

IV. INNOVATIONS IN SERVICE DELIVERY

Innovative service delivery can include providing WIC services in nontraditional locations or using alternative modes of communication (such as by telephone versus in-person, or through videos instead of written materials). Several of the programs profiled in earlier chapters include interesting innovations in service delivery. For example, the Arkansas program involved a long-distance certification process, so mothers with infants in neonatal intensive care far from home could receive breast pumps promptly. The program in Washington and Greene Counties in Pennsylvania provided peer counseling by telephone only, while most programs have an in-person component. These programs and the programs discussed in this chapter all serve rural WIC clients and seek to address transportation barriers. Other service delivery innovations, such as videos, may address literacy or language barriers.

This chapter discusses three programs that are innovative in that they include delivery of WIC services in two nontraditional settings: clients' homes and workplaces. WIC clinics are traditionally located at public health departments, hospitals, health clinics, or in free-standing buildings; satellite clinics (open only occasionally) may be in locations such as schools, church basements, or community centers. But service delivery in the home or at work remains rare.

Because of its high cost, home visiting usually implies not just services in a different location, but comprehensive and individualized services targeted at particularly high-risk clients. Because WIC funding does not cover comprehensive services, WIC services are rarely offered via home visits, unless they can "piggyback" on another program's services. At the same time, because clients view WIC positively, home visiting programs find that delivering WIC food instruments makes home visits more welcome. In both examples of home-visiting programs discussed below, WIC was collaborating with Medicaid care coordination for high-risk pregnant women and infants. The home visits were funded largely under Medicaid. WIC services provided during home visits varied, as did the frequency of home visits, but visits included delivery of food instruments in both cases.

For WIC services to be offered through home visits, WIC services must be coordinated with a home visiting program's services. The programs in northwest Michigan and in Cullman County, Alabama—both located in local health departments—are good examples of coordinated services; they coordinate at the policy, administrative, and especially the clinical levels.¹ Such

¹ The *Coordination Strategies Handbook* prepared for FNS by Health Systems Research distinguishes policy, administrative, and clinical coordination (U.S. Department of Agriculture 2002). The handbook also distinguishes three levels of closeness in how programs are related: (1) coordinated—at different locations and with different staff, but with some communication; (2) co-located—at the same or an adjacent location; and (3) integrated—under the same administrative management. The home-visiting programs described below are largely integrated, in that they ultimately are under the same division of the Health Department and at least some staff deliver services for both programs. However, records for WIC and the Medicaid care

coordination can lead to more seamless service for clients (of which coordinated home visits are just one example) and cost savings for WIC. We thus describe the range of coordinated services delivered in these programs, not just the home-visiting component, in order to clarify the context for home visits.

Workplace visits to provide WIC services are not widespread. However, as more WIC mothers enter the workforce under welfare reform, such programs may become more relevant. The program described here is on a rural Indian reservation with a small number of employers and significant transportation barriers for clients. In general, offering WIC services in clients' workplaces seems most applicable in other rural areas or areas where individual firms hire many WIC clients. For a workplace program to operate, it is important that employers cooperate. Clients must also be willing to let coworkers know they receive WIC. Such programs are clearly not appropriate in all settings. For example, the program described below, which is operated by the Eastern Band of Cherokees WIC agency, serves clients who work in motels, clerical jobs, day care centers, schools, restaurants, and stores. However, those who work in sales or service jobs that involve direct public contact have more difficulty taking time off and may lack private space to meet with the WIC nutritionist.

Overall, service delivery in homes or workplaces is an example of how WIC programs can become more flexible to meet diverse client needs. Coordination of WIC services with other programs can be an effective way to obtain both the resources and the administrative flexibility to use alternative service delivery mechanisms.

(continued)

coordination programs must be kept separate, and duplicative forms filled out at times, to meet state and federal requirements.

COORDINATION OF WIC WITH MATERNAL AND INFANT SUPPORT SERVICES² NORTHWEST MICHIGAN

OVERVIEW

Location: Grand Traverse, Benzie, and Leelanau counties, Michigan.

Start Date: 1990 in Grand Traverse, 1996 in Benzie-Leelanau (when their district health department was formed as the result of a separation from Grand Traverse County).

Target Population: High-risk pregnant women, postpartum mothers, and infants who qualify for Medicaid.

Purpose: To provide one-stop services to pregnant and postpartum mothers and infants, improve their access to services, and increase revenues for the health department.

Services: WIC services are provided in conjunction with a Medicaid-funded program of intensive support services (Maternal and Infant Support Services [MSS/ISS]) for pregnant women and new mothers, involving monthly meetings with a nurse, dietitian, or social worker. Some of these meetings occur through home visits, allowing in-home WIC coupon delivery, nutrition education, and occasional recertifications. Other health department services, such as family planning and immunizations, are also closely integrated. MSS/ISS will also pay for public or private transportation, if needed.

Funding: Medicaid covers much of the cost of the coordinated services through the MSS and ISS programs.

Why Program Was Chosen: These programs include strong coordination of services, improved health care access in a rural area through the use of home visits, and good “leveraging” of funding. WIC is used as a “carrot” to draw clients into the MSS/ISS program, and WIC, in turn, benefits from the Medicaid funding, which provides a per-visit reimbursement for MSS and ISS. These practices likely contribute to higher participation rates, more efficient operations, stronger financial status for the health departments, and better services for the community.

Key Challenges: Working out the logistics of integrated services—such as procedures for ensuring the security of food coupons on home visits—was an initial challenge. On an ongoing basis, the nurses providing both WIC and MSS/ISS services found that it was important to be clear with each other on division of administrative responsibilities and to communicate regularly with clerical staff about challenges they faced.

² Telephone interview, April 18, 2003; site visit, August 6-7, 2003.

BACKGROUND

Community Characteristics. This program operates in three Michigan health departments: Monroe County, Grand Traverse County (GT), and Benzie-Leelanau District (B-L). Other forms of coordination occur in other health departments in the state. We visited GT and B-L, which are both in the northwest “little finger” area of the Lower Peninsula of Michigan, and we will focus our discussion on these programs. This area comprises largely rural communities and small towns along Lake Michigan and Grand Traverse Bay; Traverse City is the largest city in the area, but none of these counties is considered metropolitan. Tourism and farming (especially cherries) are important industries. The population is over 95 percent white, with small pockets of Native Americans and Hispanics. Poverty rates are low, ranging from 5.4 percent in Leelanau to 5.9 percent in GT to 7.0 percent in Benzie County, versus 10.5 percent for the state on average (1999 data from the 2000 Census). Benzie and Leelanau counties are low in population and more rural than Grand Traverse; their combined health department is one of the smallest in the state.

