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WIC Dynamics combines both survey and case study data to describe the changes that occurred in local agencies between 1988 and 1993, and several individuals carried out the research. JoAnn Kuchak was project director and provided overall leadership. Michelle Hearn, Sara Sullivan and Nancy Hassett played key roles in conducting the surveys and analyzing the survey data. Nancy Pindus of the Urban Institute managed the case studies. Barbara Cohen of the Urban Institute synthesized findings concerning nutrition services. Consultants Julie Carroll of Burger, Carroll and Associates and Sara Ducey, and other staff members from The Urban Institue and Macro participated in the site visits. Valencia Clark and her publication staff produced the reports.

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Executive Summary

I. Overview of WIC Dynamics

The Food and Consumer Service of the U.S. Department of Agriculture administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), a grant program enacted by P.L. 92-443 in 1972. The goal of WIC is to improve the health of participants by providing supplemental foods, nutrition education, and health care referrals.

WIC Dynamics is a study of the impact of participation growth associated with infant formula rebates, new regulatory and legislative requirements, and economic factors that occurred since 1988. Mail surveys were used to collect data from all[1] State agencies and a nationally representative sample[2] of local agencies. Case studies were performed at 22 local agencies. WIC Dynamics describes selected components of WIC service delivery, the impact of rapid growth and other factors on local agencies, and local agencies' responses to those factors. The objectives are to:

1. Determine the effects of rapid growth and other changes on local WIC agencies' service delivery;

2. Determine the impact of increased participation and other changes on the program's integration and coordination with local health care delivery systems;

3. Assess the nutrition services provided to WIC participants in the context of a period of change; and

4. Assess the impact of increased participation and other changes on State agency administration and oversight of local WIC programs.

II. Major Study Findings

One finding of the WIC Dynamics case study component is the enthusiasm and willingness of local agencies to do as much as possible for the population being served. While the study findings suggest that many local agencies may be stretching their available resources to meet program growth, the findings also indicate that WIC staff are approaching this growth with commitment, creativity, energy, and enthusiasm. Consideration of the extent to which local agencies have extended themselves to meet the challenges of the past years, and being sensitive to the "process" of growth—the need for planning, time to phase it in, and the need for stability in both program requirements and growth pace—will go a long way in assuring that service quality is sufficient to support positive program outcomes.

[1]Seventy-seven (91%) of the 85 State agencies responded.

[2]A 95 percent response rate was achieved from the sample of 300 local agencies surveyed.

A. Effects of Rapid Growth and Other Changes on Local Agency Service Delivery

Program-Related and External Factors Affected Program Operations and Service Delivery

During the study period (1988-1993), participation increased by 45 percent, and a number of new Program requirements were introduced. More than half of the local agencies identified the factors in Exhibit 1 as having had impact on their operations during this period:

Exhibit 1

Factors That Affected Local WIC Agencies, 1988-1992

FACTOR	LOCAL AGENCIES %	AFFECTED PARTICIPANTS %
Breastfeeding Promotion and Support	88	93
Caseload Increases	86	94
Infant Formula Rebates	86	90
Federal Funding	78	87
Medicaid Expansion	77	83
Economic Downturns	77	82
Food Cost Fluctuations	70	78
Automation Initiatives	68	79
State Funding	63	57
Service Coordination	60	62
Reprioritizing Caseload	60	72
Shortages of Nutritionists	57	74
Drug Abuse Education	57	67

How Local Agencies Reacted

Local agencies responded to the growth and new requirements in a variety of ways. There was evidence of efforts to increase efficiency and make maximum use of existing resources. More than 50 percent of local agencies indicated that they took the following actions or felt the impact in the following ways:

Scheduled less time per participant (57% of the agencies, serving 63% of the participants).

Made changes in nutrition education. More than half of the agencies increased use of **group nutrition education** (57%) and used more **handouts and pamphlets** in delivering nutrition education (56%).

Changed content of food package and frequency of issuance. Sixty-three percent of agencies issued **multiple food instruments**, which reduced the number of times that participants visited the agency to pick up instruments. Fifty-one percent of local agencies spent less time tailoring food packages and issued **standard food packages** more often. Standard packages are specific quantities of supplemental foods for sub-categories of WIC participants, designed to address categorical, nutrition risk, and other factors. The use of standard food packages can reduce the level of time and effort needed to tailor individual food packages.

