	100	77	21	14
Pamphlets	100	80	21	14
Food Models	84	67	7	4
Food Demonstrations	26	51	2	5
Tests	26	39	7	6
Audiotapes	24	23	14	19
Slides	14	35		
Films/Videos	62	77		
Flip Charts	58	61		
Computer-Assisted Instruction	3	2	0	0
Other	2	5	0	0

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, and 22 case studies, WIC Dynamics, 1993.

It is interesting to note that almost 80 percent of the case study site agencies reported using audio-visual presentations on breastfeeding (not shown on table). This might reflect the numerous educational videotapes that have been produced and marketed on this topic. Other topics presented through audio-visual techniques by almost half of the agencies include description of a good diet, importance of a good diet for fetal growth, and nutritious snacks.

One of the more interesting activities noted during the case study visits was the use of "nutrition parties" in Portage-Columbiana, OH. This popular activity, which targets children, has attracted up to 400 children at some parties. The nutrition parties involved the use of games and healthy snacks as a way of teaching children (with some parental involvement) about good nutrition. This agency also provides nutrition education to kindergarten and Head Start students. Using a picnic basket, they teach children about the basic food groups.

Breastfeeding Promotion and Support. The most frequently mentioned change in nutrition education since 1988 has been the increased emphasis placed on breastfeeding (97% of agencies). Fourteen of the case study sites also reported this as a significant change in their agency's operations. Breastfeeding promotion has taken various forms, e.g., the use of peer support groups, the employment of or coordination with lactation consultants, the screening of all education materials distributed to exclude those promoting bottlefeeding, the development or use of written and audio-visual materials on breastfeeding, contacting women while they are still in the hospital after delivering their infant, providing special classes to all pregnant women, and emphasizing the benefits of breastfeeding in all individual and group sessions prior to and after delivery.

According to case study findings, both WIC and non-WIC staff have been involved in breastfeeding promotion. Among the WIC staff, the most commonly used staff were registered dietitians or licensed nutritionists (17 agencies); equally used were other nutritionists, non-degree paraprofessionals, and lactation consultants (9 agencies). Non-WIC staff mentioned were nurses (5 sites) and other nutritionists (3 sites).

Some of the case study sites were quite active in their breastfeeding promotion and support activities. Both Montgomery County, MD, and Palm Beach, FL, emphasized peer counseling programs. Both agencies rely on volunteers from the community who receive some formal training on breastfeeding counseling and make themselves available to WIC participants both before and after their delivery dates. Palm Beach County reported that the peer counseling program was instrumental in increasing the number of breastfeeding WIC participants from 164 to 312. Another effort to promote breastfeeding was reported in Wilkes-Barre, PA, whose agency started a free breast pump pilot program. They purchased 120 manual breast pumps and distributed them, at no cost, to WIC participants.

Barriers to Providing Education. Local agencies reported several difficulties they face in providing nutrition education. As illustrated in Exhibit IV-10, between 45 and 65 percent of the local agencies surveyed reported the following factors as barriers (listed in rank order of frequency of being mentioned): participant interest, space, too little staff time per participant, participant time, too few staff, child care, and transportation.

Participant interest was the barrier most frequently reported by agencies (64% of agencies, serving 57% of the participants). Although reported less frequently by agencies, space was a barrier cited by agencies serving 77 percent of the participants, and too little staff time per participant was cited by agencies serving 68 percent of the participants. The following sections discuss these barriers in greater detail.

Exhibit IV-10

Factors That May Act as Barriers to Providing High-Quality Nutrition Education

Barriers	Agency (%)	Participant (%)
Participant Interest	64	57
Space	59	77
Too Little Staff Time Per Participant	58	68
Participant Time	50	56
Too Few Staff	49	64
Child Care	46	56
Transportation	45	36
Cultural Issues/Language Difficulties	27	36
Difficulty Recruiting Qualified Staff	19	32
Other	8	6

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

Participant interest and time: Maintaining participant interest is always a concern when trying to provide lengthy services to clients who may have several young children with them and may also be spending long periods of time at other service providers. Several nutritionists in the case study sites reflected on the difficulty in sustaining the interest of participants whose physicians show little or no interest in the issues and are either not supportive of the information being provided or actually contradict the information. One nutritionist gave the example of a participant with a child whose weight was seriously low. The child's physician did not believe that this was either a current problem or an indicator of other problems; therefore, when approached by the nutritionist, the parent was disinterested and refused to change any behaviors that might improve the child's weight.

Space: Limited space is a problem that was reported in the Local Agency Survey by 59 percent of the agencies. When analyzed by the number of participants affected, this problem is a barrier to the greatest proportion of participants (77%, or 4.15 million people). However, in the case studies, about two-thirds of the sites reported that their space provided adequate privacy for individual education sessions. Only one-third of the case study sites reported adequate privacy for group sessions. Relatively small space was cited as a major problem in many of the sites. For example, counseling that occurs in a room close to a crowded lobby tends to be noisy, creating a distracting and potentially stressful environment. Counseling in a large room where other participants are also being counseled lacks necessary privacy. Group classes conducted in a waiting area may have to contend with constant movement of people in and out of the area.

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Small areas for group counseling may create physical discomfort and result in a distracted, disinterested audience.

Staff at the case study sites expressed concern over continued program growth without an increase in available space. Many sites have already moved to larger space and foresee another move in the not-too-distant future. Staff at sites in Atlantic City, NJ, and Martinsville, VA, expressed concern that in their localities, large enough space may not be available. Other sites report that more spacious facilities would require them to leave space that is being provided as an in-kind service, and therefore, would greatly affect their budget.

Staff time and availability: Survey respondents cited restricted staff time for nutrition education as a problem affecting local agencies serving 68 percent of the participants; it was also one of the most commonly mentioned issues in the case studies. As the WIC Program has expanded its scope (providing more referrals, addressing topics such as substance abuse, focusing on immunizations), and as general documentation requirements have increased, staff time with clients has been reduced. This limited time can easily result in less education being provided. Case study site staff also commented that methods of presentation may change to non-human contact such as the exclusive use of videos, pamphlets, or audio materials. In the Local Agency Survey, since 1988, approximately one-third of the agencies have reported having more staff time per participant, while slightly more than one-third reported having less time (Exhibit IV-4).

The availability of staff can also be a barrier to the provision of nutrition education. As discussed above, most agencies use nutrition professionals to provide their education. However, many of these same agencies report having problems attracting nutritionists. One of the issues discussed has been the licensure issue. For example, Virginia staff reported that only licensed nutritionists can be hired; yet, to become licensed, a nutritionist must first have a job. This limits the pool of available licensed nutritionists and changes the hiring practices for the program. Competition from other service environments creates another strain on nutritionists available to the WIC Program. For example, hospital dietitians are reported to receive higher pay than WIC nutritionists. However, WIC does not customarily require evening or weekend hours, which is attractive to many nutritionists. Other competing job opportunities include private practice nutritionists, nutritionists working in physicians' offices, and nutritionists working for specialized weight loss or health care programs.

Language/Cultural Issues: Given the ethnic diversity of the WIC population, it is not surprising that language was reported as a barrier to provision of WIC nutrition education by about one-quarter of the agencies, serving 36 percent of participants. To respond to the need for multilingual service provision, many of the sites are offering their education sessions, or at least materials, in a variety of languages. Exhibit IV-11 presents data that indicate the variety of languages (12 in all) in which nutrition education is available. Education in Spanish is the most predominant non-English language for WIC—48 percent of agencies have Spanish interpreters, and 58 percent provide nutrition education in Spanish. This type of pattern is evident for almost all of the languages for which interpreters are available, i.e., more sites offer written materials than have interpreters for a language.

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Despite the variety of interpreters and education materials available, language still remains a barrier in some sites. For example, one nutritionist in New York City, NY, expressed frustration with group nutrition education classes that include non-English-speaking participants who are unable to understand the bulk of the session content. Due to a lack of staff time, there is only one group offered and there is no attempt to address the cultural and language differences of the participants. In addition, several sites (Palm Beach County, FL; Atlantic City, NJ; Salt Lake City, UT) reported that not only language differences, but also cultural differences can present formidable barriers to education and program usage. Cultural habits and patterns may preclude some of the WIC foods and, without appropriate replacement foods or education on the use of WIC foods, many people may not be receiving the nutritional benefits intended by the program.

One of the ways in which nutritionists have helped to ease the cultural diversity problem has been to alter their nutrition education topics to meet the needs and habits of their population. In Brooklyn, NY, where a large population of the participants are Hasidic Jews, the staff have learned about the practices involved in keeping kosher and have worked with their participants within the boundaries of their religious practices. In other sites where there is a large Asian population, nutritionists have worked with a population whose typical diet does not include milk. While these cultural differences may become most evident through individual sessions, nutritionists have learned about the cultural and ethnic habits of their population and are able to appropriately tailor their group nutrition sessions.

Exhibit IV-11

Languages Available at Local WIC Agencies

Languages	Interpreters Provided (%)	Nutrition Education Provided in This Language (%)
Spanish	48	58
Vietnamese	4	8
Cambodian/Khmer	2	7
Laotian	4	9
Thai	0.9	3
Hmong	5	5
Chinese	2	3
Haitian/Creole	2	3
French	7	3
Portuguese	3	3
Native American Language	6	4
Sign Language	9	7
Other	9	6

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

Timing of sessions: The timing of nutrition education sessions has been described as a key factor in participant attendance rates. Almost all of the case study sites (21 of the 22 sites) mentioned that combining individual education with certification or recertification helped to ensure high levels of attendance. This applies less to group education sessions—9 of the 22 agencies combined group sessions with certification. This difference may reflect the nature of certification procedures. Nutritionists generally spend time speaking individually to participants during the certification period, providing an easy opportunity for an education session. Voucher pickup was also a time at which many sites provide education—17 of the case study sites offer individual sessions and 10 of the sites offer group sessions during this time. Voucher pickup offers other advantages for combining nutrition education. Nutritionists are not necessarily involved in the distribution of vouchers and therefore are free to either provide a class or to speak individually with participants. Several sites (Brooklyn, NY; Montgomery County, MD; Tangipahoa Parish, LA) used the waiting time before voucher pickup as a time in which to offer both individual and group sessions. However, other sites expressed the opinion that the chaotic nature of a small space during voucher pickup and the inability to offer any private or coherent education sessions made this a poor time for conducting nutrition education.

IV. Staff Education and Training

Education and training of WIC staff include in-service education, on-the-job training, attendance at training sessions and meetings offered by WIC State agencies, and attendance at professional conferences or continuing education programs. Local Agency Survey findings indicate that, nationally, about one-third of local agencies have cut back on training activities for staff since 1988, while nearly an equal proportion of local agencies reported that they increased training activities for staff during that period. Of the 22 case study sites, 18 (82%) participate in in-service training with other agencies.

Several local agencies have staff members specifically designated to arrange and monitor staff education and training. The Nutrition Education Coordinator in Delaware is responsible for assuring that each program is aware of new information and that information on programs other than WIC is updated. This information is kept in the Nutrition Education Handbook or the Policy and Procedures Manual. The coordinator keeps staff informed of journal offerings, and information can be requested through an automated system. The Wilkes-Barre, PA, WIC agency created a position for a training coordinator in 1989. The training coordinator arranges for all in-service meetings. The training coordinator also conducts training sessions for new employees (both classroom and on the job). In Brooklyn, NY, the nutrition coordinator is responsible for the training of professional staff. Palm Beach County, FL, WIC takes advantage of the many medical conferences and symposia offered by hospitals in South Florida. The County Health Unit has a nurse that coordinates continuing education, but Palm Beach County WIC also plans to hire its own staff trainer/development specialist to focus on the needs of WIC staff.

In-service education includes information exchanges about programs that work together, clinical topics, WIC operational issues and updates, and management skills. In-service training is generally planned and scheduled at the local level. In many programs, in-service training is

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conducted on site in conjunction with staff meetings, as often as monthly. For example, Grady Hospital in Atlanta, GA, offers in-service training on at least a monthly basis for WIC and other maternal and infant care staff. In addition to health-related in-service training, the sessions include Occupational Safety and Health Administration (OSHA) regulations, self-esteem, stress management, and computer training. There are also monthly staff meetings at which time breastfeeding education updates are shared. In Montgomery County, MD, monthly in-service education programs for staff are coordinated within the Family Health Services Division, particularly for topics that are relevant to several programs. Examples of such topics include universal precautions, AIDS, and child nutrition. Paraprofessionals must master specific topics and also attend monthly in-service training. Wilkes-Barre WIC also holds monthly in-service training sessions. Once per year they have an overnight session. In addition to standard topics, Wilkes-Barre, PA, WIC surveys the staff regarding which topics they want to cover. In Delaware, paraprofessionals participate in biannual nutrition education training sessions, and they received special training on using new nutrition education materials when these were developed.

Statewide training programs address changes in WIC regulations, nutrition education, new program issues, and coordination with other programs. In Delaware, there are presentations describing each public health program to the care team, which consists of WIC, child health, and prenatal providers. Colocation and integration naturally teach staff about the other programs offered. Periodically, speakers from other service programs are invited to county-wide meetings. A WIC coordination staff meeting is held biannually. Each meeting focuses on a different aspect of coordination. For example, a recent meeting addressed adolescent pregnancy. In Cleveland, OH, there are numerous interagency and interdepartmental meetings, and speakers from other local agencies are brought to WIC to speak about their programs and share information. New York State provided training on substance abuse; Ohio has an annual symposium with workshops and speakers; and New Jersey holds quarterly meetings with WIC and public health nutrition providers. These meetings include in-service training and updates on current issues in nutrition and in the WIC Program. There is a Maryland WIC directors' meeting monthly, which is attended by about 30 people from 13 counties. At these meetings, county WIC directors discuss caseload counts, changes needed, what people are doing in their programs, nutrition education materials, and a general update on WIC activities. The State of California held meetings to train staff in a number of programs on the use of the Wellness Guide, a document with information on various services available in California.