Target Population. WIC and MSS/ISS coordination is targeted to low-income, high-risk pregnant and postpartum women and their infants. Medicaid (or other state or federally funded maternity care programs) must cover the pregnant woman or infant to be eligible for MSS/ISS services. Mothers or infants must also have one or more risk factors. For pregnant women, being a teenager or suffering from substance abuse, homelessness, or stress are among the risks that qualify them for MSS. As in WIC, the risk factors are sufficiently broad that essentially everyone who is income-eligible can qualify. Risk factors for ISS are somewhat more limited, but also include babies with eating/feeding problems, prematurity, or low birth weight.

Staff reported that most clients are white and many stay home or work part-time (or irregular or evening hours) in low-wage service jobs. Some are seasonal workers in the tourist industry. In GT, many have some college education. B-L has a migrant camp with largely Spanish-speaking residents, which are served by a migrant health center that hosts a Health Department satellite WIC clinic once a week in the summer. Hispanics are about 5 percent of clients in GT and about 14 percent in B-L. Language barriers can be a problem in serving them, as there are no Spanish-speaking staff members in B-L and few in GT. The migrant health center supplies a translator, and in the B-L offices they use a telephone service or a local volunteer if the client does not bring someone to translate. The GT health department sees fewer Native Americans clients than in the past, as a local casino has given them higher incomes. However, B-L has seen Native Americans increase from 5 to 8 percent of the caseload since 1997.

Lack of housing and lack of good jobs are the major challenges for clients in the area. Housing can be very expensive, because the demand for summer homes drives prices up, and homelessness is a concern. Many jobs are seasonal or have irregular hours, and there are few opportunities for advancement. GT staff did not see access to health care as a major problem in the area; there is a large regional hospital, services from the health department, and an adequate supply of doctors who take Medicaid. In B-L, staff were more concerned about access, as they find that local providers accept only limited numbers of Medicaid clients. Distance to health care providers and jobs with no health care benefits are also concerns for many members of the community.

WIC Program—Grand Traverse. The GT WIC program served about 1,800 clients in March 2003, including about 200 pregnant women.³ The main clinic in Traverse City is open 5 days a week, and there are two satellite clinics—one in Kingsley open once a month, and one in Interlochen open one day every other month. At the main clinic, they schedule one day a week to be the nutrition education and coupon pick-up day for clients who are in the middle of their certification period. On that day, there are “parent sharing sessions” each hour from 8 A.M. to 6 P.M. On the same day, MSS/ISS nurses do intakes for pregnant women into MSS and WIC; this is described further below. The other four days of the week are largely for certifications and recertifications (for those other than pregnant women). The GT clinic has extended clinic hours on some days, staying open until 6 P.M. instead of 4 P.M., and will serve walk-in visitors whenever possible.

In GT, there are 15 nurses and 1 nutritionist who provide WIC services; 10 of the nurses and the nutritionist also provide MSS/ISS services.⁴ The nurses rotate their hours between WIC and the other health department programs. In general, the nurses see clients on two clinic days a week in the various programs (WIC, MSS/ISS, Immunizations, Reproductive Health). Other days are used for paperwork, meetings, or home visits. Some of the nurses work part-time.

WIC Program—Benzie-Leelanau. The B-L WIC program served about 700 clients in March 2003, including about 70 pregnant women. There is a weekly clinic in each county at the health department offices—one is in Lake Leelanau and the other in Benzonia—one in Thompsonville, which is open once a month, and the migrant clinic, which is open once a week during the summer months (June to October).

At Lake Leelanau, staff run a WIC clinic for a full or half day each week (depending on demand), and they provide the immunizations at the same time, so families are able to get all services in one trip. The caseload is too small to run nutrition education classes in Leelanau, so nutrition education contacts are often one on one. Each pregnant client sees the nutritionist at least once—this counts as an MSS visit if they are enrolled in MSS. The nurses assess weight gain (and growth for infants) at each visit. The regular WIC appointments, when not combined with MSS, are set up at the rate of 20 per day. The appointments, depending on the type, are for 15 to 30 minutes with each client. If a mother has several children on WIC, she receives several consecutive appointments. The scheduling is similar in Benzonia.

There are five nurses and four clerical staff at B-L—two nurses and two clerical staff in Lake Leelanau, and three nurses and two clerical staff in Benzonia. Staff at each site may travel to the other site to fill in, or for meetings or special events. The Director of Personal Health is a nurse, but she does not carry a caseload.

³ Participation figures reflect food coupons issued. They are based on participation reports for March 2003 provided by the state WIC agency.

⁴ GT also had a part-time nutrition educator who conducted classes, but she was about to be laid off.

Program History. The integration of WIC and MSS/ISS services developed gradually at GT. The MSS program began in 1988, and ISS was added in 1993. A new supervisor for both WIC and MSS joined the agency in 1990, and she worked to integrate the services. First, they cross-trained all the nurses in both WIC and MSS (and later ISS) and began doing combined intakes. The second stage of integration, several years later, was when they began delivering WIC coupons as part of MSS/ISS home visits, along with WIC nutrition education contacts. The major challenge was figuring out a system for issuing the coupons in advance of the visits and ensuring their security. In the last three years, as a third step, the GT WIC nutritionist has taken on a bigger role in the MSS/ISS programs. She now meets with every pregnant woman in MSS on one of the clinic visits, and manages some ISS cases.

The B-L District Health Department opened in 1996 with all new staff. They integrated services from the beginning, in part because of necessity, since the staff was so small. B-L took the concept of integrated services and the approach to scheduling from the Northwest Michigan health agency in Charlevoix, as they shared their administrator in the early years of the B-L health department.

PROFILE OF INNOVATIVE PROGRAM

The MSS/ISS Program. The Maternal and Infant Support Services programs are case management programs for high-risk pregnant women, new mothers, and infants. Funded through Medicaid, the programs are intended to prevent infant mortality and promote healthy development. The MSS/ISS program is statewide, but services are provided in much of the state through Medicaid managed-care plans, and are not generally integrated with WIC services. In Northwest Michigan, they have generally not had Medicaid managed care that provides MSS/ISS, so the health departments provide these services.

MSS involves up to nine visits during pregnancy and the immediate postpartum period, generally on a monthly basis. The first visit is an in-depth assessment/screening with a nurse. After the assessment, the full MSS team (all nurses who provide MSS services, the nutritionist, and the social worker) meets to develop a plan of care for the client. The second visit in Grand Traverse is a combined visit to the nutritionist and the social worker. This “RD/MSW” day occurs about once a month. The nutritionist goes over a nutrition plan with each client, and the social worker can help them address any housing, transportation, or family issues. In B-L, clients are also scheduled with the Registered Dietitian (RD) and the social worker (Master’s in Social Work or MSW) early in pregnancy, and further visits are scheduled as needed after the plan of care is reviewed by all members of the MSS team. The nurse who conducted the intake generally makes the remaining visits after the assessment, but there are exceptions. For example, some mothers may need to see the nutritionist again due to a special need. At least two of these visits are supposed to be home visits, if possible, including the one immediately after the birth, which may include enrolling the newborn on WIC. In some cases, the nurses make more than two home visits, with the major reason being transportation problems that make it difficult for the woman to come in. Other situations in which home visits occur more than twice include pregnant women who are on bed rest, mothers with child care problems, and, sometimes, women who did not come to their scheduled appointment at the office—staff try to avoid losing them.