Changed administrative procedures. The study period found local agencies **overbooking appointments** (71%) and **extending clinic days** of service (51%) to respond to the new requirements and other factors. More than half indicated that they made greater use of **computers** (68%). Yet, 62 percent reported that they **delayed completion of paperwork** and 59 percent reported **increased paperwork**. At the same time, 51 percent reported that they **streamlined recordkeeping.**

Changed space use. Seventy-two percent of the local agencies reported making **more efficient use of space**. Although somewhat fewer than half of the agencies reported this, note that 48 percent, serving 66 percent of the participants, **moved to new facilities**, and 40 percent, serving 66 percent of the participants, **added new clinic sites**.

Local Agency Concerns about Facilities and Staff

The majority of local agencies (67%), serving 82 percent of the participants, reported their current **space** to be **inadequate**. The most frequently (65%) reported factor that hindered high-quality WIC services was inadequate facilities and materials.

Almost two-thirds (61%) of the participants are being served in local agencies that perceive their **number of staff** to be less than sufficient. Yet the majority of local agencies cited that they did not have any **vacant staff positions**. About one-half of the local agencies (52%) found it difficult to **recruit professional staff**. The most problematic barrier cited to filling staff vacancies was **salary and benefits** which were not competitive. Shortages of certain types of staff were also problematic; for instance, 21 percent of the local agencies reported a shortage of nutritionists and 14 percent cited a shortage of dietitians as reasons for not filling vacant positions.

B. Integration and Coordination with Other Programs

The WIC Dynamics Study explored service coordination and integration between WIC and other programs. *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 features such as colocation, sharing of staff, sharing of records, and combined eligibility determination procedures.

Coordination with Health Care

The study found that WIC local agencies appear to be well coordinated with other health and social programs. Examples of coordination that were identified in WIC Dynamics included coordination (and sometimes integration) of Medicaid and WIC eligibility; integration of WIC and immunization services; coordination of nutrition education with case management of high-risk pregnant women; and sharing of client demographic, eligibility, and service use information through automated data processing systems.

Health organizations such as a local health department, a community health agency, or a public hospital sponsor about 88 percent of the local agencies. There are a greater number of WIC sites without on-site health services than might be expected, given the high proportion of agencies that are sponsored by health organizations. In 52 percent of local agencies, all clinics have on-site health care, but these agencies serve only 39 percent of all participants. Nationally, only 14 percent of local agencies (serving 9% of the participants) provide no health care services at any of their sites. Twenty-nine percent of the local agencies reported that they have difficulty obtaining health care services for WIC participants at their principal clinic sites.

The **most common health care services** available on site at principal WIC clinics are: breastfeeding support programs, family planning services, and immunizations, followed by other health screening, Early Periodic Screening Diagnostic Testing (EPSDT), and pediatric care. Less than 40 percent of the principal WIC clinics have obstetrical/gynecological, Medicaid screening, or dental care available on site.

Local WIC Agencies Coordinate with a Diverse Set of Providers

A number of Federal, as well as State initiatives, have been implemented in an effort to increase 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; required State Medicaid programs to provide for coordination between the Medicaid and WIC Programs; and directed States to set reasonable Medicaid reimbursement rates for providers.

In some locales, WIC is not as well coordinated with private providers as it is with public health departments. The case studies suggested several reasons for this. Communication efforts are sometimes hindered when there is no well-established network, and each provider must be contacted separately. 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.

Availability of Non-Health Services

Fewer than one-third of the principal clinics have social service programs, food assistance programs, transportation, or AFDC on site. Less than 15 percent of the principal clinics have Head Start, child care, housing, and adult education/job training services on site. Application forms for non-health services are available more frequently: social service programs (35%), food assistance programs (32%), and AFDC (25%).

Services Funded by Other Sources

Only one-fourth of the local agencies use only WIC funds to pay for space (23%) and utilities (24%). A little more than half of the local agencies use a combination of WIC and non-WIC funds for space and utilities. WIC funds are used exclusively for educational materials in 62 percent of the local agencies; for computer equipment in 54 percent of the local agencies; and for medical equipment in 49 percent of the local agencies.

Twenty-nine percent of the principal clinics use non-WIC on-site staff for hematological measurements. Interestingly, over one-fourth of the sites responded that they did not know whether hematological measurements were provided on site by non-WIC staff. In highly integrated sites, agency staff tend to be unaware of funding sources for WIC services, staffing, or facilities.

WIC's dependence on other programs for funding, staffing, and other assistance is an indication of the high degree of resource sharing with other programs serving the same target group.