Continuing education is geared to professional staff and is available outside of the WIC agency. In Portage-Columbiana, OH, the local director requires all staff to complete one continuing education course each year on topics such as client relations and computerization. Three to four sessions a year are required for dietitians to fulfill minimum requirements for registration and licensure (RD and LD) in the State. Some sites noted that funding for attendance at such outside courses or workshops is limited. In Cleveland, OH, each staff member is paid up to 3 days per year for continuing education. Palm Beach County, FL, WIC provides for all of the education classes needed for continuing education credit (for RDs, LDs, and nurses).

In summary, the local case study WIC agencies are active in promoting staff training and continuing education through in-house programs, programs offered by State WIC agencies, and professional conferences and educational programs offered by other organizations. In many instances, educational programs are coordinated with other agencies, particularly health departments and hospitals.

V. Food Package Delivery Methods

WIC participants receive a monthly food package designed to supplement their diets. The foods provided are high in protein, calcium, iron, and vitamins A and C. These are the nutrients frequently lacking in the diets of the program's target population.

According to the survey findings, there were two changes in the preparation of food instruments that occurred more often than others: the issuance of multiple food instruments and the more frequent issuance of standard food packages (packages that are not tailored to meet the individual's specific nutritional risk condition). Between 1988 and 1992, 63 percent of the local agencies, serving 68 percent of the participants, began issuing multiple food instruments. Fifty-one percent of the agencies, serving 55 percent of the participants, began issuing standard food packages more frequently. Hence, local agency staff may be spending less time tailoring food packages for individual WIC participants. This does not necessarily mean, however, that food packages do not meet individual participant needs. Rather, many WIC State agencies have developed a range of standard food packages to meet the needs of various categories of WIC participants. Local agency staff can then prescribe specific food packages for participants based upon categorical, nutrition risk, and other factors. The use of standard food packages can thus reduce the level of time and effort spent by local WIC staff on tailoring WIC food packages to meet individual needs.

Over 40 percent of the agencies began writing food instruments at the local agency level and began issuing computer-generated food instruments. While the issuance of multiple food instruments can be viewed as increasing efficiency, it also has the effect of reducing the amount of staff contact with participants. Many WIC agencies schedule nutrition education concurrently with issuance to provide an added incentive to attend. During the site visits, researchers observed that 17 (of the 22) agencies coordinated voucher pickup with individual nutrition education, and 10 agencies coordinated voucher pickup with group nutrition education.

Site visit findings indicate that many local agencies have taken steps to streamline the food instrument issuance process. In several agencies, checks/vouchers are issued for more than 1 month at a time, thus reducing the number of times the participant must come into the office and the staff time needed to issue these instruments. At one case study site, the requirement to sign the vouchers in the WIC office (in addition to signing when the vouchers are actually used) was eliminated, significantly reducing the amount of time the participant spent receiving the vouchers.

According to the local agency survey data, the actual time spent waiting for and receiving food instruments varies from less than 5 minutes to more than 30 minutes, with the greatest percentage

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of people being served within 15 minutes (Exhibit IV-12). One important observation is that the waiting time is often as long as the time it takes to receive the food instruments, and substantially longer in the larger agencies than in the smaller ones. In addition, when comparing the waiting time to the actual issuance time, it appears that while some participants must wait longer than others, the actual food instrument issuance time remains more consistent between agencies.

Exhibit IV-12

Time Spent Waiting For and Receiving Food Instruments

	Less Than 5 Minutes		6 to 15 Minutes		16 to 30 Minutes	
	Agency (%)	Participant (%)	Agency (%)	Participant (%)	Agency (%)	Participant (%)
Waiting	42	24	44	47	7	21
Issuance	41	46	47	42	4	6

Source: Based on estimates for 1,777 local WIC Agencies; Local Agency Survey, WIC Dynamics, 1993.

Since 1988, this waiting time decreased in 31 percent of the agencies (Exhibit IV-13). Fifteen percent of the agencies, serving 20 percent of participants, reported that the waiting time increased, which again indicates that the waiting time is longer in the larger agencies. Thirty-three percent of the agencies indicated that the time involved in the actual issuance process decreased, while 11 percent of the agencies felt that the issuance time increased. Fifty-six percent of the agencies reported no change in their issuance time.

Exhibit IV-13

Change in Time Spent Waiting For and Receiving Food Instruments

	Increase in Time		Decrease in Time		No Change	
	Agency (%)	Participant (%)	Agency (%)	Participant (%)	Agency (%)	Participant (%)
Waiting	15	20	31	32	48	44
Issuance	11	11	33	34	50	50

Source: Based on estimates for 1,777 local WIC Agencies; Local Agency Survey, WIC Dynamics, 1993.

Local Agency Survey responses indicate that both the waiting time and the issuing time for food pickup are usually less than 10 minutes. There are only three States that continue to deliver food directly to the participants; however, in several agencies, some food, such as formula or infant

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cereal, is available for pickup in an emergency situation, so some agencies reported information on food pickup.

Instruction on voucher use is usually provided by either nutrition staff or the clerk issuing the vouchers. Participants receive information about who can use vouchers, who can act as a proxy, how to select and purchase foods, and where approved WIC vendors are located. In one site—Montgomery County, MD—the agency had a book for participants with pictures of all the various WIC foods that they could purchase. Other agencies have posters on the walls with WIC foods, handouts with lists of approved foods, or empty containers of approved WIC foods on a shelf. Many sites repeat the instruction each time the vouchers are distributed.

VI. Evaluation Activities and Local Agency Perception of Quality

Evaluation activities. Evaluations of WIC nutrition services are conducted both formally and informally. The most common formal evaluation is the annual or program audit by the WIC State agency, which includes areas such as nutrition education, recordkeeping, and certification/recertification procedures. The majority of local agency directors interviewed during the case study visits were unaware of the Nutrition Services Standards developed by the National Association of WIC Directors and FCS. Rather, States often share their guidelines with local agencies, which in turn use these in developing their nutrition services plan. The State evaluations are often used to provide feedback to the agency about ways in which they could improve their services. Interviews with some agencies (for example, Brooklyn, NY, and Palm Beach County, FL) revealed that staff were often aware of the feedback given in the most recent evaluation and were incorporating such feedback into their program operations.

This annual review also encourages internal evaluation and nutrition services planning on the part of local agencies. For example, the WIC Program in Portage-Columbiana, OH writes agency and nutrition goals every year in its grant application to the State of Ohio. As part of this process, the local agency staff work together to identify areas in which they need to improve. The WIC local agency in Wilkes-Barre, PA, produces an annual local agency plan that describes the program and the community; presents a nutrition education plan; and evaluates goals and objectives for the past year and projections for the future. The plan also includes a description of coordination with other programs. This plan is used by the State agency in planning operations for the coming year. The State of Pennsylvania also distributes a planning questionnaire which solicits from the WIC local agencies the areas that need the most State attention.

In Delaware, the nutrition education coordinator conducts periodic evaluations of each clinic. These are reviewed with the area WIC supervisors, who discuss each evaluation with the appropriate clinic manager. They discuss recommendations with clinic staff. The WIC supervisor also surveys staff on operational issues such as hours and days when changes are contemplated. Both WIC local agencies visited in Ohio maintain monthly counts of referrals for each clinic site. Other regular monitoring activities reported in site visits include client surveys,

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record reviews, and analysis of management reports provided by State agencies or via the local agency's WIC automated data processing system.

In addition to evaluation by the WIC State agency, many of the case study agencies are subject to periodic evaluations by their sponsoring organizations. County health departments, municipal governments, and non-profit organizations undertake financial audits of local WIC Programs. In Hudson, NY, health department financial audits include a review of the participants' files. In New Haven, CT, the WIC Program participates in chart reviews and other quality control activities with staff of the hospital's Primary Care Center.

Finally, several case study sites reported participation in special evaluation studies. Most of these studies were short term (1 year or less), and addressed a wide range of issues related to WIC operations. In Tangipahoa Parish, LA, the Health Unit, which includes WIC, has served as the test site for a number of State initiatives (such as automation), which have evaluation components. Over the past 5 years, local agencies in Delaware have conducted studies of breastfeeding practices and patient flow.

Quality of Nutrition Education. The overall perception of WIC local agency staff is that the current quality of nutrition education in comparison to 1988 has improved—21 percent believe that quality is substantially higher, 43 percent report it is somewhat higher, 23 percent report it is about the same, and 13 percent report it is lower (Exhibit IV-14). Responses to other survey questions indicate that WIC local agency staff do perceive some problems related to delivering nutrition services. Fifty-seven percent have too little staff time per participant, 44 percent have an inadequate number of professional staff, and 9 percent have less than sufficient skills among their staff for providing nutrition education.

Exhibit IV-14

Degree of Change in the Quality of Nutrition Education Since 1988

Agencies' Perceptions of Change in Quality of Nutrition Education Since 1988	Agency (%)	Participant (%)
Substantially Lower	3	3
Somewhat Lower	10	15
About the Same	23	17
Somewhat Higher	43	47
Substantially Higher	21	18
Total	100	100

Source: Based on estimates for 1,777 local agencies, Local Agency Survey, WIC Dynamics, 1993.

Follow-up telephone calls to the Local Agency Survey respondents with this apparent discrepancy revealed that, although the amount of contact with participants diminished, they believe that they have refined and improved their materials and that their staff are better prepared. In addition, local agency staff viewed the increased emphasis on breastfeeding promotion and the broad range of education topics covered in their sessions (e.g., immunization, child safety, and dental health) to be indicative of improved quality of nutrition education.

The survey data on improved quality is not supported by the case study data. When case studies were conducted, there was much discussion by agency staff about the expansion of the WIC nutrition education to include topics such as substance abuse and immunizations. While these topics are important, staff believe they often take precedence over providing adequate nutrition education. Staff frequently spoke of the need to provide more information and to document it in less time than was previously available. Nutrition education sessions (particularly individual sessions) last, at most, 30 minutes, but often last less time (5–10 minutes at 21% of sites and 10–15 minutes at 28% of sites). During the time allotted for a session, staff conduct a participant's diet assessment, discuss and document general medical and social information, make and document referrals, possibly develop an individual care plan, and give or discuss nutrition education with a participant.

VII. Assessment of Nutrition Services

The case study interview guides and observation checklists incorporated each of the areas addressed by the FOM Nutrition Services standards. These standards were established for two reasons:

- "1. To provide State WIC directors and nutritionists with a method for evaluating the quality of nutrition services in their programs, and
2. To encourage States to use their evaluation information to improve nutrition services in their programs."²

Since the FOM standards are directed to State agencies, and our site visits were to local agencies, it was not possible to directly evaluate performance against the FOM standards in this study. For example, some standards that relate specifically to State activities could only be assessed anecdotally from case study information. Overall, it appears that States have set standards for performance and have provided guidelines to local agencies that are being followed. The remainder of this section presents the 12 FOM standards and examples of local agency activities that relate to the standards, as was ascertained during the case study site visits.

²Introduction. WIC Focus on Management Nutrition Services Standards and Assessment Checklist, Attachment III, RFP FNS-90-049SLS, June 1990.

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Nutrition/Health Assessment (Standards 1-3)

STANDARD 1: The State agency has documented nutrition risk criteria referenced as necessary by current scientific research, that are applied consistently by all local agencies in the State.

STANDARD 2: The State agency has standardized dietary assessment procedures based on current practice which are used consistently by all local agencies in the State.

STANDARD 3: The State agency has standardized anthropometric and biochemical assessment procedures, based on current practice, which are used consistently by all local agencies in the State.

All case study sites used intake and assessment forms that were distributed from their State's WIC office. These forms all included standardized growth charts and criteria for evaluating food intake data and biochemical data. States did vary in some ways—e.g., some obtain hematocrit results, while others obtain hemoglobin results to test for blood iron content. In addition, some States rely solely on food frequencies to conduct a dietary assessment, while others rely on 24-hour recall, and some use both methods. Local agencies are usually free to add any additional information to their records but must complete the State forms for each participant.

Nutrition Education/Services Plan (Standards 4-8)

STANDARD 4: The State agency has standard policies for all nutrition education contacts, which include type and number of contacts appropriate for participants' risk status.

STANDARD 5: The State agency has standard evaluation procedures for monitoring the nutrition education provided in local WIC agencies.

STANDARD 6: The State agency promotes the use of appropriate, quality, and accurate nutrition education materials.

STANDARD 7: The State agency develops and updates annually a WIC nutrition services plan that includes a needs assessment, long-term and short-term goals and objectives, and an evaluation component as part of the State plan.

STANDARD 8: The State agency assures that local agencies develop an annual nutrition education plan to include a needs assessment, goals, objectives, action plans, and an evaluation component.

The majority of case study sites reported that their staff participated in some State training sessions. These sessions covered topics ranging from administration of WIC services to techniques for providing nutrition education. The nutrition education materials that were used by case study sites were a combination of State-issued materials and locally developed materials.

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For example, in New York City, NY, one site supplemented the State materials with a site-developed pamphlet illustrated by a clerical staff member. All sites reported State evaluations occurring at least on a biannual basis. In addition, local agencies reported being required to submit a 2-year nutrition plan to the State for approval. Comments on the plan and from the evaluation were to be used by the local agencies to modify or improve their services. The plan was updated as necessary on an annual basis.