ISS is delivered entirely through home visits. Medicaid funds 10 visits for most cases, but can fund 9 more if the baby has a medical problem, and up to 37 if there are drug or alcohol problems in the family. In general, the same nurse who saw the family during the pregnancy also follows them after the birth. Staff usually visit once a month, but sometimes, for older children, they visit every other month. In GT, the nutritionist handles some ISS cases instead of a nurse, particularly if there is a growth or feeding issue, such as tube feeding, failure to thrive, chromosomal problems, or children older than 1 year who are on formula for a special health care need.

Each MSS/ISS staff member, whether nutritionist, social worker, or nurse, is a support person and is not providing primary care. The nurse does crisis intervention, parenting education, and health and nutrition education, and provides the mother with moral support and connections to other resources, as needed. The staff follow up by telephone frequently. For example, telephone calls are made to schedule appointments, follow up with no-shows, check in with the client's doctor, or make referrals to other agencies, such as the Family Independence Agency (FIA), which is Michigan's Temporary Assistance for Needy Families (TANF) program.

How WIC Services Are Integrated with MSS/ISS. WIC and MSS/ISS intakes are integrated. In GT, when a pregnant woman calls to sign up for WIC, she is scheduled for a combined intake appointment, which lasts about an hour. In that initial appointment, she first meets with the prenatal outreach and advocacy staff member (a skilled clerical position), who screens her for Medicaid (and enrolls her, if needed), whether she has a prenatal care provider, and income-eligibility for WIC. After this, she sees a nurse to screen her for MSS and WIC nutritional risks. The overall goal is to offer pregnant women the full range of services. These appointments are available one day each week.

Intake is also coordinated in B-L. When a pregnant woman calls to sign up for WIC, she is generally placed on the schedule for a combined WIC/MSS intake. If a woman comes in for a pregnancy test, and it is positive, the staff also try to schedule a WIC/MSS intake for her. Joint scheduling does not always work in B-L, however, because of timing. The MSS clinic is held on only three days a month, but WIC rules require that a pregnant woman be seen within 10 calendar days after her initial call. Sometimes, initial visits can be coordinated with clerical and MSS staff on a nonclinic day.

When clients come in for the intake appointment, the nurses do not emphasize that WIC and MSS are separate programs, but instead describe how they are going to receive WIC coupons and also periodically see a nurse who will check on how they are doing and answer any questions they may have about their pregnancy. Many clients refer to the nurse as their "WIC nurse," even though she is providing primarily MSS services.

Over time, as noted above, clients see the same nurse for WIC and MSS/ISS services. In particular, MSS/ISS clients can arrange to pick up their WIC coupons during an MSS office visit, or to have them delivered by the nurse during a home visit. When nurses bring WIC coupons, it makes home visits welcome, and is particularly convenient for clients who lack transportation. Many of the parenting education contacts during these visits (and the weight checks) can also be counted as WIC nutrition education contacts. For example, most ISS visits involve discussions of breast-feeding issues or age-appropriate infant feeding. However, WIC

recertification usually requires an office visit. The nurses will try to do recertifications in the home if the mother has particular difficulty getting to the office, but the test for iron levels requires equipment that is not easily transported. The recertification that is easiest to do in the home is the “midcheck” for infants around 6 months of age, as no blood test is required at that point for most babies.

Another way in which services are integrated is that the nutritionist has a key role in both programs; in GT, as noted above, she carries an ISS caseload. In addition, the breast-feeding support component of the two programs is integrated. The WIC Coordinators in GT and B-L both have special certification in lactation (one is an Internationally Board Certified Lactation Consultant [IBCLC] and one is a Certified Lactation Educator). Because of this certification, the WIC Coordinators can provide home visits to new mothers to address lactation issues or provide lactation consultations in the office. These visits are charged to MSS. However, it is WIC that provides training in breast-feeding for the nurses and provides breast pumps to give or lend to new mothers. (The Healthy Futures program, described further below, also helps promote breast-feeding.)

Participants Served by Joint Services. In Grand Traverse, about 50 percent of pregnant WIC clients are in MSS; most who are not in MSS are those with private insurance. The MSS program serves about 120 women a month. In Benzie-Leelanau, about 80 percent of pregnant WIC clients are in MSS; the MSS caseload is about 55 women a month. In some cases, women who have been in MSS previously or have had previous children may opt out of the services.

Not all MSS clients continue in ISS. In Grand Traverse, about 75 percent of families continue from MSS to ISS; the caseload is about 90 infants each month. In Benzie-Leelanau, staff estimated about 80 percent continue, which would be a caseload of about 44. The most common reasons for not participating in ISS include returning to work and losing Medicaid coverage. In addition, some experienced mothers do not feel they need the services.

Coordination with Additional Programs. There are many ways in which these health departments coordinate services for pregnant and postpartum women and infants, in addition to the coordination between WIC and MSS/ISS. Since spring 1998, both GT and B-L have participated in a program called Healthy Futures—the program covers any birth at Munson Hospital, the only hospital in the area for giving birth. Federal Maternal and Child Health block grant money funds this program. Every mother, while in the hospital, is offered a home visit from a nurse within the first weeks postpartum. The nurses from the health department do these visits, although the hospital maintains a central registry for the program. The nurse does an assessment for WIC, Medicaid, and ISS and makes referrals to these programs as appropriate. The nurse will also follow up by phone. Healthy Futures visits reach 75 percent of first-time mothers, which helps increase awareness of and participation in WIC and ISS. Healthy Futures is an important mode of outreach to those who do not know they qualify. It may also have helped increase WIC breast-feeding rates in these counties, as it provides a personal visit to mothers right after the birth that includes breast-feeding assistance, if needed.

Other services that are coordinated with WIC and MSS/ISS include Medicaid enrollment, reproductive health services, and immunizations. During the WIC/MSS intake visit for pregnant women, if they are not already enrolled in Medicaid, they are screened for Medicaid eligibility.

If eligible, they can complete the first steps in the enrollment process without having to visit the FIA office. This enrollment process is especially helpful for women in B-L, who would otherwise have to travel 20 to 30 miles to Traverse City. The health department nurses can also offer reproductive health services during ISS visits or arrange for clinic appointments, as both health departments are Title X providers. In addition, they make immunizations available at the same time children are coming in for WIC appointments, and monitor immunization status during ISS visits. Finally, they provide referrals to a range of other programs, including FIA.