C. Nutrition Services in the Context of a Period of Change

Almost two-thirds of local WIC agency respondents perceived that since 1988, the quality of WIC nutrition education has increased. Local Agency staff noted increased emphasis in breastfeeding promotion and that a broad range of educational topics are covered in nutrition education sessions.

Most Nutrition Education Is Provided by Trained Nutritionists or Other Professional Staff

WIC nutrition education staff are composed of nutritionists, dietitians, diet technicians, paraprofessionals, and other health professionals. Only one-third of the local agencies reported using paraprofessionals to provide nutrition education. Over 87 percent of local agencies reported that their professional staff have sufficient or more than sufficient skills and experience to provide nutrition education. The majority of case study sites used nutritionists to provide nutrition education, and 75 percent report that they have at least one licensed or registered nutrition professional. Sites often used a mix of professionals and paraprofessionals as their nutrition team.

Nearly All Agencies Offer Individual Nutrition Education, but Group Education Programs Have Increased

Ninety-eight percent of all agencies offer **individual nutrition education** sessions. Since 1988, over half (58%) of the agencies have increased their use of **group education** sessions. Ten percent of the agencies serving 18 percent of the participants offer very large groups (30 people or more). Nearly one-half (49%) of the local agencies, serving 64 percent of the participants, cited too few staff as a barrier to providing quality nutrition education.

The Range of Topics Covered in Nutrition Education and Counseling Has Broadened and Includes Health-Related Topics

In addition to nutrition topics, more than 90 percent of the local agencies offer topics such as dental health and the risks of substance abuse. Case study sites reported other counseling topics, including the importance of immunization, parenting skills, smoking cessation, and child safety. More materials, including pamphlets and audio-visual aids, are available to local WIC agencies.

Emphasis on Breastfeeding Promotion Has Increased

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—for example, 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 infants, providing special classes to all pregnant women, and emphasizing the benefits of breastfeeding in all individual and group sessions prior to and after delivery.

State Agencies Have Implemented Nutrition Services Standards

"Focus on Management" Nutrition Services Standards have been jointly developed by FCS and the National Association of WIC Directors. Overall, it appears that State agencies have implemented standards for delivering nutrition services.

WIC Nutrition Services Meet Standards

The study included an assessment of the nutrition services delivered at the 22 case study sites. Nutrition services were assessed against the "Focus on Management" Nutrition Services Standards jointly developed by FCS and the National Association of WIC Directors. Overall, it appears that the case study agencies provide nutrition services that comply with these standards.

D. State Agency Administration and Oversight

State Allocation of Administrative Funds and Caseload to Local Agencies Varies, but Is Heavily Influenced by Local Agencies' Unserved Population and Capacities to Serve

States identified the following factors as most important in allocating administrative funds to local agencies: the local agencies' historical ability to serve the assigned caseload (80%); the WIC priority groups currently being served (75%); and the percent of potentially eligible participants being served (72%).

Administrative fund allocation reflects the economies of scale that larger States can achieve. Fifty-six States, serving 74 percent of the participants, allocate 60-80 percent of their **administrative funds** for local level expenses. Small States allocate lower percentages of administrative funds (20% of States with 4% of the participants). Forty-five percent of State agencies use an administrative cost-to-participant ratio to fund local agencies. These States serve 77 percent of the participants.

The methods for assigning **caseloads** to local agencies vary greatly. During periods of rapid growth, a large proportion of States allocate caseload based on requests from local agencies (30%) or allocate proportionately to all agencies (18%).

Federal Funds Are Supplemented by Other Sources of Funding in 57 Percent of the State Agencies

Fifty-seven percent of State agencies, serving 81 percent of participants, reported receiving funds other than Federal WIC funds to support their program. Other funding sources include private grants, county or local funds, or State appropriations, which 27 percent of State agencies reported.

Program Performance Standards Are Widespread, but Not Universal

Performance standards are used to monitor local agency compliance with WIC regulations and the quality of nutrition services provided. These program performance standards vary among the States. Sixty-one percent of the State agencies, affecting nearly three-fourths of the local WIC agencies, report that they use performance standards. Smaller States, serving 11 percent of the participants, reported that they have not developed performance standards.

State Agency Activities Support Program Coordination and Integration

Most WIC State Agencies (97%) reported that they participate in immunization programs. Ninety percent participate in joint efforts with other agencies to provide services to women and children. Other State initiatives in support of coordination and integration include joint program application forms, integrated data systems, and interagency planning activities.