Qualifications and Role of the Nutritionist (Standard 9)

STANDARD 9: The State agency assures that a qualified nutritionist provides WIC services and that the role of the WIC nutritionist is defined.

Although each study site employed "qualified" nutritionists, the definition of "qualified" differed across States. Some only employ registered dietitians or licensed nutritionists, while others only require a master's or bachelor's degree in nutrition. However, there was a clear definition in each site that was approved by the States for who qualified as a nutritionist and what that person's role was in the WIC Program. These definitions were generally documented in a program manual and were often given to case study research staff.

Nutrition Staff Training (Standard 10)

STANDARD 10: The State agency assures through training that competent staff perform certification procedures and provide nutrition education.

As is mentioned above, local staff, particularly nutritionists and WIC directors, attended various State training sessions. Often the lead nutritionist attends the State meetings and, in turn, trains other local staff.

Food Package (Standards 11-12)

STANDARD 11: The State agency has uniform policies and guidelines for food package tailoring in accordance with current authoritative medical and health information.

STANDARD 12: The State agency has policies and procedures for authorizing WIC foods that are based on cost, availability, nutritional value, and participant acceptance.

Most of the case study sites reported that food package tailoring mostly occurs at the State level. States usually have established a variety of packages that local nutritionists choose from when working with a participant. Local agencies are still able to customize a food package for particular special needs, but this was not reported to be a frequent occurrence. State WIC

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administrators were reported to be the decisionmakers about the foods that could be used or substituted within the WIC food package.

Overall, it appears that State Agencies have implemented standards for delivering nutrition services and the case study agencies provide nutrition services that comply with these standards.

In summary, the study found positive indicators of WIC nutrition services. Individual participant assessments, care plans, and nutrition education are carried out by qualified staff. Even with tremendous growth, nearly all local agencies continue to offer individual nutrition education sessions to participants. Agencies have increased the use of group sessions and materials as the nutrition education services offered to participants. Despite caseload growth, most participants wait 10 minutes or less for nutrition education sessions which cover a range of topics and are delivered using a variety of methods.

WIC local agencies are aware of the factors that affect and the barriers that complicate the delivery of high-quality nutrition services. One-third of local agencies have maintained the level of staff education and training activities, and another third have increased these activities. Changes in practices have increased the efficiency of the food voucher issuance process. State Agencies and many sponsoring agencies monitor and evaluate nutrition service delivery at local agencies on regular basis. While barriers do exist, a majority of local agencies report that they have maintained or increased the quality of their nutrition services since 1988. It appears that overall, local agencies have accommodated caseload increases while maintaining the quality of nutrition services delivered to WIC participants.

Chapter V

Integration and Coordination with Other Programs

Chapter V. Integration and Coordination with Other Programs

I. Overview

The WIC Program has always functioned as an adjunct to health care, and referral to appropriate health care is one of the key services provided by the WIC Program. The WIC Dynamics Study explores the impact of growth and other changes affecting the service delivery environment on service coordination and integration between WIC and other programs. In the WIC Dynamics Study, *coordination* refers to activities such as referrals among providers, the transfer of information between providers, avoidance of unnecessary duplication of functions, the scheduling of services in a way that does not interfere with other programs serving the same population, and joint planning for service delivery or special programs. *Integration* refers to a set of services operated and perceived from the client's point of view as one program. Integration implies colocation, sharing of staff, sharing of records, etc. One example of integration—*One-Stop Shopping*—refers to the colocation and integration of eligibility processes for WIC, Medicaid, and maternal and child health programs and service delivery or arrangement for needed services. In some settings, integration is not possible, but good coordination exists, which provides participants the services they need.

The findings presented in this chapter must be considered in the context of the WIC operating environment, which is characterized by a diversity of program structures and models for coordination of services. Evidence in the literature (see, for example, Macro 1990; Summer, 1991) as well as the site visit findings of this study confirm that each local WIC Program functions within a unique and dynamic service delivery system and health care marketplace. As the WIC Program reaches more eligible women and children, it is possible that the increased referrals and efforts to coordinate service delivery generated by WIC will place an increasing strain on an already overburdened health care system (Pindus et al., 1986; Hill, 1988; National Commission, 1988). Conversely, WIC Programs that have experienced rapid growth may be forced to limit some of their outreach and referral activities due to limited time, space, or other constraints (FCS, 1990). A number of Federal as well as State initiatives have affected the availability and accessibility of health care in local communities. The 1989 Budget Reconciliation Act (P.L. 109-239) expanded Medicaid coverage for pregnant women, infants, and children up to age 6 if family income is below 133 percent of the poverty line. The Act also required State Medicaid programs to provide for coordination between the Medicaid and WIC Programs. The expansion of Medicaid eligibility and the growth of the WIC Program have occurred at the same time that the U.S. Department of Health and Human Services funded a perinatal care initiative in community and migrant health centers (Macro Systems, 1991), Healthy Start Initiatives in selected communities, and immunization and lead screening initiatives through State health departments (HRSA, 1993; Biemesderfer, 1993; King, 1993). At the same time, State health departments have experienced serious strains on their budgets, and economic downturns have increased the demand for services and changed the profile of the population seeking assistance in many communities. During the past decade, a malpractice insurance crisis in many States has limited the availability of obstetrical care for poor women (Lewis-Idema,

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1988). The 1989 Budget Reconciliation Act (P.L. 109-239) also directed States to set reasonable Medicaid reimbursement rates for providers.

II. Integration and Coordination with Local Health Care Delivery Systems

Each WIC agency must ensure that its clients have available and accessible health care. This may be facilitated in a number of ways, including organizational sponsorship and program location. As shown in Exhibit V-1, the Local Agency Survey indicates that about 88 percent of WIC local agencies are sponsored by a health organization such as a local health department, a community health agency, or a public hospital. Of the 22 local agencies visited, over three-fourths are sponsored by health agencies, including one sponsored by a private voluntary hospital and one by a private proprietary hospital.

Exhibit V-1

Local Agency Sponsorship

Local Agency Sponsorship/Type	Local Agencies in Survey (%)	% Covered Participants	Local Agency Case Study Sites (#)
Health Agencies:			
State	2%	9%	3
District	6%	12%	1
Multi-County	7%	9%	2
Single-County	46%	28%	2
Municipal	2%	9%	4
Community	17%	11%	0
Indian	5%	2%	1
Hospitals	2%	4%	4
Total: Health Organizations	88%	84%	17
Community Action Programs	7%	6%	1
Other	5%	10%	4
Total	100%	100%	22

Source: Based on estimates for 1,777 local WIC agencies, Local Agency Survey, and 22 case studies, WIC Dynamics, 1993.

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Sponsorship by a health agency may facilitate coordination by increasing awareness of programs sponsored by the same agency and by reducing barriers to sharing of information or staff. Nine of the 22 sites visited in this study integrated WIC with more than one other health service. These nine more integrated sites include the three case study sites sponsored by State health agencies. The other six integrated sites are sponsored by single or multicounty health agencies (three sites), district health agencies (one site), and hospitals (two sites). State agency sponsorship facilitates coordination in Delaware, for example, because WIC, Medicaid, and public health programs use the same automated data processing system. Agreements regarding access to certain parts of each program's database are simplified by the fact that all programs report to the same administrator. In Portage-Columbiana, OH, the use of a Combined Program Application form implemented by the State in November 1991 facilitates integration. Clients complete this form when they apply for WIC, Child and Family Health Services, Health and Human Services programs, and Expedited Medicaid. Application for all of these programs can be made at the point of entry of any one of them.

Hospital sponsorship promotes integration at the WIC Program sponsored by Yale-New Haven Hospital in New Haven, CT. The WIC Program is a hospital clinic and is seen as an important part of the entire pediatric and prenatal care network, both by those inside and outside the WIC Program. Nearly all pregnant women and young children seen at the hospital's Primary Care and Women's Clinic are referred to WIC. At the same time, WIC staff help identify clients' health and social problems that would benefit from other hospital-based services.

Sponsorship and location may not always be identical. For example, a WIC Program sponsored by a health agency may also operate satellite clinics at a distance from the public health center, or a Program sponsored by a community agency may rent space from a hospital outpatient department to facilitate linkages to health care services. In Atlantic City, NJ, the city health department sponsors the WIC Program, but WIC is not located in the public health centers because of insufficient space. In San Antonio, TX, the city's Health District sponsors the WIC Program, but only 5 of 12 WIC clinic sites are colocated with Health District programs. However, health agency sponsorship still facilitates coordination in both of these local WIC agencies. In Atlantic City, the prenatal nutritionist at one health center enrolls patients in WIC, and all public health clinics provide anthropometric measurement and blood work for WIC at no charge to the patient or WIC. As part of the Health District, the San Antonio WIC Program is included in a Memorandum of Understanding that addresses the sharing of patient information between programs.

Colocating WIC services with health care services can be beneficial to both WIC staff and participants. Participants can receive their WIC services and health care in one location, while staff may find it easier to refer WIC clients to and communicate with health care providers. There are a greater number of WIC sites without on-site health services than might be expected, given the high proportion of sites sponsored by health agencies. Data from the Local Agency Survey indicate that, nationally, 14 percent of local agencies, serving 9 percent of participants, have no WIC clinics with on-site health care. While 52 percent of local agencies report that health services are available at all of their clinic sites, these agencies only serve 39 percent of all WIC participants. Exhibit V-2 details the availability of health care services on site.

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According to the survey, obtaining health care services for WIC participants is typically a problem in 29 percent of the sites.

Exhibit V-2

Availability of On-Site Health Services

On-Site Health Service Available at:	Local Agencies in Survey (%)	Participants Affected (%)
No Sites	14	9
< 1/3 of sites	8	14
1/3 - 2/3 of sites	19	19
> 2/3 of sites	7	20
All Sites	52	39
Total	100	100

Source: Based on estimates for 1,777 local WIC agencies; Local Agency Survey, WIC Dynamics, 1993.

The case studies provide additional information on the availability of health services on site. The 22 local agencies visited reported having from 1 to 5 different service settings each for all of their clinic sites. As shown in Exhibit V-3, the service setting reported most often (nearly two-thirds) was a public health clinic. Fourteen agencies reported other settings that have health services available. Therefore, well over half of the service settings included in the local agency site visits were colocated with health services. However, the range of health services available varies in each location. For example, all public health clinics do not provide dental care and routine primary care, and family planning clinics do not provide services for infants and children.

Exhibit V-3

WIC Service Settings for Case Study Sites

WIC Service Setting	Number of Local Agencies Providing Services in This Setting
Public Health Clinic	13
Hospital	5
Community Health Center	3
Migrant Health Center	1
Indian Health Center	1

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WIC Service Setting	Number of Local Agencies Providing Services in This Setting
Neighborhood Center*	7
Free-Standing (WIC Only)	8
Homeless Shelter	2
Family Planning Clinic	2
Government Office Building	1
Total Service Settings Reported	43

Source: 22 case studies, WIC Dynamics, 1993.

* Not limited to health.

Overall, coordination opportunities and initiatives exist. They succeed to varying degrees based on the availability and structure of local health care services. Case studies indicate that communication efforts are sometimes hindered when there is no well-established network and each provider must be contacted separately. As Exhibit V-4 shows, WIC participants receive their health care from a variety of sources. Over one-third of the WIC sites visited indicated three or more provider types as the primary source of health care for their clients. This presents a challenge to coordination. The following sections describe how such coordination is implemented.

III. Integration and Coordination with Specific Health Services

One objective of the case studies was to determine the impact of participation and other changes on WIC's integration and coordination with local health care delivery systems. WIC has served as an important link between an at-risk population of women and children and providers of maternal and child health services. This is best demonstrated by coordination with high-risk prenatal care services, well-baby care, immunizations, and screening for Medicaid eligibility. Several WIC Programs visited in this study have taken significant steps to increase colocation and coordination with health services since 1988. For example, reorganizations of WIC agencies in Delaware (1989 and 1991) and Salt Lake City, UT (1989), provided for full WIC services at clinic sites, colocation of WIC with health services, and closer organizational ties between WIC and public health. Immunization initiatives were noted as an area of change affecting local agency operations by nearly all of the sites visited, and Medicaid expansions and related initiatives (such as Healthy Start) were indicated as an area of change by over two-thirds of the case study sites.

Exhibit V-4
Primary Sources of Health Care for WIC Participants at Case Study Sites

Local Agency	Public Health Clinics	Community Health Center	Migrant Health Center	Indian Health Center	Private Physicians/Groups	Hospital Clinic(s)	Hospital Emergency Room	HMOs
Hudson, NY					X			
Brooklyn, NY	X	X						X
NYC, NY	X	X				X		X
New Haven, CT					X	X		
Montgomery Co., MD	X	X			X			
Delaware	X				X		X	
York, PA	X				X	X		
Wilkes-Barre, PA					X			
Atlantic City, NJ	X				X			
Martinsville, VA					X			
Atlanta, GA						X		
Gainesville, GA	X				X	X		
Palm Beach Co., FL	X		X		X	X		
Cleveland, OH	X	X			X	X	X	
Portage-Columbiana, OH	X				X	X		
San Antonio, TX	X				X			
Temple, TX					X			
Tangipahoa Parish, LA	X				X	X		
Ft. Duchesne, UT				X				
Salt Lake City, UT	X				X			
Long Beach, CA	X							X
Bellflower, CA				X				

Source: 22 case studies, WIC Dynamics, 1993.