Publicity and Outreach Efforts. The health departments each have a brochure on MSS/ISS services that is distributed to various agencies to give to their clients. They also do outreach to physicians in the area about both WIC and MSS/ISS. In GT, WIC and MSS/ISS staff work with Planned Parenthood, the Pregnancy Resource Center (a Christian group), FIA, and the Women's Center. In turn, all these groups refer pregnant women to the combined WIC/MSS program. In B-L, health department staff send brochures on WIC and MSS every six months to local day care providers, Head Start centers, and family practice physicians. They put up WIC posters in local grocery stores and other community locations, and check on them every six months. Both GT and B-L also distribute information at health fairs and community events.

In all these counties, health department staff also work extensively in coalitions with other social service agencies, and they reported that these contacts are often very important in getting the word out about their programs.

ORGANIZATION AND MANAGEMENT

Staff and Organizational Structure. Both programs visited were in small health departments, with one supervisor, the Director of Personal Health Services, in charge of WIC, MSS/ISS, and several other programs. The Director in B-L works part-time and shares some supervisory duties with the MSS/ISS Coordinator, who is based at the other clinic. Both supervisors are very committed to integrated services.

In each office, one senior nurse serves as the WIC Coordinator and another as the MSS/ISS Coordinator. The Coordinators generate reports for the state, coordinate training and quality control in the rules of the specific program, and serve as the primary resource for staff with questions about program rules. They also provide line services. The WIC Coordinators at both sites have special training in breast-feeding support. The WIC Coordinator in GT is an IBCLC, and the WIC Coordinator in B-L is a Certified Lactation Educator. In each case, the health department funded the coursework and training for their credential.

Other nurses in these health departments have their own areas of specialty, such as reproductive health or HIV counseling, but, in general, "everyone does everything." In particular, most nurses provide both WIC and MSS/ISS services. The clerical staff is also cross-trained in all clerical aspects of each program.

Coordination of Paperwork and Record Keeping. The WIC and MSS/ISS programs have separate policy and procedures manuals and separate paperwork in separate program charts, but staff try to make services seamless from the client perspective. Most of the records are in hard

copy, although some information from the intake interview is entered into the statewide WIC automated system. A major reason that the records must be kept separately is that MSS/ISS is covered by HIPAA, the law that protects the confidentiality of health information, whereas WIC is not. Thus, MSS information cannot go in the WIC file. In GT, they simply note in the WIC file if there was a visit under MSS and the general reason for the visit. In B-L, a copy of the WIC health history is kept in the MSS or ISS chart. In the WIC charts, a notation is made that the client is enrolled in MSS or ISS. In both offices, nurses try to mesh the WIC and MSS Health Histories during the initial interview so they do not have to ask the same things twice—but they must fill out both forms. In B-L, the MSS chart also includes a visit log that tracks all visits and calls, including calls to physicians and FIA and any other community resources to which the client was referred. One challenge is for nurses to remember to check both charts when a visit is for both programs.

Staff Training and Quality Assurance. The WIC Coordinators go to state-sponsored WIC trainings and report back what they have learned. Others attend if funding is available, particularly if the training is nearby. The WIC Coordinators spoke favorably about the state-level training in facilitated group discussion and in the infant/child feeding approaches of Ellyn Satter.⁵

In each office, there is a monthly, all-day meeting of all staff (including clerical staff), which includes updates on each program and training in any new procedures or policies. In B-L, chart reviews are also conducted to make sure staff are following procedures consistently. The WIC Coordinator and MSS Coordinator review charts for their programs.

Funding. Staff must charge their time to WIC and MSS/ISS separately. GT did a study of how much time during an intake appointment was spent on WIC and found it was about 15 minutes. So, initially, they charged 15 minutes to WIC and the remaining time, about 45 minutes, to MSS. Later, they started charging the entire visit to MSS, as they realized that the process of enrolling the client in WIC fell under the definition of MSS screening. Overall, the program leads to savings for WIC; the only increased cost is for coordinating issuance of food coupons with home visits, which is now routine.

MSS/ISS funding has been secure. In fact, rates were increased a few years ago. The major change has been as Medicaid has moved into managed care, managed care organizations need to approve MSS visits for their clients. There is only one Medicaid managed care provider in GT and none in B-L, however, so clients still have the option of seeing fee-for-service providers (including the health department).⁶

⁵ See the profile of the Learn Together Approach training in Chapter III.

⁶ Clients must always have at least two options for care.

ASSESSMENT AND LESSONS LEARNED

Program Strengths. Most state Medicaid programs now have case management programs for high-risk pregnant women and infants. However, many have not integrated these services with WIC. The programs in GT and BL are strong examples of program integration in terms of management, staff, and client services, although the programs remain administratively separate.

It is difficult to assess the role of the integration of services in outcomes for these programs, as many other factors may be at work. Nonetheless, program staff believe that they are serving more eligible women in WIC and MSS/ISS than they would if the programs were not coordinated, and achieving better outcomes (such as higher breast-feeding rates). Although by no means conclusive, some data suggest that these counties may serve a greater percentage of the target population than elsewhere. In particular, the percentage of infants on WIC and Medicaid is about equal to the state average in GT and higher than the state average in B-L (based on data from the Michigan WIC Website), although the poverty rate in both areas is lower than the state average. Both health departments certify new mothers as breast-feeding at about twice the rate as the state as a whole. However, this probably reflects a local environment sympathetic to breast-feeding and the effects of the Healthy Futures program as well as the effects of the integrated services. Furthermore, staff reported that providing WIC coupons during MSS/ISS home visits or MSS office appointments reduced the proportion of “no-shows” for the MSS/ISS appointments.

Another important outcome from the point of view of program staff is the ability to draw on federal funds more effectively to support the combined services, as Medicaid reimburses for MSS/ISS services on a fee-per-visit basis, while WIC nutrition services funds are related only to the number of clients. This is particularly important in a tight budget environment.

The programs have not done studies of client satisfaction, and even if they had, there is no way to compare clients’ views to what they would have been in a less integrated program. However, staff uniformly reported positive feedback from clients moving to the area from other parts of the state, in terms of access to services.

Nurses in both offices reported that their ability to deliver a wide range of services makes their jobs much more satisfying, for several reasons. First, they can try to help clients receive whatever services they need, as they are trained in all the health department programs and well linked to other community services. Second, they can follow up with MSS/ISS clients over time, so they become familiar with their situations. Finally, several reported that they find their job’s variety keeps it challenging and rewarding.

Key Challenges. As discussed earlier, the major operational challenges were developing systems for ensuring the security of food coupons delivered to clients during home visits and arranging clinic schedules to provide joint services effectively. Keeping up with the paperwork for both programs can also be a challenge.

Because the nurses work on multiple programs, they learned that it is important to be clear about the division of administrative responsibilities for each program, such as ordering supplies, or these tasks can fall through the cracks. In addition, it is important to be sensitive to the needs

of clerical staff, who may have more difficulty juggling their tasks than the nurses realize. For example, clerical staff had to learn to handle the demands of generating WIC food coupons both for WIC appointments and for MSS appointments. The nurses reported that the monthly staff meetings were useful forums for working out these issues.