Automation Has Increased in Local WIC Agencies

Thirty-five of the 77 responding State agencies reported that all of their local agencies used PC/minicomputers, while 31 State agencies reported that all had mainframe support. Only 11 States (serving less than 1 percent of participants) reported that none of their local agencies use computer support.

E. Capacity

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 at or above capacity. This is an important consideration in determining the program's ability to accommodate future caseload growth.

F. Conclusions

Dramatic growth and new requirements have had a two-fold effect on local WIC agencies. These factors have contributed to WIC's evolution and development into a major maternal and child health program. But these factors also present a challenge to local agencies in providing quality services. WIC Dynamics Study findings indicate that many local agencies are meeting these challenges by increasing operational efficiency and maximizing available resources. Such steps include increasing services integration and coordination, obtaining in-kind contributions, and sharing staff and facilities with other programs. While services integration and coordination is desirable from the client's perspective, it can present significant challenges when other programs and services do not grow at the same rate as WIC.

Chapter I

Introduction

Chapter I. Introduction

I. Brief Description of the WIC Program

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a grant program administered by the Food and Consumer Service of the U.S. Department of Agriculture. Enacted by P.L. 92-443 in 1972, the goal of WIC is to improve the health of participants by providing supplemental foods, nutrition education, and health care referrals.

The Federal Government provides separate grants for food and nutrition services and administration to 85 State WIC agencies.[1] In turn, the State agencies fund local WIC agencies to deliver services to participants. Local agencies certify women, infants, and preschoolers by establishing that income eligibility guidelines are met (185% of poverty or less) and that a certified professional authority determines the candidate to be at nutritional risk. Local agencies provide nutrition education, make referrals to health care and other services, and typically distribute food instruments (checks, vouchers, bank drafts) that are accepted by participating retail food stores.[2] WIC food instruments are valid only for the purchase of specified foods. In 1992, an average of 5,396,569 participants received benefits each month through 1,777 local agencies. Local agencies operated in more than 8,200 clinics, and more than 47,000 food stores participated in the program.

II. Changes in the WIC Program

Since its inception, the WIC Program has grown dramatically. Between 1988 and 1992, a 45 percent increase in participation occurred due to increased Federal funding and a State-initiated cost containment strategy (rebates from infant formula manufacturers). During this period, Congress also refined and reshaped the WIC Program. New requirements were placed on State and local agencies to encourage cost containment,[3] to provide special accommodation to the homeless,[4] to provide referrals for drug abuse education,[5] to serve incarcerated women, and to

[1]Comprised of the 50 States, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and 31 Indian Tribal Organizations in existence in 1992.

[2]Mississippi, Vermont, and Ohio use direct distribution or home delivery systems to provide food benefits to participants.

[3]P.L. 100-237 and P.L. 100-356, passed in 1988, permit part of the money saved as a result of infant formula rebates and other cost containment measures to be converted to administrative funds.

[4]The Hunger Prevention Act of 1988 (P.L. 100-435) required delivery of WIC benefits to the homeless through special accommodation.

[5]The Anti-Drug Abuse Act of 1988 (P.L. 100-690) required local agencies to provide drug abuse education to WIC participants.

improve accessibility for working women.[6] In addition, local agencies were required to place further emphasis on breastfeeding promotion and to encourage immunizations in children. Other programs also had impact. Eligibility for Medicaid expanded, and increased coordination and referrals between Medicaid and WIC were also required.[7,8]

Legislative Mandates

In its 20-year history, the Special Supplemental Food Program for Women, Infants, and Children (WIC) has experienced two phases of caseload growth. During the first phase, from 1974 to 1987, the program's caseload expanded steadily from year-to-year. Various legislative and regulatory actions implemented during this period refined WIC's funding, administration, and services. During this first phase, the program developed and matured. In the second phase, which started around Fiscal Year 1988, WIC began to experience large annual increases in participation, due primarily to the infusion of more funds, in the form of infant formula rebates and large annual appropriation increases. Monthly participation in Fiscal Year 1988 averaged 3.6 million, but one year later in Fiscal Year 1989, average participation climbed to 4.1 million, an increase of 500,000. In January 1994, 6.3 million women, infants, and children participated in WIC.