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The following exhibit (V-5) summarizes the range of services and level of coordination at the case study sites. The response columns are not mutually exclusive. For example, some local agencies had several sites, some with health services colocated with WIC, and others with health services available by referral. In some cases, services were integrated or colocated for a particular target group, such as pregnant teens or high-risk pregnant women, but not for all WIC participants. This is the case at the Grady Memorial Hospital WIC Program in Atlanta, GA, which serves pregnant women, high-risk infants, and children. Infants who are not high risk are certified by Grady WIC, but are then transferred to other WIC Programs in the city. Services reported as "integrated" for the case study sites were routinely incorporated in the eligibility determination, screening, appointment scheduling, or WIC service delivery process in some way. For example, Montgomery County, MD, and Gainesville, GA, have integrated intake processes, where a new client is screened and, if eligible, is enrolled in several public health programs, Medicaid, and WIC at the same time. Exhibit V-5 shows that the service most often integrated with WIC is related to breastfeeding promotion, found in over three-quarters of the sites. In addition to breastfeeding promotion as part of nutrition education by WIC staff, WIC Programs were integrated with peer counselor programs, support groups, breastfeeding hotlines, and lactation consultants. These programs were sponsored by public health departments, private organizations such as La Leche League, local hospitals, and Healthy Mothers/Healthy Babies Coalitions.

Immunizations and health education were also frequently integrated with WIC. New York State requires that all children participating in the WIC Program be screened for immunizations, and WIC staff are responsible for checking that immunization records are current. Participants who are not up to date on their immunizations must come in for voucher pick-up on a monthly basis. Once they are up to date on their immunizations, they receive their vouchers on a bimonthly basis. At the Medical and Health Research Association (MHRA) WIC Program in New York City, where most WIC sites are located in Child Health Stations, it is not uncommon to see a nutritionist walking a participant to the immunization clinic. Delaware's automated data processing system enables the WIC nutritionist to check a participant's immunization status and generate referrals to the public health clinic for immunizations. In San Antonio, TX, immunizations are available at 4 of 12 WIC clinics, and are provided on a walk-in basis to WIC clients.

According to the Local Agency Survey data (Exhibit V-6), the most common health care services available on site at principal¹ WIC clinics are breastfeeding support programs, family planning services, and immunizations, followed by other health screening; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); and pediatric care. Those available on site in less than 40 percent of the clinics are: obstetrical/gynecological care, Medicaid screening, and dental care. Health services most often colocated with WIC in the case study sites are well-baby/well-child care and health education, each located at over two-thirds of the sites. Routine primary health

¹"Principal" clinics are the largest clinics, up to 6, in the 1,777 local WIC agencies (see Chapter 3, p. III-1, for more detail on principal clinics in WIC Dynamics).

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Exhibit V-5

Health Service Availability and Coordination/Integration at Case Study Sites (N=22)

Service	Integrated	Colocated	Referrals	No Interaction	Service Not Available Locally
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	2	10	8	2	1
Lead Screening	2	6	6	3	
Other Health Screening	2	7	6	2	
Breastfeeding Support	18	4	3	1	
Dental Care	1	11	12	1	
Family Planning		12	10	1	
Immunizations	6	11	8		
Ob/Gyn Care	1	12	10	1*	
Well-Baby/ Pediatric Care	3	15	13		
Routine Primary Care		13	16		
Health Education	4	15	7	1	
AIDS Testing, Counseling, Treatment	3	12	11		
Sexually Transmitted Disease (STD) Clinic		12	10	2	
Medicaid Eligibility Determination	3	5	17		

* This WIC site served only children.

Source: 22 case studies, WIC Dynamics, 1993.

Numbers do not total to 22 because of more than one applicable answer.

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care services were colocated at over half of the sites. Over half of the 22 local agencies reported colocation of obstetrical/gynecological (ob/gyn) care; family planning; immunizations; AIDS testing, counseling, or treatment; and sexually transmitted disease clinics. Colocation facilitates coordination in activities such as client monitoring and information sharing and coordinated appointment scheduling. Of the 22 case study sites, over three-quarters reported sharing clinical information with other health care providers. Nine sites indicated that they meet with other providers to discuss individual cases. In seven sites, the WIC record was integrated with the patient record used by other providers at the site. Twelve sites coordinate WIC appointments with appointments for other services. One of the most integrated WIC sites visited is Tangipahoa Parish, LA. WIC is not considered a separate program here, but simply one of the services offered by the Health Unit. The staff work for all of the programs simultaneously, and there is one medical record. All staff are cross-trained so that, for example, clerks in the Health Unit are as proficient in WIC procedures as in immunizations, family planning services, treatment of sexually transmitted diseases, or child health services.

Exhibit V-6

Services Available On Site at Principal WIC Clinics

Health Services	Principal WIC Clinics (%)	Non-Health Services	Principal WIC Clinics (%)
Breastfeeding Support Program	71	Substance Abuse Counseling	30
Immunizations	67	Social Service Programs	29
Family Planning Services	50	Food Assistance Programs	20
Other Health Screening	48	Transportation	19
EPSDT	47	AFDC	16
Pediatric Care	44	Housing	13
Medicaid Screening	38	Head Start	12
OB/GYN Care	38	Child Care	10
Dental Care	16	Adult Educ./Job Training	9

Source: Based on estimates for 1,777 local WIC agencies; Local Agency Survey, WIC Dynamics, 1993.

Coordination with health services is not limited to sites where services are colocated, however. In fact, some sites, such as Atlantic City, that had no health services available on site, developed good service coordination with other providers as an outgrowth of their reliance on these providers for WIC anthropometric and hematologic data. In San Antonio, TX, where colocation

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of WIC with full health department services is not possible at all sites, some services are being specifically targeted to WIC participants at the same time and place as WIC. For example, in at least one San Antonio WIC clinic, EPSDT program staff are present at WIC clinics, although this is not a site where the two services are colocated. Intake screening for EPSDT is done at the same time as WIC certification. Lead screening and hematocrit testing are coordinated, and both programs use the information. WIC measures height and weight and provides this information to EPSDT. The client is then certified for WIC, receives EPSDT counseling, and picks up WIC vouchers. Case study observations indicated that it did not necessarily take longer for the participant to receive the additional coordinated services. Time required varied depending upon the logistical arrangements. For example, in the San Antonio case described above, lead screening and hematocrit testing are accomplished through a single blood test, and the time spent receiving EPSDT counseling would otherwise be spent waiting for vouchers to be prepared. On average, 15 participants are referred each morning and each afternoon of the coordinated clinics.

Medicaid eligibility determination was colocated with WIC at over one-third of the case study sites. Medicaid eligibility determination was integrated with the WIC certification process at three of these sites. At the other sites, appointment scheduling for WIC and Medicaid was coordinated, and WIC staff were aware of income eligibility guidelines and documentation requirements for Medicaid. Increased coordination of WIC and Medicaid is an outgrowth of the Medicaid expansions, which required increased coordination and extended adjunctive WIC income eligibility to a large proportion of women, infants, and children. Local Agency Survey data indicate that at 14 percent of local agencies, nutrition services are covered by Medicaid. For example, under Healthy Start in Montgomery County, MD, New Haven, CT, and Palm Beach County, FL, individual nutrition counseling to high-risk pregnant women is reimbursed by Medicaid. Although the nutritionist providing the counseling may not be part of the WIC Program, counseling is scheduled to meet the WIC nutrition education contact requirements in coordinated programs. Another example is the California Comprehensive Perinatal Services Program (CPSP), which uses MediCal funds to provide prenatal care to low-income women. At one program in Long Beach, CA, the nutritionist at one of the CPSP programs does nutrition screening and counseling for WIC. If her screening indicates that a patient would be eligible for WIC, she schedules an appointment for her at the WIC clinic and provides the patient with a copy of her anthropometric measurements, diet assessment, and prenatal weight gain graph. This level of coordination is extremely helpful to the WIC staff.

IV. Integration and Coordination with Social Services

As the second column in Exhibit V-6 shows, services other than health care are available much less frequently on site. Nearly one-third of the principal clinics have substance abuse counseling, social service programs, food assistance programs, transportation, or AFDC on site. Between 9 and 15 percent of the principal clinics have Head Start, child care, housing, and adult education/job training services on site. However, the ability to apply for the following types of services is available in at least 25 percent of the principal WIC clinics: social service programs (35%), food assistance programs (32%), substance abuse counseling (28%), and AFDC (25%).

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Availability of on-site social services at the case study sites showed a similar pattern, with integration and colocation occurring much less frequently than with health services (see definitions of integration and coordination at the beginning of this chapter). Nine of the 22 case study sites were integrated with one non-health service; none were integrated with more than one. In the sites visited, colocation with non-health services was most commonly found with family counseling and substance abuse treatment, with each at about one-third of the sites.

Exhibit V-7

Availability and Coordination/Integration with Community and Social Services at Case Study Sites (N=22)

Service	Integrated	Colocated	Referrals	No Interaction	Service Not Available Locally
EFNEP	1	3	9	6	3
Food Bank	1	2	14	4	
Family Counseling		8	14	1	
Domestic Violence		4	17	1	
Substance Abuse Treatment		7	17		
Drug Testing	1	5	11		
AFDC	1	2	20		
Food Stamps	1	1	21		
Transportation		2	16	5	
Adult Ed/Job Training	1	3	16	4	2
Head Start	1	1	18	2	
Child Care	1	3	12	2	1
Homeless/Shelter Programs	1	3	16	2	2
Housing Assistance		4	15	4	

Source: 22 case studies, WIC Dynamics, 1993.

Note: Numbers do not total 22 because of more than one applicable answer.

As with health care services, the location and the availability of services affect the integration and coordination of WIC with social services. For example, the WIC Program in York, PA, is sponsored by a community action agency and is located at a neighborhood center. The program

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is not colocated with any maternal and child health services, but its services are colocated and coordinated with the sponsor's case management program. About half of the WIC clients at this site also see social workers in the case management program, which provides housing assistance, budget counseling, and referrals to other agencies (e.g., drug treatment facilities, domestic abuse prevention services, shelters, etc.). Clients are often escorted from WIC to a social worker at the case management program.

Although colocation with social services is not routine, coordination does occur, and most services are available on a referral basis. In Salt Lake City, UT, the Expanded Food and Nutrition Education Program (EFNEP) coordinates its teaching activities with and conducts nutrition education activities for WIC. The Palm Beach County WIC Program has access to drug-screening information on participants who receive their care from the health department, and it refers active drug users to treatment programs. In the case study sample, the services with which WIC Programs were least likely to interact were: EFNEP, transportation, food banks, and adult education/job training programs. For some sites, these services were not available in the local area. This was reported to be the case most often for EFNEP, adult education/job training, homeless or emergency shelter programs, and child care programs. The Local Agency Survey indicated that obtaining non-health care services is a problem in 32 percent of the local WIC agencies.

V. Outreach

Outreach activities are directed toward community health and social service providers as well as toward potential participants, and they include information dissemination and the use of itinerant and mobile services.

Information Dissemination. Most case study sites provide information about WIC to public health providers (20 sites), social service providers (16 sites), private physicians (19 sites), and local hospitals (18 sites). Outreach to providers includes keeping providers informed of WIC Program eligibility requirements; changes in regulations, location, or service hours of clinics; addressing provider groups at meetings; and meeting individually with providers to establish good working relationships and an understanding of the WIC Program. A number of communities visited have task forces and advisory councils that facilitate coordination. Respondents in Portage-Columbiana, OH, noted that the WIC representative at community advisory council meetings exchanges information with other members of the health and social services community and uses this group as a resource for speakers at group education classes and staff in-service training.

The frequency and intensity of outreach to potential participants varies depending upon the local agency's assessment of its ability to accommodate additional participants. Since the most common source of referral to WIC is "word of mouth," more formal participant outreach activities are undertaken on an as-needed basis. Over three-fourths of the case study sites used publicity, such as posters in libraries, supermarkets, and other public places, as well as newspaper articles about the WIC Program. Nearly two-thirds of the case study sites reported participation in coordinated outreach activities. For example, WIC Programs in Portage-Columbiana, OH, and

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Temple, TX, worked with Head Start in targeting children for outreach. Participation in community health fairs was reported by WIC Programs in Palm Beach County, FL; Portage-Columbiana, OH; Hudson, NY; and New Haven, CT. WIC Programs in Salt Lake City, UT; New Haven, CT; and Delaware participated in "Baby Your Baby" media outreach campaigns to low-income pregnant children. WIC Programs in Atlantic City, NJ; San Antonio, TX; Long Beach, CA; and Hudson, NY, targeted outreach to teens through teen parent programs and high schools.

Itinerant/Mobile Services. Another type of outreach to participants—the use of vans, mobile units, or other motorized facilities—was reported to be used by 7 percent of WIC local agencies surveyed, affecting 11 percent of participants. The case studies revealed that the use of such vehicles was often shared or coordinated with other agencies. For example, the Palm Beach County WIC Program is working with Catholic Charities to provide nutrition education on the mobile health van operated by that organization. Other participant outreach activities involve providing WIC services on site to "hard-to-reach" participants. The MHRA WIC Program in New York City and the Salt Lake City WIC Program provide services at homeless shelters; Montgomery County WIC has one clinic location at a Hispanic community center; and Delaware WIC coordinates with public health field nurses who make home visits to assure that newborns of high-risk mothers are on WIC.