Lessons Learned. Medicaid-funded programs to provide case management to high-risk pregnant women and infants are natural partners with WIC, as they target the same populations and share the major goals of improving birth outcomes and the health of mothers and children. Program staff in the three northwest Michigan counties identified several factors that they felt contributed to successful service integration in their programs:

- The WIC and MSS/ISS programs were operated by the same agency and had one manager with responsibility for both programs.
- Each agency's management and staff were committed to a client-centered approach—they wanted to provide clients with the services needed in a seamless fashion, and keep the paperwork for the separate programs in the background.
- Staff and management worked together to make the logistics work, particularly in the areas of scheduling appointments and tracking WIC food coupons that were to be delivered during home visits. It is important not to overwhelm nurses and clerical staff with their varied responsibilities. In turn, staff need to be organized and able to juggle.
- WIC is a useful way to draw clients into an intensive case management program. It is also important to offer the services to clients positively, and as a package.

Most staff also felt that service integration was most appropriate in small agencies, where staffs are small and caseloads tend to be smaller as well. One noted that paraprofessionals sometimes handle scheduling and assessments in larger WIC agencies, which implies that procedures cannot be as flexible. However, one manager argued that some integration is possible in larger agencies, as long as services are co-located. She had worked in a larger WIC agency, and said that her former agency was now working on integrating WIC and MSS/ISS services to some extent.

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STEPS AHEAD/WIC COORDINATION⁷ CULLMAN COUNTY, ALABAMA

OVERVIEW

Location: Cullman County, Alabama.

Start Date: Steps Ahead began about 10 years ago; collaboration with WIC in Cullman County occurred gradually—current staff were not able to say exactly when the process started.

Target Population: Low-income pregnant and postpartum women eligible for both Medicaid and WIC.

Purpose: The purpose of the Steps Ahead program is to ensure that every pregnant woman has access to medical care, with the goal of lowering Alabama’s infant mortality rate and improving overall maternal and infant health. The program collaborates with WIC as one way to reach these goals.

Services: In Cullman County, the Steps Ahead program is coordinated closely with WIC, as both programs are run out of the county health department. Staff coordinate initial appointments for WIC and Steps Ahead and do cross-referrals. In addition, Steps Ahead funds a home visit for high-risk women immediately after the birth. Among other services, the nurse who conducts these home visits is able to do WIC certifications or recertifications and to issue WIC food coupons to the new mother.

Funding: The Cullman County Health Department is a subcontractor to Alabama Maternity, Inc., which operates the Steps Ahead Program. Services are billed to WIC or Steps Ahead as appropriate, including time spent on home visits. Staff are all state employees.

Why Program Was Chosen: The program is an example of coordinated case management between WIC and Medicaid for pregnant and postpartum women, which sometimes results in delivery of WIC services via home visits. It also operates in a rural setting, where transportation to appointments can be a barrier. Specifically, appointments are coordinated, so women can receive needed services at the same time. Follow-up with no-shows is also coordinated. To augment the “one-stop services” further, families can also enroll in Medicaid at the Health Department.

Key Challenges: About 10 percent of clients typically do not show up for their appointments or make an effort to reschedule, in part due to significant transportation barriers.

⁷ Telephone interview, April 11, 2003.

BACKGROUND

Community Characteristics. Cullman County is a rural county in northern Alabama with a population of about 78,000 in 2001. It is largely agricultural but also has some manufacturing firms. The county is located halfway between Huntsville and Birmingham, about 45 miles from each. It has few minority residents (5 percent), unlike the state as a whole (30 percent). Although median income is slightly lower than that of Alabama overall, the percentage of residents in poverty is also lower (13 percent versus 16 percent for the state), based on Census data for 1999.

Target Population. Pregnant and postpartum women who participate in both Steps Ahead and WIC receive coordinated services. Pregnant women who are on Medicaid and wish Medicaid to cover their maternity care and delivery are required to have their care coordinated through the Steps Ahead program, with coverage continuing for about 60 days after the birth (until the end of the month containing the 60th day). When pregnant women call in for a WIC appointment or an initial Steps Ahead appointment, they are scheduled for a joint intake for both programs, unless they have other medical coverage.

WIC Program Background. In March 2003, the monthly WIC caseload in Cullman County included 350 prenatal women, 217 postpartum women, 122 breast-feeding women, 31 exclusively breast-feeding women (no formula), and 672 infants. The county health department serves as the WIC agency and site of the only WIC clinic in the county. Three staff members work primarily on WIC—the WIC nutritionist, the WIC Coordinator (who is a nurse), and a WIC clerk. However, all nurses at the health department are trained to do WIC certifications, and all clerks are trained to issue vouchers.

Program History and Objectives. Collaboration between WIC and Steps Ahead care coordination happened naturally in Cullman County because both programs were located in the health department and run by health department staff. In many areas in Alabama, WIC and the Medicaid maternity care coordinator are in separate locations, which makes it much harder to coordinate services. There are other communities in which the health department handles both functions, but they are not coordinated as in Cullman.

PROFILE OF INNOVATIVE PROGRAM

The Steps Ahead Program. In 1988, Alabama began the Alabama Medicaid Maternity Care Program (AMMCP), which established locally coordinated systems of care so that women on Medicaid would receive maternity services in environments that emphasize quality, access, and cost-effectiveness.⁸ The purpose of the program is to ensure that every pregnant woman has

⁸ Until 1999, the AMMCP operated on a waiver system that had to be renewed every two years and relied on primary contractors for implementation. Primary contractors established and monitored delivery care systems, frequently subcontracting out to service providers. Primary contractors included hospitals, federally qualified health care centers, county health departments, and nonprofit organizations. However, in 1999, the state elected to convert the waiver program to a state plan option. This changed the waiver program to an operational program, which

access to medical care, with the goal of lowering Alabama’s infant mortality rate and improving overall maternal and infant health. The AMMCP is organized into 14 maternity care districts. Cullman County is in District 5, which consists of nine counties. Services are provided by Alabama Maternity, Inc., and the program is known locally as Steps Ahead.

Steps Ahead provides maternity care to women who choose to use Medicaid to pay for their maternity costs. Benefits include covered costs of maternity care, delivery, and hospital care. In Cullman County, there are two hospitals that provide primary care services for Steps Ahead clients. The care coordinator and registered nurse, who are health department employees, provide care coordination and health education services under a subcontract with the Steps Ahead program. During their pregnancy, women must see the care coordinator three times. Doctors will not see Medicaid patients for prenatal care unless they have a referral slip from the care coordinator.

First, the care coordinator (also considered to be a social worker or case manager) completes a social assessment on a new program participant. Assessments are conducted at the health department, which also houses the local WIC agency. In fact, the staff focused on the two programs have adjoining offices.