This report, The WIC Dynamics Study, focuses on the second and current phase which began in 1988 and is distinguished by two significant factors. First, as stated earlier, WIC began to experience extraordinary program growth with annual average monthly participation increases approaching and exceeding 500,000 persons. Secondly, and perhaps more significantly, WIC's role in the spectrum of maternal and child health services took a major shift. WIC evolved from being an adjunct to maternal and child health services to becoming the gateway program through which many low-income households enter the public health system. As Congress and others became aware of WIC's expanded role, they began to view the program as a vehicle to increase services to low-income mothers and their children. Through WIC, participants are informed about and referred to a range of programs and services including immunizations, food assistance, AFDC, Medicaid, drug and alcohol abuse counseling, and smoking cessation programs. The results have been two-fold—WIC local agency responsibilities have expanded but many WIC local agencies have become "one-stop shopping" sites for an array of health and social services.

The WIC Dynamics Study examined, among other factors, the effects of increased caseloads generated by infant formula rebates. Until Fiscal Year 1988, WIC food costs increased steadily each year. In Fiscal Year 1988, P.L. 100-237, The Commodity Distribution Reform Act and

[6]In 1989, P.L. 101-147 required service to incarcerated women at State option and more accessible clinic hours for working women.

[7]The Budget Reconciliation Act of 1989 expanded Medicaid eligibility, required that all pregnant women and preschool children receiving Medicaid be notified of WIC, and required a single application for Maternal and Child Health, Medicaid, WIC, and other programs.

[8]P.L. 101-147 required WIC to refer participants to Medicaid, AFDC, and Food Stamps.

WIC Amendments of 1987, building upon the success of State infant formula cost containment, required that States adopt, where feasible, cost containment initiatives such as rebates, competitive bidding, direct food distribution and home delivery systems to help reduce expenditures for the purchase of supplemental foods. Of these initiatives, infant formula rebates are the most widely used and have had the greatest effect on cost containment. Under contractual agreements with infant formula manufacturers, WIC State agencies receive a set rebate amount for every can of infant formula purchased for WIC participants. Thus, rebates allow WIC to serve more participants without increasing the appropriated food grant. In Fiscal Year 1992, infant formula rebates totalling over $750 million supported one-fifth, about 1,200,000 million participants each month, of the WIC caseload.

When infant formula rebate systems were first implemented, the larger caseloads increased the administrative burden of WIC State and local agencies. While rebates reduced food costs and allowed more participants to be served with the States' food grants, considerable strain was placed on program administrative funds. More participants had to be served on a fixed administrative grant. The growth in participation, in effect, reduced the amount of administrative dollars per participant in the program. At some point the growth in participation would be severely constrained because administrative funding would be insufficient to maintain the level of administrative services. P.L. 100-237 contained provisions which allowed States, under certain conditions, to convert a specified portion of the food grant to cover the costs of nutrition services and program administration for the additional participants added due to food cost savings.

To relieve the administrative funding constraints, P.L. 101-147, the WIC reauthorization legislation signed into law in November 1989, contained provisions to change the amount of the Federal appropriation for administrative funding. The basis for food funding remained as before, with FCS allocating food grants based upon each State agency's current operating level and ability to serve those potentially eligible for WIC services, especially those at greatest nutritional risk. Prior to FY 1989, the administrative portion of the Federal appropriation was a set percentage of the total, about 20 percent. With the implementation of P.L. 101-147, administrative funding was changed to a per-participant basis. The administrative per-participant grant is based upon the national average for FY 1987, the year prior to large-scale implementation of rebate systems, adjusted annually for inflation. The new funding method increases the amount available to cover program administration and takes into account the variance among States' participation levels and other factors which promote effective program administration.

At about the same time that participation began to increase dramatically, Congress began to enact new legislative mandates which expanded the scope of WIC's intervention with individual participants. Some of the mandates require local agency staff to counsel and provide information to WIC participants on a range of nutrition and health related topics. Others, such as WIC Farmers' Markets Demonstration Projects, increased benefits available to some WIC participants. Following is a brief description of some of the Federal legislation enacted since 1988 which contained provisions with potential impact on local agency operations and service delivery.

- **The Hunger Prevention Act of 1988,** P.L. 100-435, provided grants in up to 10 States to conduct Farmers' Market Demonstration Projects in which WIC participants receive vouchers which can be redeemed for fresh fruits and vegetables at local farmers' markets.

- **The Anti-Drug Abuse Act of 1988,** P.L. 100-690, requires the WIC Program to provide information about the dangers of drug abuse; refer participants suspected of drug abuse for treatment or counseling; and distribute drug abuse materials to participants.