VI. Referrals

As the previous sections on coordination with health care and social services indicate, all local agencies refer at least some of their participants to other services or agencies. However, the frequency of these referrals, the methods for determining who to refer, and tracking that referral vary from agency to agency. The referral process has several parts: the procedures followed in making a referral, either by WIC to other providers or by other providers referring clients to WIC; documentation of the referral in the patient record and/or in other clinic reports; and followup of referrals. Referrals vary according to each agency's concept of "referral," the location and capacity of the referral services, and the existence of established working relationships with other agencies that facilitate the referral process. The survey of local agencies found that the two most common barriers to referring clients to other agencies are that services are not available or are only available on a limited basis (in 40% of the agencies); and the lack of or limited transportation to services (in 46% of the agencies). When comparing procedures in 1988 versus 1992, the responses indicate that the amount of staff time spent on referrals is *somewhat* more in 37 percent of the principal clinic sites, and *substantially* more in 20 percent of the principal clinic sites.

The concept of referral can vary from simply informing a client that a service is available, to providing a client with an application for another program, to calling the other agency and arranging an appointment for the client. In some colocated programs, a referral is completed by walking with the client from the WIC clinic to the referred service, such as the prenatal or child health clinic. The case study sites provided some insights into the variations in referral procedures. Over two-thirds of the sites have resource directories or guides available to WIC

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staff members to assist in making appropriate referrals. Over half of the sites reported coordinated appointment scheduling, which occurs most often in colocated sites. Appointment scheduling may be coordinated by checking with the prenatal or well-baby clinic on the client's next appointment date, or a more formal scheduling procedure through a single receptionist may take place. A written procedure or form is used to refer participants from WIC to other providers in nine of the 22 sites. Over three-quarters of the sites document referrals in the client record. Thus, many sites do not require a form to initiate a referral, but still document referrals that are made. In fact, referral codes were standard on intake forms for automated agencies. However, what constitutes a "documentable" referral varies not only from agency to agency, but also among WIC staff in the same agency. In some cases, referrals were documented only if a staff member called a provider or agency on behalf of a participant; in other cases, referrals were documented if a specific name and telephone number was provided to the participant; and sometimes staff members recorded referrals if they had simply mentioned the availability of a particular service or provided a flyer describing the service. While referrals are often a matter of staff judgement, over one-third of the sites make automatic referrals based on established criteria. For example, Delaware's ADP system automatically generates referrals to Medicaid, Food Stamps, and immunizations, if the client meets eligibility criteria. Several sites indicated that computerized appointment scheduling, integrated with other public health programs, was planned as an enhancement of existing systems, but none of the sites visited had yet implemented such a system.

Although all of the case study sites actively referred participants to a wide range of health and social services, only seven sites routinely followed up on referrals. In most cases, follow-up activities were informal and were determined on a case-by-case basis, depending upon the staff member's assessment of a client's need for close monitoring and on the amount of time available.

Referrals to WIC from other providers followed a written procedure or used a form designed for the purpose of referral in over one-half of the case study sites. The most common example of this type of referral occurs when a private physician refers a client to WIC and provides the anthropometric and laboratory information needed for WIC certification. For example, Portage-Columbiana, OH, WIC has agreements with Child and Family Health Services and two local clinics to obtain blood work and with Planned Parenthood to obtain pregnancy results. The Local Agency Survey found that 16 percent of local agencies use non-WIC medical providers for certification. Some WIC Programs provide physicians and public health clinics with referral forms for this purpose. Delaware, for example, provides physician referral slips in the form of pads similar to those used for writing prescriptions. Although information for certification is accepted from referring physicians and health centers, WIC staff must still complete certification. Only 3 of the 22 case study sites had CPAs outside of the WIC Program. In Atlantic City, NJ, the Healthy Start Program at one prenatal clinic provides its own WIC certification (using their public health nutritionist) for initial WIC certification, including counseling and nutrition education. This program issues one month of checks, and then clients come to the main WIC clinic for their second and subsequent contacts. Before certifying someone at Healthy Start, a call is made to the WIC clinic to make sure that the client is not already enrolled in the program. In Ft. Duchesne, UT, a public health nurse from the Indian Health Service is authorized to certify individuals for WIC. She is colocated at the WIC clinic one afternoon per week to provide

immunizations and other services, which facilitates communication of eligibility determinations to WIC staff. In Delaware, public health nutritionists are authorized to certify for WIC. Since WIC is fully integrated with public health and each public health clinic client has one medical record, WIC certification information is readily available to WIC staff.

VII. Relationship with the Medical Community

An increasing number of WIC participants are receiving care from private providers as a result of initiatives that have expanded Medicaid eligibility for pregnant women and children and provided incentives for physicians to accept Medicaid patients. Thus, WIC Programs are coordinating with the private medical community to a greater extent. In some cases, interaction with the medical community prior to these initiatives was very limited because of the small role of these providers in caring for WIC participants. This has been an area of considerable change.

In Louisiana, KIDMED—a Medicaid initiative—raised the reimbursement rates for private physicians seeing Medicaid patients to one of the highest in the Nation. As a result, the private physicians are very willing to take on new Medicaid patients. The result for the WIC Program and the Tangipahoa Parish Health Unit has been that children continue to come to the Health Unit for WIC vouchers and nutrition education, but private physicians do medical screening. Physicians do not certify for WIC, but complete a "Referral to WIC Certification" form, which includes anthropometric and hematological information. In Hudson, NY, managed care providers have asked to conduct presentations about the Medicaid program at WIC clinics. In San Antonio, TX, the Health District is finding that private physicians are increasingly serving Medicaid patients and that prenatal clients are going to private providers instead of public health clinics. This is creating the need for WIC to strengthen its association with private providers and community-based hospitals. A dramatic example of the change in source of care is Palm Beach County, where several Medicaid HMOs have entered the market. Staff at two of the WIC program's six clinic sites estimated that the proportion of their clients who are being seen by private providers has increased from 5 percent to about 50 percent in less than 1 year. WIC staff have begun working with the HMOs and have found that some are very active in referring clients to WIC and distributing WIC materials to clients, while others are less interested in increasing coordination with WIC. The WIC Program sends a staff member to do WIC certification on site at one HMO.

Sites that rely on physicians for height, weight, and hematocrit measurements have more established relationships with the private medical community. Nearly half of the case study sites used physicians for this service, at least for some WIC clients. However, coordination with the private medical community is difficult, because there is no central contact point for all providers. WIC staff must work with each provider, group practice, non-profit clinic, and HMO separately. WIC staff in Palm Beach County are finding that they obtain less information on a client referred to them by a private physician, and it is harder to reach physicians by telephone to follow up for more information.

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The case study findings indicate that coordination with private providers is considered critical by WIC staff, not only for timely enrollment in WIC, but also for providing consistent nutrition education messages to clients. Areas of greatest concern in this regard were attitudes toward breastfeeding; understanding infant formula rebates and WIC's limitations on formula brands; and attitudes about infant feeding practices, such as use of iron-fortified formula and introduction of solid foods. In some areas, such as Delaware WIC, physicians are prescribing birth control and other medications that can impede breastfeeding without explaining these potential side effects to mothers. Several sites, including Atlantic City and Montgomery County, noted that a considerable amount of staff time was spent explaining the infant formula rebate program to physicians, notifying them of changes in the WIC-approved brands, and explaining that a change in brands for a patient on WIC required a physician's written authorization. Staff at the Palm Beach County WIC Program noted that private doctors' standards for height and weight are often different from WIC's. Some WIC Programs, such as those in Delaware, Montgomery County, and Salt Lake City, have found that participation on boards that include physicians, such as breastfeeding advisory boards and community health planning coalitions, helps to explain WIC to the medical community and establish ongoing communications.

VIII. Sharing of Staff and Resources

As discussed in Chapter III, sharing of certain types of staff and resources with other programs is fairly common for WIC local agencies. Referring back to Exhibit III-8, only 23 percent of agencies had space and utilities exclusively funded from their WIC budget. Space and utilities were least likely to be exclusively funded by WIC, while educational materials, computer equipment, and medical equipment were more likely to be funded exclusively by WIC. Case study site visit data also support this finding. Exhibit V-8 summarizes site visit data on a number of indicators of resource sharing. Shared facilities were common among case study sites, often as part of colocation with other services. In most cases, WIC was not paying rent for the facilities because they were provided by a government entity, such as the county or municipal health department. Sharing of equipment occurred much less frequently. A typical example of equipment sharing is the scales which are used by both WIC and public health staff.

Exhibit V-8**Resource Sharing at Case Study Sites**

Indicator/Activity	Number of Sites
WIC Services Provided by Staff of Other Programs	12
Administration/Support Provided by Staff of Other Programs	6
WIC Pays for Services Received from Other Programs	4
WIC Provides Services to Other Programs	6
Shared Facilities	19
Shared Equipment	6

Source: 22 case studies, WIC Dynamics, 1993.

Sharing of staff occurs for both administrative and clerical functions. Administrative functions include building security and maintenance, shared reception staff, and the processing of financial and administrative matters by WIC's sponsoring agency. Sharing of clinical staff occurs primarily in WIC clinics that are colocated or closely coordinated with health services and share staff for the purpose of obtaining anthropometric and hematological measurements. Based on the survey of local agencies, 29 percent of local agencies use non-WIC on-site staff for hematological measurements at their principal clinic sites. Interestingly, over one-fourth of the sites in the Local Agency Survey responded that they did not know whether hematological measurements were provided on site by non-WIC staff. An example from one of the site visits provides a possible insight. Staff in Tangipahoa Parish were "stumped" by the question, "Is there sharing of staff and resources?" Their programs are, in fact, so integrated that WIC is considered as a service of the public health unit, not a separate program. All staff participate in all programs. No fees are charged to WIC for rent, security, maintenance, or other building services. Nursing staff provide height, weight, and blood work for WIC patients, and this service is not charged to the WIC Program. Local agency staff did not know whether an indirect cost rate was charged to WIC because this is handled at the State level in Louisiana.

Programs that are well integrated might well have difficulty identifying whether certain services are provided by non-WIC or WIC staff. Exhibit V-9 summarizes site visit observations concerning the provision of services by non-WIC staff. Physicians and nurses were the most likely non-WIC staff to be involved in service provision for anthropometric measurements and blood work. Non-WIC nutritionists are used for a wider range of services, including nutrition counseling and breastfeeding promotion. At site visits, health aides, nurses, and nutritionists at colocated sites were often observed taking heights and weights of WIC participants if the WIC staff were running behind schedule, and staff of public health clinics that had obtained certification information as part of a prenatal or well-child visit provided the information to the WIC nutritionist on a slip of paper.

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Exhibit V-9

WIC Services Provided by Non-WIC Staff at Case Study Sites

Service/Activity	Number of Sites with Various Categories of Non-WIC Staff Providing WIC Services					
	Physician	Nutritionist	Paraprofessionals	Nurse	Clerk	Other
Income Eligibility Determination			1		2	
Height/Weight	10	2	4	10		1
Blood Testing for Anemia	10	2	4	10		1
Nutrition Assessment		3		2		
Individual Care Plan		3		2		
Individual Nutrition Education		3		1		
Group Nutrition Education			3			
Instruction on Use of Vouchers			1		1	
Voucher Distribution					1	
Breastfeeding Promotion/Support		3		5		2

Source: 22 case studies, WIC Dynamics, 1993.

The sharing of staff and resources can facilitate the provision of coordinated, comprehensive services to clients. However, as the following chapters indicate, the reliance on non-WIC resources is a source of concern and potential vulnerability for some agencies because the non-WIC support is often informal and is not guaranteed to continue.

IX. Planning and Special Projects

Coordinated planning and evaluation activities were examined in the case study component of this study, which provided the information presented in this section. Half of the 22 sites visited conduct joint planning and evaluation activities with programs outside of WIC. Data sharing with other programs for purposes of planning, evaluation, or program monitoring occurs at nine sites (41% of the case study sites). Specific evaluation of coordination activities occurred at only three of the case study sites.

Planning. Long-range (3- to 5-year) planning for WIC is generally a State-level activity. Interagency planning occurs at both the State and local levels. For example, both case study local agencies visited in Ohio credited the State-level interagency planning committee for

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development of the Combined Programs Application. This committee includes WIC, the Department of Human Services, Child and Family Health Services, and the Children with Medical Handicaps Program. In Delaware, the State planning process involves joint meetings among all State programs serving the maternal and child health population. The meetings are held in three parts of the State at different times in a town-meeting style. There is also a regional coordinating council, which includes WIC, Medicaid, and Public Health, that meets quarterly. The Maternal and Child Health Program, which includes WIC, was also a key participant in the Child Health Task Force, which developed a framework for a Statewide comprehensive primary health care system for children in Delaware.

At the local level, WIC Programs participate in planning with their sponsoring agencies. The New Haven, CT, WIC Program participates in the overall planning for Yale-New Haven Hospital's Primary Care Center. As a result of this joint planning, WIC was incorporated in renovation plans to further integrate WIC into Maternal Health Center activities at the hospital by moving WIC closer to these facilities. In Salt Lake City, UT, the WIC Program participates in health planning activities with the county health department and with community groups. Palm Beach County, FL, WIC engages in long-range planning, both at the request of the State agency and as a way to effectively address the rapid growth and demographic changes in the community it serves. Working with the director of the county public health unit, the WIC director used a variety of data sources (including WIC participation data, census data, data on changes in birth rates, and immigration data) to project caseload. Palm Beach County has an active health services planning district that provided much of the information used in the planning process. Caseload projections were used to identify areas which would need additional services and to project staffing needs. Projections were discussed and compared with those of the health department and with community organizations, such as the local chapter of the March of Dimes. Five-year plans were developed for computer needs, staffing (direct service and administrative), and clinic sites. The entire process of compiling site survey and long-range planning data took about 2 months, but continues as information is updated and plans are refined.