During the assessment, the care coordinator attempts to get a sense of “what is going on in the person’s life” so that she can determine if a home visit would be appropriate. Typically, a Medicaid client must be categorized as “high risk” to qualify for a home visit.⁹ For example, women who qualify include those who are HIV positive, have a history of drug or alcohol abuse, suffer from a mental condition, have experienced domestic violence and/or child abuse, are late entrants for prenatal care, are expecting twins, or are under 20 years old and have two or more children.¹⁰ However, the care coordinator can use discretion if she thinks that a client warrants a home visit. For example, lack of transportation to a health care facility is a serious barrier for this rural county; there is only one private transportation company in the county, which is funded through a federal grant program. Medicaid participants can get travel vouchers to use the company’s vans free of charge.

Frequently, the care coordinator knows from the start whether someone would qualify for a home visit (for example, a pregnant teen who already has a child or a woman who will deliver

(continued)

alleviated the need to renew the waiver every two years. This change led to a shift in program rules and the use of a different system of contractors.

⁹ Before 1999, home visits were required for all women—the visits were automatically a part of service delivery. After 1999, Medicaid revised their guidelines and developed criteria for home visits. However, officials included an “other” category that granted the care coordinator some discretion in requesting a home visit.

¹⁰ Low birth weight is a common trigger for a home visit. However, the care coordinator remarked that the “home environment” (for example, domestic abuse, drug abuse) is a more common reason for a home visit than a medical condition.

twins), but sometimes certain factors do not emerge until the second or third pregnancy appointment (for example, domestic abuse). Once the care coordinator determines that a client is at high risk, an appointment for a home visit is scheduled that will take place 10 to 20 days after delivery. The registered nurse conducts the visit, which involves a range of services. An average visit lasts 1 to 1½ hours, and some last as long as 2 hours.

During the home visit, the nurse measures the infant's weight, height, and blood pressure, and asks a series of questions to make sure that the mother's health—as well as the baby's—is good overall. Most time is spent on this health assessment. If there is a medical concern, the nurse notifies the doctor from the home (or from the Health Department if there is not a phone) and makes an appointment. Otherwise, the doctor follows up with the patient directly. In addition to general health assessments, the nurse can provide selected WIC services (see next section below), make referrals to a variety of social services, discuss nutrition education, conduct family planning counseling, and counsel on breast-feeding. (Mothers have already decided whether they want to breast-feed or not, so she also can address issues such as latch-on problems.) Further, the nurse completes a questionnaire to evaluate the state of the home environment, which covers topics such as safety, income sources, presence of the father, and child care resources. The care coordinator collects these questionnaires and keeps them in the clients' files.

Program participants qualify for care coordination only for about 60 days after giving birth. Therefore, mothers must see the care coordinator for a postpartum appointment four to eight weeks after the home visit. During this “postpartum encounter,” the care coordinator verifies that the clients have kept their appointments with the pediatrician and obstetrician/gynecologist and are following up with their birth control method. The care coordinators also refers mothers back to the pediatrician if they are having trouble with breast-feeding, are dissatisfied with their formula, or are having any health problems.

How WIC Services Are Integrated with Steps Ahead. Co-location offers an opportunity to coordinate services more easily than in other maternity care districts throughout Alabama. The two programs have coordinated intake procedures. Therefore, new clients coming into WIC for the first time see a nutritionist for WIC certification and then see the Medicaid care coordinator, who can refer clients to hospitals, conduct social assessments, and make doctor's appointments. Similarly, clients who come to see the care coordinator but are not on WIC have a WIC appointment set up as well. WIC and Steps Ahead have designated Wednesdays and Fridays as “New WIC Maternity Days.” Staff from both programs can do referrals on any day of the week, but these two days have been ‘tagged’ so that staff can anticipate clients coming in for multiple services.

WIC and Steps Ahead also try to coordinate other appointments. Consolidated service delivery is especially helpful for participants who have trouble accessing transportation. Thus, a WIC client who comes in to pick up a food voucher can also have one of the three pre-delivery appointments with the care coordinator. A Medicaid caseworker is also on site to enroll eligible women and children in Medicaid. Staff work together to ensure that clients who qualify are enrolled in Medicaid and WIC and that they are receiving prenatal care. Staff from both programs verify when a particular client had her last WIC appointment (or maternity care appointment). According to the care coordinator, if a client has missed one type of appointment,

chances are high that she has missed another. To prevent this, the coordinator and WIC nutritionist can make appointments for the other program (they share the same computer system). They also work together to track down clients. For example, if a client missed an appointment with the care coordinator, the coordinator flags her WIC card with a colored tab so that, if she comes into the WIC office, WIC staff know to notify the care coordinator that the client is in the building and should come to arrange an appointment. (A similar system is used by WIC staff.)

Finally, the nurse who conducts the Steps Ahead home visits is trained to provide some WIC services during the visits. She can do certifications and recertifications. Most women that she visits have enrolled in the WIC program prenatally; only 2 to 3 percent of her caseload are new WIC certifications. The nurse does, however, process many recertification cases (that is, when a woman must be recertified in the transition between prenatal and postpartum, and the infant as well).¹¹ She also can certify the infant. The nurse can also issue food vouchers to mothers and informs them that free breast pumps and breast pads are available at the WIC agency.¹²

Participation. The care coordinator for the Steps Ahead program has, at any given point, a caseload of between 250 and 300, but these figures do not include those who are due for “last appointments” postpartum. There are about 12 new WIC/Steps Ahead clients each week, and she refers 3 out of the 12 for a home visit. Overall, she estimates that about 95 percent of Steps Ahead patients receive WIC.

ORGANIZATION AND MANAGEMENT

Staff and Organizational Structure. The current maternity care coordinator, a licensed social worker, is the primary contact for the Steps Ahead Program.¹³ If doctors or hospital staff have questions or concerns, she is available for consultation. She also conducts the social assessments and all required appointments, principal and postpartum. The registered nurse assumes responsibility for conducting the home visits. The WIC coordinator ensures that the nurse receives any policy changes in the WIC program. The care coordinator works full-time on the Steps Ahead program. The registered nurse works partly on the Steps Ahead and partly on other health department programs, but home visits for Steps Ahead are her priority.

Funding. The Steps Ahead program is funded entirely with Medicaid dollars. The Health Department bills Steps Ahead (and they bill Medicaid) using a flat rate of \$200 for three appointments with the care coordinator throughout the pregnancy and a postpartum session, and \$60 for each home visit. They can also bill Medicaid if a client moves out of the district or has a miscarriage before completing all the visits. The amount of the fee depends on the number of

¹¹ Blood work may be completed at a later visit.

¹² WIC mothers of high-risk infants can borrow electric pumps, and manual pumps are distributed to keep.

¹³ To be a care coordinator for the AMMCP, a person must either be a licensed social worker or a registered nurse.

appointments with the care coordinator. If a client does not show up, the Health Department can bill for the visit if there have been three unsuccessful attempts to contact the client. The WIC program is charged for the part of the home visit involving WIC.