Special Projects. Both the survey and case study data indicate that local agencies have initiated a variety of special projects. The survey revealed that 5 percent initiated special projects, and the case studies collected information on the nature of special projects in case study sites. A number of these projects reflected an interest in improving integration and in better understanding the health service needs of WIC participants. For example, the Wilkes-Barre, PA, WIC Program recently conducted an immunization survey to determine whether children were being immunized as required and a health insurance study to determine the number of WIC participants who have health insurance coverage. These surveys were both conducted to provide information for planning and targeting a Pennsylvania State initiative to coordinate immunization (which is covered by health insurance by State law) with WIC services. In Delaware, WIC and Maternal and Child Health have used the computer system to evaluate specific issues. For example, at the State level, they are looking at the services received or not received for cases of infant mortality and conducting cross-clinic comparisons on various issues. Since time constraints limit the number of special projects that can be undertaken, some WIC sites, such as the one in Long Beach, CA, encourage students interning at the agency to pursue special research projects.

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While both the survey and the case study sites reported a wide array of special projects, the Local Agency Survey indicated that, nationally, 43 percent of local agencies postponed or canceled special projects between 1988 and 1992.

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Chapter VI

Synthesis of Reported Changes on State and Local Agency Operations and Factors Affecting Quality of WIC Services

Chapter VI. Synthesis of Reported Changes on State and Local Agency Operations and Factors Affecting Quality of WIC Services

There have been a number of areas in the WIC Program that have changed since 1988. Increasing caseloads, infant formula rebates, and required initiatives in a variety of areas are just a few examples of the changes to which local agencies have adjusted. As part of this study, local and State agencies were asked to describe levels and impacts of many changes. In addition, questions about the quality of WIC services were included in both surveys. This section reports on these results.

I. Participation Growth

Growth in WIC participation is probably the most obvious change that has affected local agencies. Between 1988 and 1992, the number of WIC participants increased by 45 percent nationwide. The following discussion provides details of the growth.

Exhibit VI-1

Local Agency Caseload in Local Agencies by Number of Service Sites

Local Agency Number of Sites	Number of Participants per Local Agency							Total (%)
	0 to 99 (%)	100 to 999 (%)	1,000 to 1,999 (%)	2,000 to 9,999 (%)	10,000 to 24,999 (%)	25,000 to 49,999 (%)	50,000 or more (%)	
1 Site	20	58	16	6	0	0	0	100
2-3 Sites	0	44	31	25	0	0	0	100
4-5 Sites	0	25	31	43	0.75	0	0	100
6-10 Sites	0	9	20	60	9	0.35	0	100
11-25 Sites	0	5	11	51	26	6	0.58	100
Over 25 Sites	0	0	34	4	32	13	17	100

Source: Based on estimates for 1,777 local WIC agencies; Local Agency Survey, WIC Dynamics, 1993.

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Agency Size. Currently, a majority of local agencies (58%) have between 100 and 1,999 participants. Nearly all (89%) have caseloads between 100 and 9,999. Larger agencies tend to have more clinics and service sites, as Exhibit VI-1 shows.

Children, ages 1 through 5, comprise the largest proportion of the WIC caseload. Overall participant mix has not changed notably in the past 5 years. The percentage of women in WIC's caseload has decreased slightly in comparison to children.

Ethnic Populations. Information on ethnic populations served by WIC does not show any clear trends. According to FCS data, minorities, especially black and Hispanic populations, tend to be served by larger agencies. There are local agencies that serve primarily a single ethnic population—e.g., black, white, Hispanic, or Native American—but none that serve a primarily Asian population. Less than 1 percent of agencies serve a population made up of more than 25 percent Asians, a different pattern from other ethnic groups. There was no apparent relationship between growth and ethnic groups served.¹

Growth. The WIC Program has grown over the past 5 years, both in terms of funding (an increase of \$800 million from 1988 to 1992) and of participation. While caseload fluctuations occurred during this period, very few agencies experienced a decrease in their caseload over a 5-year period, and the actual growth was quite varied. Exhibit VI-2 illustrates that significant proportions of local agencies fell into a variety of growth levels. It also shows that agencies that grew by 50 percent or more serve 45 percent of the WIC participant population.

The growth rate of State agencies roughly parallels that reported by local agencies, with 77 percent of State agencies experiencing growth between 15 and 100 percent.

While the number of participants has significantly increased during the study period, the program does not serve all who are eligible. State agencies were asked how many eligible individuals were unserved at the time of the survey. The most common answer was "Don't Know" (38% of agencies). Of those State agencies that did have an estimate of number of eligibles unserved, 42 percent reported between 25,000 and 100,000 people were currently unserved within their service area. Only one agency reported that no eligibles were unserved.

¹Analysis of this topic was preliminary and limited to cross-tabulations; more sophisticated analyses may detect trends.

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Exhibit VI-2

Participation Growth in Local Agencies, 1988 - 1992

Growth in Participation	Local Agencies Experiencing this Rate of Growth (%)	Participants Served by These Agencies (%)
Less than 15%	21	13
15% to 33%	22	22
33% to 50%	18	19
50% to 100%	28	34
Greater than 100%	8	11
Not Applicable	2	0.7
Total	100	100

Source: FCS 191 Files, 1988 and 1992.

Note: Growth was calculated by comparing participation figures from the 1988 FCS 191 files with the 1992 figures. There were four local agencies in the survey that did not exist in 1988, so a growth rate could not be calculated for them. Whenever two local agencies consolidated between 1988 and 1992, the growth rate was calculated by comparing the sum of the number of participants for each local agency in 1988 to the number of participants in the consolidated agency in 1992. Similarly, whenever a local agency split into two agencies between 1988 and 1992, the growth rate was calculated by comparing the number of participants for the local agency in 1988 to the sum of the number of participants for each of the split agencies in 1992.

Geographic Service Area. The responses from the State Agency Survey indicate that WIC is operating in almost every county in the United States. Of the 77 State agencies that responded to the mail survey, 67 agencies reported that WIC operates in all areas of the State (or Tribal boundaries). Of the 10 agencies that did not serve the entire State, seven had three or fewer counties unserved in their State. Some counties are served by more than one State agency, as is the case with some of the Indian Tribal Organizations. The local agency case study site in Wilkes-Barre, PA, serves a large geographic area in a fairly rural part of the State. This agency plans to add clinics as a way of increasing its caseload and serving more participants.

II. Impact of Changes

One of the objectives of this study is to describe the impact of new requirements and initiatives on local and State WIC agencies. There have been quite a number of requirements and initiatives. Some of these started at the local or State level, such as contracts with infant formula manufacturers for a rebate. Other requirements, such as substance abuse counseling and coordination with homeless services, were initiated by Congress. Other factors that have affected

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programs have not been initiatives but rather circumstances, such as a downturn in local economy. The following sections describe various factors identified by local WIC agencies as having had an impact.

Changes in Caseload. During the case study site visits, many agencies discussed the difficulties they experienced managing caseload fluctuations. An increase in caseload was the most common change reported in the surveys, with 86 percent of local and 87 percent of State agencies indicating that an increase in caseload had affected their operations. The local agencies that reported impacts from caseload increases serve 94 percent of the participants. Many local agencies experienced one or more caseload decreases during the same 5-year period from 1988 to 1993, even if their overall caseload increased over this time period. Agencies decrease caseload by suspending new enrollment and initiating waiting lists or restricting the categories or priority groups served. Caseload decreases impacted 30 percent of local agencies. Caseload increases were more prevalent than decreases. Overall for the entire period, the trend was toward caseload growth as indicated by FCS data, which show that 92 percent of local agencies increased caseload from their 1988 levels.

Economic Factors. Based on the response from local and State mail surveys, there were a number of economic factors that impacted WIC agencies. Infant formula rebates was cited most often among these factors, with 87 percent of State agencies serving 99 percent of the participants reporting an impact. A similar percentage of local agencies reported that infant formula rebates affected their operations (86%).

Another economic factor that affected many agencies was fluctuation in food costs. Both State and local agencies reported an effect on operations (92% and 70%, respectively). As learned through a case study visit, the Delaware State agency implemented a program to attempt to control the fluctuations of food costs. Retailers that wanted to be WIC vendors were required to submit a price for each WIC food item each quarter. This price was used to cap charges at a specific level so that vendors could not charge more than this amount, regardless of shelf price. However, if the shelf price was lower than the cap, the vendors were required to charge shelf price. This effort saved the State food dollars and reduced the impact of food cost fluctuations.

Issues related to funding were also reported as having an impact on State and local agency operations. The increase in Federal funds since 1988 was the most commonly reported issue, with 78 percent (each) of State and local agencies citing this. Sixty-three percent of local agencies noted that the availability of State funds impacted them, while only 36 percent of State agencies did. The difference in these figures may be due to larger States receiving State-generated funds, where more local agencies would be affected. Of the 22 case study sites, 13 reported that limited resources of their sponsoring agency altered local operations. Finally, a downturn in the local economy was commonly cited as affecting WIC Programs, as reported by 71 percent of State and 77 percent of local agencies. Seventeen of the case study sites reported being affected by a poor local economy. Some agencies on our site visits reported that local

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economic conditions caused many more people in their communities to be eligible for WIC, which strained their ability to deliver services.

Program Requirements. Much of the change in the WIC Program over the past 5 years has been attributed to increased Federal emphasis on existing program requirements and on new State requirements. Many agencies report that their programs have been altered by these requirements, which include increased emphasis on breastfeeding promotion, drug abuse education, homeless services, immunization coordination, prenatal care initiatives, and vendor management. Each of these requirements were mentioned by over 60 percent of State agencies as having affected their programs, as shown in Exhibit VI-3.

Exhibit VI-3

Initiatives That Impacted State and Local WIC Agency Operations

Initiative	State Agencies Impacted (%)	Affected Local Agencies (%)
Breastfeeding Promotion	88	88
Drug Abuse Education	69	57
Homeless Service	62	34
Immunizations	75	*
Prenatal Care	69	*
Vendor Management	77	41

* This information was not collected on the Local Agency Survey.
 Source: Local Agency Survey and State Agency Survey, WIC Dynamics, 1993.

Information from the case studies confirm that many of these initiatives have impacted the local agencies. For example at the Wilkes-Barre, PA, case study site, a breastfeeding coordinator implemented many promotions such as providing breast pumps to WIC participants and sponsoring staff training sessions. Peer counselor programs to promote and support breastfeeding have been implemented in several sites, including Montgomery County, MD, and Delaware. The San Antonio and Temple, TX, case study sites implemented a State-mandated immunization initiative. Under this initiative, all service sites have a qualified immunization nurse available for participants. New York State has also implemented an immunization initiative, and its impact was evident in several local agency site visits. In the Brooklyn, NY; New York City, NY; and Hudson, NY, sites, the screening for all required immunizations and updating of the immunization record are part of the WIC certification process. In some local clinics, participants who are behind on their immunizations are required to return monthly for WIC vouchers, while those whose immunizations are current receive their vouchers bimonthly. The impact and the

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extent to which local agencies have incorporated initiatives vary considerably. Immunization and breastfeeding promotion have been highly integrated into the operations of many of the other agencies visited as well, and many unique and thoughtful promotions have been devised. Drug abuse education and homeless services have not been as widely adopted into the core of WIC operations as breastfeeding and immunization. While these requirements were mentioned less frequently, some examples were observed during site visits. The New York City, NY, site provides WIC services at transitional shelters for the homeless. Delaware issues vouchers for UHT milk and juice to those participants that do not have access to refrigerators. A number of sites visited indicated that lack of drug education and treatment resources (especially for women) in their respective communities limited the opportunities for drug education initiatives in WIC.

Other Initiatives. In addition to the specific initiatives mentioned in the previous sections, other factors have also impacted local WIC agencies. Sixty-six percent of State agencies and 77 percent of local agencies, serving 83 percent of participants, reported an impact from Medicaid expansions. As discussed in the previous chapter, the Medicaid expansion also resulted in more private physicians providing medical care for WIC participants.

Computerization and automation have also significantly impacted agencies. Eighty-one percent of State agencies serving 92 percent of participants cited this factor, while 68 percent of local agencies reported it. The majority of States noted that more PC and minicomputer equipment has been used since 1988, and the case study findings confirmed this use. Many of the agencies visited are using computers or are in the process of implementing a system. There is a wide range of levels of automation, however. For example, while Delaware's system is completely automated and includes other providers, New York had no automation at the time the case study visits occurred (April 1993); however, plans were underway to phase in automation.

III. Facilitators and Barriers to Providing High-Quality WIC Services

In the mail surveys, local and State agencies were asked to detail the five factors that contributed most to their ability to provide high-quality WIC services and the five factors that hindered them. After all responses were coded and entered into a database, responses composed of at least 5 percent of the local agencies were considered as relevant categories. Each survey was then re-evaluated to ensure that responses of "other" truly did not fit into any categories. In addition, those categories mentioned by less than 5 percent of respondents were then included in the "other" category. Exhibits VI-4 and VI-5 list the factors and percentage of agencies that mentioned that particular category.

Factors that Promote High Quality. Issues related to staffing were the two most frequently cited factors by local agency respondents. Sixty-nine percent of local agencies cited **caring or concerned staff**, and 53 percent cited **qualified, well-trained staff**, as factors that promote quality. State agencies cited these two factors at 57 percent, most frequent, and 42 percent, fourth most frequent, respectively. State Agency respondents cited **support/cooperation within**

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the WIC Program as the second most frequent factor. This includes support from various sources such as the community, sponsoring agencies, other service programs, or within the WIC Program itself. **Quality nutrition services** was the third most frequently cited factor from the Local Agency Survey. These included features such as individualized client attention, quality materials and equipment, and breastfeeding promotion and support activities. State agencies responded with **ongoing program improvement** as the third most frequently cited factor. Aspects of ongoing improvement include training and the use of standards and quality assurance techniques to evaluate operations and service and to use this information to promote positive change. **Quality clinic operations** was the fourth most frequently cited factor in the local agency survey and fifth most frequently cited by State agencies. Features such as extended or flexible hours, efficient voucher or scheduling systems, and computers or automation were included in this factor. **Referrals/integration** was the fifth most frequently cited factor for local agencies.

Exhibit VI-4

Factors That Promote High-Quality WIC Services

Factor	Local Agencies (%)	State Agencies (%)
Caring, Concerned Staff	69	57
Qualified, Well-Trained Staff	53	42
Quality Nutrition Services	49	26
Quality Operations of Clinic	38	36
Referrals/Integration	31	34
Support/Cooperation within the WIC Program	*	55
Ongoing Program Improvement	*	51
Adequate Facilities	30	23
Support from the Community and Other Services	28	18
Staff - General	15	27
Ongoing Training/Instruction for Staff	17	*
Participant Support	6	*
Vendor Monitoring/Cooperation	2	8
Other	23	13

* This answer was not frequently reported in this survey.

Source: Local Agency Survey and State Agency Survey, WIC Dynamics, 1993.

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Exhibit VI-5

Factors That Hinder High-Quality WIC Services

Factors that Hinder	Local Agencies (%)	State Agencies (%)
Inadequate Facilities/Materials	65	31
Shortage of Staff	39	49
Lack of Funding/Funding Fluctuations	25	45
Inefficient Operations	24	30
Too Many Requirements/Paperwork	24	40
Not Enough Time	37	21
Geographical/Transportation Issues	37	21
Lack of Support/Training	10	31
Staff Attitude/Turnover	17	23
Unresponsive Participants	33	4
Staff - General	7	8
Language/Literacy Barriers	9	4
Lack of Non-WIC Services for Participants	3	9
Weak Infrastructure	*	8
Vendor Issues	*	6
Lack of Community Support	2	*
Not Enough or Poor Nutrition Education for Participants	2	*
Other	27	18

* This answer was not frequently reported in this survey.

Source: Local Agency Survey and State Agency Survey, WIC Dynamics, 1993.

Factors That Hinder High Quality. **Inadequate facilities** was the most commonly cited barrier by local agencies, with 69 percent reporting this factor. Included in this category were responses indicating the lack of privacy and lack of play areas for children. However, only 31 percent of State agency respondents cited inadequate facilities as a barrier. The next most frequently cited barrier was **shortage of staff**. While some agencies specified a particular type of staff such as nutritionist or bilingual, others reported that there were too few people overall

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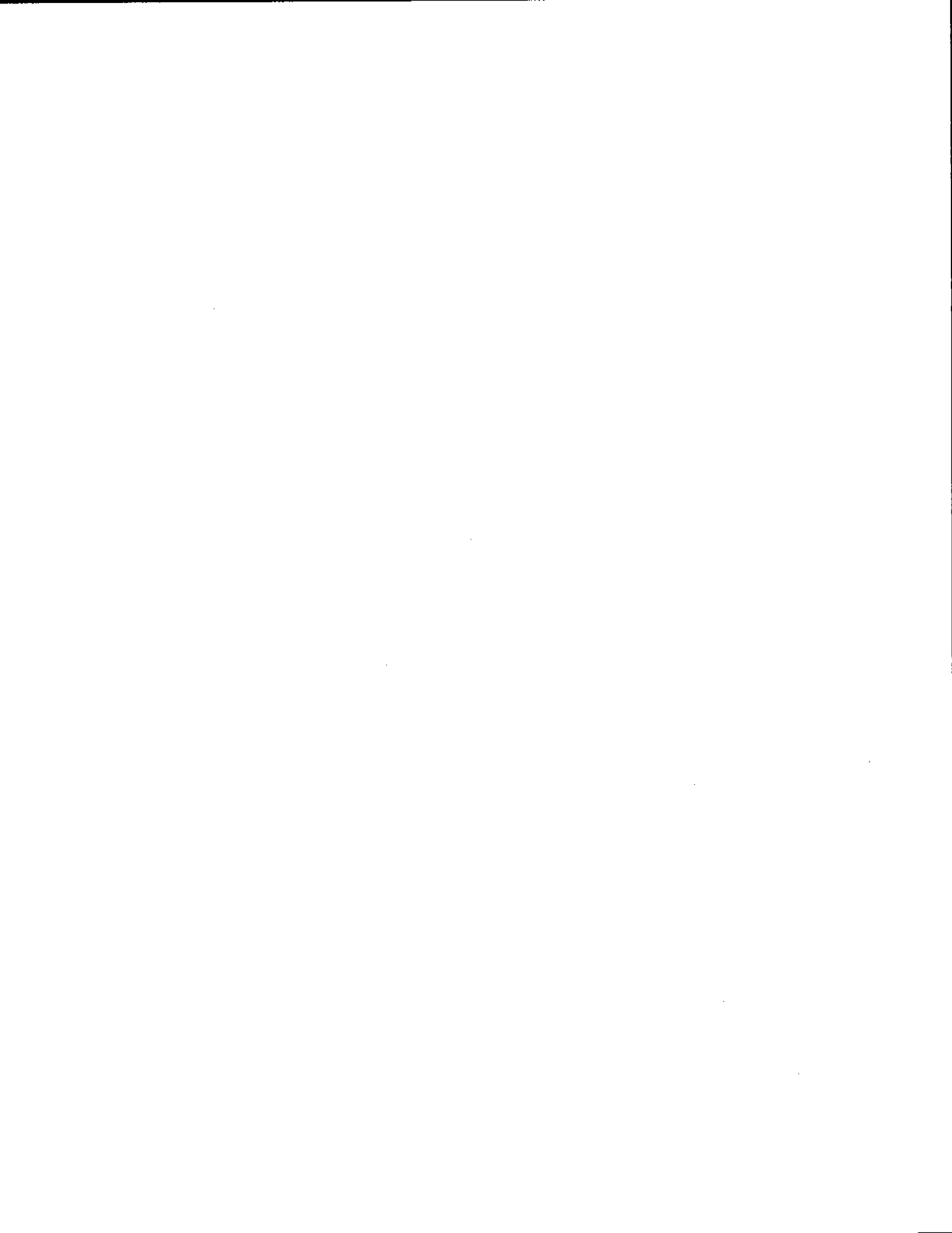
to handle the caseload. Again there was a discrepancy between local and State agency's perceptions of the issue. Staff shortage was the most frequently cited barrier, 49 percent, by State agencies. A related barrier is **staff attitude/turnover**, which was cited by 17 percent of the local agencies. The next most frequently cited barrier for local agencies was **not enough time** and **geographical/transportation**, each reported by 37 percent of agencies. Only 21 percent of the State agency responses listed these two barriers. The fifth most frequently cited barrier among local agencies was **unresponsive participants**, 33 percent.

It is interesting to note the discrepancies between the perceptions of State and local agency staff on the factors that affect quality in WIC. The most striking observation from Exhibits VI-4 and VI-5 is the differences in the ranking of factors by the two types of respondents. Perhaps this can be attributed to the differences in perspectives of WIC local agency directors and State agency directors. Local agency directors may focus more on those factors that influence their daily encounters with WIC participants. However, State Agency directors may focus more on the broader policy issues related to managing the program statewide and have fewer opportunities to interact with participants or provide direct service delivery.



Chapter VII

**Current Operating Capacity and Perspectives
on Accommodating Future Growth**



Chapter VII. Current Operating Capacity and Perspectives on Accommodating Future Growth

In order to understand the impact of changes and assess the potential for further growth, it is necessary to first have an understanding of the current operating capacity of WIC agencies. Operating capacity refers to a local agency's capability to deliver services effectively relative to caseload size. Current operating capacity was specifically addressed in both the State and Local Agency Surveys. The local agency findings are supplemented by case study information. The case study site visits also explored issues concerning future growth. These findings are presented in the second part of this chapter.

I. Current Operating Capacity

There are many factors that contribute to a local agency's capacity to serve its current caseload and accommodate future growth. These factors include adequacy of current space, staffing, funding, operating hours, efficiency, and other administrative operating features. The Local Agency Survey included the following question regarding capacity: "How close are you to **operating at maximum capacity** (relative to the size of your WIC caseload and your capacity to deliver services effectively)?" To get the State Agency's perspective, a similar question was included in that survey: "In your opinion, in what capacity are local agencies in your State currently operating?" For both surveys, 69 percent of respondents indicated that local agencies were operating above capacity. This is an important consideration when determining the program's ability to accommodate future caseload growth. Following is a discussion of some of the factors which affect local agency capacity.

Capacity To Serve. State agencies were asked to characterize the capacity of their local agencies with regard to the level at which the existing local agencies are currently operating. While 43 percent of the State agencies (less than half), characterized their local agencies as being above capacity, those State agencies represent 60 percent of all WIC local agencies and 61 percent of WIC participants. Thirty percent of the State agencies indicated that their local agencies are below capacity; however, they account for only 9 percent of all local WIC agencies. Thus, the capacity for growth, as portrayed from the State-level perspective, is lowest in the agencies serving larger numbers of participants.

Space and Facilities. In order to be able to serve participants adequately, the facilities in which WIC operates must be of adequate size, appropriately partitioned, with sufficient waiting room space, furniture, play areas, etc. When local agencies were asked if their current space was adequate, only 33 percent replied that it was. The 67 percent of agencies that reported inadequate space served 82 percent of participants, so the larger agencies reported this problem more frequently. When given the opportunity to discuss general barriers to high-quality services, 65 percent of local agencies wrote that inadequate facilities or materials were a problem. Some comments included were that the space was too small, located in a dangerous area, there was not enough privacy, or there was no area for children. Almost half of the local agencies surveyed reported moving to a new facility. Although the survey did not collect information on the

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reasons for moving, the site visit findings suggest that agencies may move to ameliorate these problems. However, even though half of the local agencies have moved, more than half still report inadequate facilities.

The case study findings echoed these space concerns. Fourteen of the 22 agencies visited reported having space lacking in privacy for individual sessions, 19 agencies reported inadequate seating for individual sessions, 14 reported the same problem for group sessions, and 15 agencies reported using space for groups that did not allow all participants to either see or hear the instructor and audio-visual materials.

Staff. In addition to space, staff and the shortage thereof were reported as one of the main factors affecting operating capacity. The following examples illustrate the impact that staff issues have upon capacity.

- Local agencies commonly reported that they had less than sufficient numbers of staff, with larger agencies reporting this more frequently. Almost two-thirds of participants are being served by agencies that reported insufficient numbers of staff. This is true even though the majority of agencies reported that the numbers of staff have increased since 1988. It appears that, in the view of local agencies, staffing levels have not grown sufficiently to accommodate the WIC caseload.
- Over half of the local agencies reported that they have difficulty recruiting qualified staff, particularly for professional positions. This can be a problem even for agencies with available funds to hire staff. The primary barriers cited were salaries and benefits that were not competitive, hiring freezes, and labor shortages. It should be noted that these factors generally are beyond WIC's control. In those States where WIC staff are State, county, or municipal employees, recruiting procedures and salary/benefit levels are established outside of the WIC Program.
- Over one-third of local agencies have reported difficulty in retaining staff once they were hired, a more common factor for agencies that serve larger numbers of participants.
- When given the opportunity to identify barriers to providing high-quality services, 39 percent of local agencies and 49 percent of States cited staff shortages as a barrier.
- Data from the case studies indicate that 19 of the 22 agencies visited are concerned about their need for more staff to accommodate future program growth, and 12 of the agencies were concerned about the shortage of qualified nutritionists in the area. Several of the case study sites (e.g., New York City, NY; Atlantic City, NJ; Wilkes-Barre, PA) reported that this shortage was due to the general unavailability of nutrition staff, in particular, and to the relatively non-competitive salary level of WIC nutritionists.

These findings indicate that the shortage of staff is viewed by both State and local agencies as having a serious impact on capacity.

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Funding. Funding availability is one of the major factors influencing operating capacity. It is an underlying issue in facilities, staff, and other areas. A number of agencies report that insufficient funding is a problem for them. One-quarter of local agencies and 45 percent of State agencies noted that a lack of funds or the fluctuation of funds hindered their operations. Another issue relating to funding is the use of non-WIC sources of funding. One of the benefits of sponsorship or colocation that many WIC Programs have experienced is the receipt of in-kind services. Among the in-kind services received are: facilities, copying or FAX machines, telephone lines, reception staff, and security staff. Many local agencies report using staff and non-labor resources not paid for by WIC:

- As noted in earlier sections of this report, 16 percent of local agencies, serving 27 percent of participants, use non-WIC-funded health care workers to conduct certifications.
- Only 23 percent of local agencies pay for space and utilities with exclusively WIC funds, while 24 percent report that space and utilities are entirely funded by other sources. The remainder report a combination of WIC and non-WIC funds.
- In order to obtain hematological measurements for participants, 29 percent of principal clinics report typically using non-WIC staff on site to conduct this test. In addition, 43 percent report typically using results brought in by the applicant that were conducted by an outside health care professional, such as a private physician or community health clinic.