ASSESSMENT AND LESSONS LEARNED

Program Strengths. Program officials listed several program successes. First, clients often do not know about many of the resources that are available to them before meeting with the care coordinator. For example, many postpartum mothers do not know about child care subsidies. The care coordinator's role in making referrals for a wide range of services is "a huge benefit." The WIC coordinator thinks that the collaboration between Medicaid, Steps Ahead, and WIC helps ensure that clients enrolled in only one program, but qualifying for both, have access to all services. In her opinion, it is a "win-win situation for getting women on WIC, Medicaid, and prenatal care." The registered nurse thinks that an important element of Steps Ahead home visits is early intervention, particularly detecting a problem before it develops into a more serious medical condition.

Moreover, exit surveys that clients fill out after their postpartum appointment are forwarded to the main office, and these results have been overwhelmingly positive.

Key Challenges. The biggest challenge cited by program staff was patient compliance—having women come in for all scheduled appointments. About 10 percent of clients miss their appointments and do not make an effort to reschedule. Staff spend a lot of time trying to track them down, although coordination with WIC helps. Transportation is the main reason that clients have difficulties meeting their scheduled appointment. As long as clients keep their appointments, program staff have the necessary resources to meet their maternity care needs. They also see the coordination between WIC and Steps Ahead as proceeding smoothly.

Lessons Learned. Staff felt that co-location has been a key factor to successful coordination between WIC and the AMMCP, especially in Alabama's system of using private contractors to provide care coordination. They believe Cullman County is the only county in Alabama that integrates WIC with Medicaid maternity care coordination. In this case, the programs are operated through the same agency, and their proximity (and some cross-training of staff) allowed them to develop methods and strategies for working together to serve clients better. Having adequate staff and a strong commitment to the collaboration by staff of both programs was also important.

Both Steps Ahead and the program in Michigan suggest that, when institutionally appropriate, including WIC services as part of home visits for high-risk mothers on Medicaid makes the visits more welcome to the mothers. In addition, coordination of assessments and follow-up visits increases participation in needed services and reduces burden on high-risk families.

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WIC SERVICES IN WORKPLACES¹⁴
EASTERN BAND OF CHEROKEE INDIANS, NORTH CAROLINA

OVERVIEW

Location: Eastern Band of Cherokee Indians reservation in North Carolina.

Start Date: Before 1991.

Target Population: WIC participants who are members of the Eastern Band of Cherokee Indians and work on the reservation.

Purpose: To improve access to WIC by bringing services to clients' places of employment.

Services: Receipt of food vouchers, assistance with completing WIC applications, follow-up nutrition contacts, and referrals.

Funding: No additional funding for this initiative.

Why Program Was Chosen: WIC staff provide certain services to clients at their places of employment, improving access in a rural area. WIC staff make arrangements with employers to offer services during employee breaks or lunch hours. This idea may be of interest to other agencies in rural areas or areas with large employers who employ many WIC clients.

Key Challenges: Initially, clients often did not show up for appointments. Staff lost valuable time that they could have spent with other clients, and they had to reprint pre-dated food vouchers that were not claimed. Telephone reminders have reduced this problem.

¹⁴ Telephone interview, April 15, 2003.

BACKGROUND

Community Characteristics. The Eastern Band of Cherokee Indians (EBCI) covers 88.5 square miles in five rural counties in western North Carolina; the largest tribal land holdings are in Jackson and Swain Counties. The population of the EBCI is 13,033, of whom 7,476 live on tribal lands. Tourism is a primary industry in the region, since the reservation borders the Great Smokey Mountains National Park. The WIC manager estimated that Indian craft stores and motels make up 80 percent of businesses on tribal lands, although they do not employ the most residents. The Tribe, Tribal Enterprises,¹⁵ and the casino hotel are the largest employers and provide year-round employment—with 930, 500, and 1,800 workers, respectively.

WIC Program Background. The EBCI WIC program—staffed by a manager, a full-time nutritionist, a part-time nutritionist, a fiscal grants coordinator/administrator, and two clerical workers—had an average monthly caseload of 562 women, infants, and children in fiscal year 2002 (about 100 cases per staff member, although the project manager and grants coordinator/administrator do not provide direct services unless filling in for an absent employee).¹⁶ In August 2003, there were 124 women enrolled in the WIC program. The WIC agency, which serves the entire EBCI, operates from 7:30 A.M. to 5 P.M. and is co-located in the Indian hospital, which is centrally situated on the reservation. This convenient location enables clients to attend WIC and maternity care appointments on the same day. WIC staff attempt to accommodate clients' schedules by offering a walk-in clinic on Mondays, which offers the same services as during regular business hours. A satellite clinic operates on a monthly basis, but staff there only schedule appointments and process paperwork for clients.

Staff can also make referrals to the hospital's health care clinic. If during an appointment the WIC nutritionist detects that the mother is not getting appropriate health care for her child—particularly during the first year after birth—she makes a well-child appointment at the hospital. The nutritionist can also encourage expectant mothers to schedule their initial prenatal appointment at the health care clinic.

Program History and Objectives. Program officials instituted service delivery in work sites to make it more convenient for WIC clients to receive services, which were available only during typical business hours. At that time, the region faced high unemployment rates and offered few employment opportunities. The primary employers, a craft factory and a textile plant, were fairly strict about allowing their employees to leave in the middle of a shift for a WIC appointment. Because workers received minimum wage and could not afford to take unpaid leave during the regular work day, many of them—about half—opted to skip WIC appointments.

WIC program staff decided to negotiate with the owners of the two factories and a small casino to create an agreement that would help deter employees from forfeiting needed services. As a result, staff could visit the work sites on Wednesday mornings and meet with clients in the

¹⁵ Tribal Enterprises includes the hospital, schools, and the Boys Club.

¹⁶ Caseload is from [www.fns.usda.gov/pd/wifypart.htm], accessed September 24, 2003.

break rooms. Initially, the only service that WIC offered at employment sites was delivering food vouchers to participants.

Target Population. Members of the EBCI who participate in WIC are eligible to receive WIC services in their places of employment if their work sites are located on the reservation. The service delivery area includes Cherokee, Graham, Haywood, Jackson, and Swain Counties in North Carolina. About 45 percent of EBCI WIC mothers work, either full- or part-time. Although the WIC manager has received requests for workplace services from EBCI members who work in the small towns that border the reservation, they do not qualify, because they fall outside the EBCI's jurisdiction.

PROFILE OF INNOVATIVE PROGRAM

Services Provided. A WIC nutritionist and clerk deliver selected services in places of employment. While initially WIC distributed food vouchers for only one or two months at a time, the program expanded services in the mid-1990s. Clients now can obtain three months of food vouchers and receive assistance in filling out a WIC application. The nutritionist can refer clients to the diabetes clinic, the dental clinic, the food stamp program, the Food Distribution Program on Indian Reservations, Head Start, Medicaid, or the Children's Health Insurance Program, as appropriate. While she cannot make well-child appointments on site, she encourages clients to call her at the main office to remind her to schedule an appointment for them. In addition, the nutritionist can conduct follow-up nutrition education contacts with low-risk clients. (These second contacts can include information for children, although children are not present at the work sites.) Examples of low-risk topics include weaning, healthy snacks, folic acid, solid foods, dental care, 5-A-Day, and physical exercise. However, certifications, recertifications, and prenatal nutrition education sessions must still take place at the WIC agency.