From a federal perspective, resource-sharing in WIC may be desirable if it fosters coordination and integration with other programs and services targeted toward low-income women and children. Other programs (which recognize WIC's role as a gateway program) may be willing to provide resources to WIC to gain access to this target population.

Quality of Nutrition Education. With inadequate space and staff, it becomes even more of a challenge to provide services of high quality. More than a third of local agencies reported a decrease in the amount of time per participant spent on nutrition education, whereas 57 percent reported spending more time on referrals. Additional program requirements may also take time away from nutrition education. Many agencies reported an increase in use of group nutrition education, with 66 percent of participants being served by these agencies. Case study findings indicate that, where group nutrition education has increased, it is being substituted for the second nutrition education contact, particularly for those participants who are not high-risk. Group classes may not properly target the specific nutritional risks experienced by those participating in the group. They also may be inappropriate for some participants due to language and cultural barriers. Handouts, while presenting information concisely, may not be understood due to literacy or language barriers. One staff member in New York City, NY, reported that too often they found their handouts being left in the waiting area or dropped on the ground near the WIC office. This could also be an indication as reported by many local agencies of the difficulty in maintaining clients' interest in nutrition education.

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Local Agency Operations Factors. The following factors may also alter an agency's capacity to serve participants.

Waiting Time: The amount of time that participants have to wait in the clinic before receiving services is an indication of an agency's capacity. Over 26 percent of participants are served by local agencies that report the typical waiting time to be certified for WIC exceeds 30 minutes. Some local agencies reported waits of 2 hours or more. During one site visit, researchers observed signs in the waiting room notifying participants to plan for a 2-hour wait prior to their appointment.

Extended hours/days of clinic service: Almost half of all local agencies reported extending their clinic service schedule, by either extending the days of service or the hours the clinic was open. P.L. 101-147 mandated extended hours to serve working participants. In addition to improving access for working participants, extended clinic hours and days of service increase clinic capacity by permitting the clinic to serve more participants in the same facilities.

Efficiency Increased: Some of the questions on the Local Agency Survey were related to the efficiency of operations at the agency. Fifty-one percent of agencies reported streamlining recordkeeping, and 68 percent made greater use of computers. In addition, 72 percent reported making more efficient use of their space and facilities during the study period. Other factors that might indicate increased efficiency in the last 5 years is the shift toward more automation, group nutrition education, and the issuance of multiple food vouchers at a single appointment.

Specific Changes in Administrative Operations: More than half of local agencies reported an increase in the amount of paperwork they were doing, and 62 percent reported that the completion of paperwork or reports was delayed. Special projects were postponed or canceled by 43 percent of agencies. Administrative functions are forced to be a lower priority for agencies. This is supported by the answers to the open-ended question regarding barriers to high-quality services, where many agencies responded that "Not Enough Time" was a barrier. Similarly, 57 percent of agencies reported spending more time on referrals.

These areas related to capacity show that many agencies have pursued options and have been successful in increasing the efficiency of their operations. However, agencies continue to be constrained by inadequate facilities, staff, time, and funds, at a time when caseloads continue to increase. When specifically asked at what capacity they were operating, 30 percent reported that they were operating below capacity, 50 percent reported that they were operating at capacity, and only 20 percent reported being above capacity. Follow-up telephone calls to agencies that gave apparently contradictory responses regarding space and other issues and capacity revealed that many responded relative to their State-assigned caseload—if below assigned caseload, they indicated that they had excess capacity. Others said that they were willing to serve more participants, and assuming an infusion of sufficient resources, felt that they could do so. Although case study sites were not specifically asked about current operating capacity, most sites were operating at or above capacity, based on on-site observation and interviews with WIC staff. Three sites appeared to be operating below capacity.

II. Perspectives on Accommodating Future Growth

This section presents case study findings about future growth. When available, supporting data from the Local Agency Survey are included. One of the most powerful findings of the case studies is the enthusiasm present among the staff for doing as much as possible for the population being served. During case study interviews, staff consistently spoke about the various things they might be able to do to accommodate further growth in their programs. However, they also mentioned concerns they have about what might occur and how it might occur. Before presenting the issues surrounding future growth as expressed by WIC agency staff, there was a great deal of uncertainty about the definition of "growth." For the purposes of interview discussions, staff were told to define growth as serving as many people in their area that were in need of services.

It should also be noted that growth is not anticipated to be a problem for some agencies because they consider themselves to be already serving most of the eligible population. For example, WIC staff in New Haven estimate that only 15 percent of the population eligible for WIC in Connecticut are not on the program. If this is correct, the increased client load may not dramatically affect current operations. In Wilkes-Barre, staff do not believe there will be an immediate increase in participants at existing offices because they are currently serving all priorities without waiting lists, and expansion will consist of opening new clinics to reach unserved parts of their catchment area. The WIC Program at Grady Memorial Hospital in Atlanta has excess capacity because caseload has decreased in response to competition from other providers. WIC staff in Temple, TX, indicated that they are serving fewer participants than their targeted caseload, and that they could serve an additional 800 participants without adding staff.

Practical Issues of Growth. The growth of the WIC Program would have several practical impacts on local agency service delivery. Many of the issues have been discussed in the previous section regarding current participation status and the growth encountered since 1988. Local agencies cited factors that they must address concerning future growth.

Space: Space is currently a problem for many of the local agencies. Most of the case study sites expressed concern about space with respect to future growth. Eighteen of the 22 agencies visited were concerned about their waiting room space, 16 about space for individual sessions, 16 about space for group sessions, and 17 about space for voucher distribution. Some sites (e.g., Atlantic City, NJ, and Martinsville, VA) expressed concern over finding any space in their geographical location that could accommodate the agency's needs.

Staff Resources: Agency staff were concerned about the ability to provide all the mandated services to clients in a timely fashion with their current staffing levels. In the Local Agency Survey, many of the agencies (58%) indicated that the time per participant was currently too limited, and this presents a potential barrier to the provision of quality nutrition education.

Part of program growth could involve an expansion of the existing network with which program staff are involved. Networking is a crucial element for building a referral system and building

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community support for the program. Activities include information dissemination, participation in planning meetings, cooperating in community service activities, and serving on advisory boards with public and private health providers, breastfeeding promotion groups, health care coalitions, and schools, Head Start programs, and other community organizations. Agency staff referred to their already limited time available for participant contact and were concerned that there might be an inadequate amount of time available for increased networking.

In-Kind Services: WIC coordinators of two case study sites expressed concern that, if one of the results of program growth is the need for separate, larger space, they will no longer be able to be housed by sponsoring agencies, thus losing in-kind services. The result to the WIC Program would be an increased per-participant cost. One WIC coordinator noted that there are no assurances that resources provided by the city will continue if the WIC Program expansions exceed the amounts the city has available for in-kind support of WIC.

Quality of Services: The quality of services, particularly nutrition and voucher education, is integrally related to space and staffing issues. While local agencies expressed the view that they have improved the quality of nutrition education (i.e., refined instructional materials and techniques and have better qualified staff), there has been increased use of group education, and a broader range of relevant counseling topics are covered, with less time devoted to nutrition education.

Health Care Providers: The availability of health providers could also alter the WIC Program. If an agency relies on non-WIC providers to complete the medical history needed for certification (almost half of the case study sites), and there is a lack of appropriate providers in the community, growth in the WIC Program may affect the certification process and delay enrollment for many participants. Six case study sites indicated that a shortage of physicians or other health care providers was a major concern with respect to WIC growth. In some cases, there was an overall shortage of health providers in the community, while in other cases, there was a shortage of physicians serving the Medicaid-eligible population.

Referrals: Since part of the WIC Program mandate is to provide referrals to participants for other health and social services, growth should create an increase in referrals. Several sites expressed concern that increased referrals from WIC could overburden existing health and social service delivery systems. For example, WIC Program staff in Delaware noted that, while WIC services would be able to accommodate full funding, there is not enough sick child care available, especially in rural areas, and an expansion of WIC and increased referrals could exacerbate this situation. In Tangipahoa Parish, LA, where WIC is part of a fully integrated public health unit, many staff interviewed were concerned that increased WIC participation could rob the community of other health services as health unit personnel struggle to keep up with the increased WIC caseload.

Colocation Arrangements: As local WIC Programs have continued to grow over the years, some have outgrown other services with which they are colocated. This imbalance, in some cases, has caused tension between WIC and other colocated programs. One example of this is the

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Martinsville agency, where the WIC Program is colocated but not integrated into health department services. A great strain reportedly exists between WIC and the health department services due to the perception that WIC is a self-contained program that must be kept separate. WIC may be perceived as being in competition with other health department programs and resources, rather than to an adjunct to health services. WIC is located in the county health department facilities where other health services are offered, but, because of space limitations, no other clinics were held simultaneously with WIC. It is possible that, in cases such as this, growth will lead to separate locations, which might ease the strain and improve staff morale but could also decrease or complicate WIC's integration and coordination with other health and social services.

On the other hand, in some colocated agencies (e.g., Palm Beach County, FL; Delaware; New York City, NY; Tangipahoa Parish, LA), colocation has had a major role in the integration of WIC services with other health and social services. In these sites, if WIC outgrows the available space, service integration and client accessibility could be affected.

Community Constraints: As WIC agencies expand, there are several ways in which the community would both affect and be affected by the program. Factors such as transportation and health provider availability would directly effect program growth. Transportation is one of the most troublesome community constraints on service delivery. This is currently a problem for many agencies (46% of Local Agency Survey responses), and expansion of the WIC Program is likely to exacerbate the problem for these agencies and perhaps become a problem for others. In order to increase program participation, WIC agencies are likely to reach out to people who have not been participating due to various barriers, one of which may be lack of transportation. In some sites, such as Palm Beach County, WIC was able to address the transportation issue by relying on the health clinic van to bring people to the clinic in which they are colocated. They scheduled their appointments around the participants' appointments for medical services, since Medicaid reimbursement is provided for transportation to medical appointments, but not to WIC-only appointments. If growth would mean moving out of the health clinic site, the van would no longer be available and transportation would become a major barrier to service delivery.

Process Issues of Growth. Along with the practical concerns about the continuing success of the WIC Program under a new period of growth, there are several concerns about how growth might occur. Generally, WIC agency staff are concerned about whether or not the growth process would include provisions that would help to ensure the program's integrity and allow for continued improvement. The remainder of this section outlines some of the specific concerns voiced by agency staff during the case study site visits.

Consistency of Growth: Since its inception, WIC has grown steadily. However, agencies have also experienced periods in which they have had to contain program growth or even decrease their participation. This process is one that greatly concerns many WIC agency staff. One New York City agency explained the detrimental effect of the constant change from periods of expansion to periods of contraction. Decreasing participation is often achieved by creating waiting lists for specific participant categories. When word got out in the community that WIC

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had a waiting list, many would-be participants who were not in that wait-listed category did not apply for the program, thinking that they would not be able to get into it. A year after the waiting list was no longer in use, potential participants were still under the impression that the waiting list existed and were hesitant to apply for WIC benefits. This site and others expressed concern over the nature of the growth process, hoping that problems could be avoided.

Planning Time: In order to properly and adequately address the practical concerns discussed above, WIC agency staff felt that they would need advance planning time. This time would be used not only to find adequate space or staff, if necessary, but also would be used to properly reorganize their service delivery. Staff referred to the need to rethink the ways in which they offer nutrition education (group or individual), voucher education (group or individual), the use of audio-visual materials or handouts, the length of the time between voucher pickups, and the ways in which they could be effective in their outreach efforts.

Increase in Regulations: WIC staff expressed concerns about whether increased funding for WIC would be accompanied by increased regulation and regimentation of the program. Many sites indicated that current regulations and reporting requirements (e.g., regarding waiting times, voucher issuance, staffing, and nutrition education contacts) were burdensome because of the amount of documentation required. WIC staff noted that each new program aspect results in new reporting requirements, such as obtaining documentation of formula substitutions from physicians since the implementation of infant formula rebates. Directors who have worked in the program for 10 years or more have seen regulations grow with funding and caseload.

This concern related to service quality as well as program capacity. Staff expressed concern over the abundant documentation, referrals, and other counseling requirements that WIC staff must incorporate into their limited time with participants. If program growth includes an increase in program requirements, there is concern that the quality of WIC services will suffer.

Increase in Program's Scope: WIC staff have seen the scope of WIC broaden in response to new program requirements, as well in response to changing (and often more complex) needs of WIC participants. At the local level, WIC staff are aware that, as they expand to serve harder-to-reach populations, the client needs they must address may be broader in scope and intensity. WIC is already seen as a "gateway" to other services, and this role may increase with program growth. For example, WIC staff in Salt Lake City noted that the community's expectations of WIC are high. Future roles for WIC that were mentioned included "preventive health triage" and "WIC could be the agency that keeps people from falling through the cracks." While WIC staff agree that WIC has become an important community public health resource, they voiced belief that expansion of the program's scope goes beyond growth in participation and should be carefully planned and appropriately funded.

In summary, the findings of the State Agency Survey, the Local Agency Survey, and case study site visits provide valuable new information on WIC Program operations, coordination of WIC services with other community providers, and implications for future growth. During the study period (since 1988), the WIC Program has grown and significant changes have occurred in the

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health and social service needs of WIC participants and in the service delivery networks in local communities. WIC local agencies have improved efficiency and stretched resources to respond to these changes. For the most part, WIC local agencies are optimistic and willing to address the challenges of further expansion, but are concerned about the implementation of such growth in light of their current facility and staffing limitations.