The WIC nutritionist and clerk make rounds to various work sites each Wednesday from 9:30 A.M. to 12 noon. Staff do not follow a formal schedule (such as serving the tribal administrative offices on the first Wednesday of each month), but instead schedule clients for the next available and most appropriate date. They also track which clients need food vouchers. This allows WIC staff the flexibility to meet the needs of clients based on their demand for services. Individual sessions generally last 10 to 15 minutes. On any given Wednesday, staff visit one to six workplaces.

Because pre-dated food vouchers are printed ahead of time, clients must make appointments in advance through the main office or a satellite office. The nutritionist can answer quick questions from those who are not on the schedule, but otherwise she directs clients to make an appointment or attend the walk-in clinic on Mondays. Because appointments are frequently made several months in advance, the clerk mails reminder notices in advance and telephones the client the day of the scheduled appointment to remind them of the session and verify that they still work for that employer, and that they are not absent. If the client is not available, then the food vouchers are not printed and the appointment is cancelled or postponed.

WIC has expanded the number of workplaces where it delivers services throughout the 1990s. The textile plant shut down, but employment opportunities in the region have grown over

the past several years, including jobs in the tribal government and in small craft stores that cater to tourists.¹⁷ Employers in the service delivery network include five day care facilities, two restaurants, Cherokee Elementary School, Cherokee High School, several motels, an office supply store, an arts and crafts co-op, seven tribal offices (the health and medical, housekeeping, finance, legal, construction, and extension services divisions, along with the visitor's center), Cablevision, the Bureau of Indian Affairs, the Department of Housing and Urban Development, and a new tribal office complex that houses multiple programs, a library, and a wellness center.

Participation. The proportion of WIC clients who take advantage of service delivery in places of employment is small as compared to overall enrollment. From January 1 to September 10, 2003, WIC staff visited 43 work sites and provided services to 102 WIC participants. Thus, they served about 13 clients a month (and/or their children), out of a caseload of 562.

Coordination and Collaboration. For this initiative to succeed, employers must be willing to allow WIC staff to visit their places of employment to deliver services. The WIC manager reported that most employers are quite flexible with their employees' work schedules to accommodate short appointments during regular business hours and permit employees to meet with WIC staff on site. Workers at a local factory can arrange to meet the nutritionist and clerk in the break room, and tribal government workers can meet with staff at their desks most of the time. If a client interacts frequently with the public (for example, as a sales clerk in a craft store) and is busy when the nutritionist arrives, the nutritionist can either wait for a lull in business or arrange to return to the store later that day. At the local Head Start program, the lead teacher and teacher's assistant take turns meeting with WIC staff outside the classroom.

Publicity and Outreach Efforts. Because the EBCI reservation covers a small geographic area, residents learn about the WIC program and its service delivery in work sites entirely through word of mouth. The WIC manager noted that available social services are "known entities" in the community, especially since many families have lived on the reservation for generations. Other organizations will refer clients to the WIC program if they are not participating, but there is no formal referral or marketing process for the work site service delivery option.

ORGANIZATION AND MANAGEMENT

Staff and Organizational Structure. A full-time nutritionist and one of the clerical workers conduct the service visits to the work sites. The WIC manager, who has a bachelor of science degree in nutrition and dietetics, can fill in for the nutritionist if needed. The nutritionist

¹⁷ A larger casino replaced the small one in 1998 and ceased on-site WIC service delivery. The management is quite strict and would not permit employees to alter their break schedules to accommodate WIC appointments. However, the WIC manager does not think that a substantial number of casino employees miss critical services, since many of them earn high enough wages to make them ineligible for WIC. Furthermore, many casino employees work evening hours, which makes it possible for them to come to WIC in the daytime.

handles the low-risk nutrition contacts, makes referrals, and assists with completing WIC applications, while the clerk oversees the distribution of food vouchers.

Funding. No additional funding is required to implement the service delivery at local businesses on the reservation. Rather, staff adjust their labor efforts to alternative locations as opposed to delivering services solely at the traditional clinic sites. The WIC manager predicted that the work site initiative will continue indefinitely as long as there is a demand for the service.

ASSESSMENT AND LESSONS LEARNED

Program Strengths. According to the WIC manager, the biggest success of the initiative is that scheduling sessions in work sites greatly eases burden for clients. They no longer must take time off from work—often unpaid—to complete routine WIC visits, such as submitting program applications, collecting food vouchers, and receiving second nutrition education contacts and referrals.

While the WIC manager has not administered a formal survey to collect feedback, informal comments suggest that clients appreciate the option of service delivery in places of employment and would like to see the alternative system continue.

WIC staff think that the initiative is running smoothly. The only thing that the manager would change if her staff had adequate time and resources would be to assist clients who live and work in small towns that border the reservation and have requested WIC services at their work sites. Most—but not all—of these people are EBCI members, but they work outside the reservation and thus do not qualify. This anecdotal evidence suggests that residents in other rural areas might welcome the opportunity to receive certain WIC services at work.

Key Challenges. The WIC nutritionist and clerk encounter very few ongoing challenges in meeting clients at their places of employment. With the exception of the large casino that opened in 1998, business owners and supervisors have welcomed the on-site services. Initially, staff frequently wasted valuable time by arriving at a site only to discover that the employee was sick or on vacation, or had resigned. Further, it became necessary to reprint pre-dated food vouchers, which the clerk needed to generate in advance of the appointment. As a solution, in 2001, they began to call a day or two in advance to confirm the appointment. Now a clerk calls the morning of the scheduled appointment before printing the food vouchers or visiting the work site.

Lessons Learned. This WIC initiative is potentially replicable, though the extent to which it could be replicated in other regions would depend upon how receptive employers and clients were, the population's size and geographic parameters, and caseload levels.

If a client does not work in an environment conducive to a flexible break schedule—such as an administrative office with minimal public interaction—then WIC staff would need to negotiate with the supervisor to arrange a time period to conduct appointments. Clients would also need to be willing to receive services at work, where their privacy could be compromised (at least in that their employer and coworkers would know they participate in WIC).

Moreover, implementing a comprehensive service delivery system in work sites could be easier in rural areas as opposed to urban centers in some situations, but not in others. In metropolitan areas, a larger volume of clients would require that WIC staff be selective and concentrate on a core group of employers, which may eliminate some clients from this service, depending on where they work. At the same time, not as much travel time would be needed in urban centers, whereas great distances in rural regions could limit the number of work sites visited. The EBCI WIC manager also noted that a sizable portion of clients may work second and third shifts. Determining where clients are employed, and whether they work during regular business hours, would help program officials plan services.

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