- **The Child Nutrition and WIC Amendments of 1989,** P.L. 101-147, included over 30 changes to WIC's administration and operations. Among those affecting local agency service delivery are adjunctive Medicaid eligibility for Food Stamp, Medicaid, and AFDC recipients and a set-aside for breastfeeding promotion and support activities.

- **The FY 1992 Agriculture Appropriations Act,** P.L. 102-142, directed USDA to work closely with States to better target participation to the most nutritionally at risk and work to enroll hard-to-reach eligible women, infants, children.

- **The WIC Farmers' Market Nutrition Act of 1992,** P.L. 102-314, established and authorized the WIC Farmers' Market Nutrition Program (FMNP) through 1994. This act expanded the Farmers' Market Program to more States and extended Farmers' Market benefits to WIC applicants on waiting lists.

- **The FY 1993 Agriculture Appropriations Act,** P.L. 102-341, directed USDA to continue efforts to involve the WIC Program in the "Weed and Seed" Initiative administered by the U.S. Department of Justice. The Weed and Seed Program promotes neighborhood revitalization and attempts to reclaim communities embattled by drugs and crime. The Act also directed the WIC Program to better target participation to those most nutritionally at risk and to work to enroll hard-to-reach eligibles. WIC was instructed to include immunization education as part of the services provided to participants.

- **The Child Nutrition Amendments of 1992,** P.L. 102-342, included a provision to make homelessness and migrancy predisposing nutritional risk criteria for WIC eligibility. The Act also directed USDA to conduct several activities to increase breastfeeding promotion.

- **The WIC Infant Formula Procurement Act of 1992,** P.L. 102-512, contained provisions directed at USDA and WIC State agencies in procuring infant formula rebates. However, one provision which had the greatest potential impact on WIC local agencies requires States to include, in their annual State plans, a description of how they will reduce the purchase of unprescribed low-iron formula by WIC participants.

- **The National Voter Registration Act of 1993,** P.L. 103-31, requires States to designate as voter registration agencies all offices in the State that provide "public assistance." The Act defines public assistance to include those State agencies that administer or provide services under the WIC, Food Stamp, AFDC, and Medicaid programs.

- **The FY 1994 Agriculture Appropriations Act**, P.L. 103-111, included funds for a major expansion of the WIC FMNP. The Act also prohibited any FY 1994 WIC administrative funds from being used by any clinic providing WIC services if that clinic allows smoking within the space used to administer the program. In addition, WIC food packages must be tailored to include foods that are rich in folic acid, and WIC nutrition education, including exit counseling, must cover the benefits of such foods. The Act also specified that the dangers of tobacco use and exposure to second-hand smoke are to be included in alcohol and substance abuse prevention counseling in WIC. WIC clinics are also directed to provide immunization education to WIC participants.

The Federal level is not the only source of mandates which affect local WIC service delivery. State-initiated policies and actions also affect operations and service delivery at local WIC agencies. Individual WIC State agencies have considerable latitude to establish and implement their own policies and operating standards within the Federal regulatory framework. For example, Federal regulations specify the type and maximum prescribable quantities of foods provided in the WIC food packages. However, most of the State agencies have established policies which restrict the brand, form, and packaging of foods which can be purchased with WIC vouchers. WIC infant formula rebates, a very successful cost containment strategy, are another example of State-initiated practices. The effects of infant formula rebates were immediate and obvious, larger caseloads at the local WIC agencies. Combined, these Federal and State mandates have affected local agencies and their ability to serve growing numbers of WIC participants. The WIC Dynamics Study sought to examine this effect and to produce some national-level estimates of the impact of these changes on local agency operations.

III. Study Purposes and Objectives

The overall goal of the WIC Dynamics Study is to describe selected components of WIC service delivery at the State and local agency levels, and to focus on the impact of rapid growth and other factors that affected the local agencies since 1988. The research objectives are:

Local Agencies

1. Determine the effects of rapid growth and other changes on local WIC agencies' service delivery.

2. Determine the impact of increased participation and other changes on the program's integration and coordination with local health care delivery systems.

3. Assess the nutrition services provided to WIC participants in the context of a period of change.

State Agencies

4. Assess the impact of increased participation and other changes on State agency administration and oversight of local WIC programs.

Exhibit I-1 summarizes the topics related to each of these research objectives.

IV. Overview of Methodology

WIC Dynamics is composed of two separate research activities. Research Objectives 1 and 4 were addressed primarily through mail surveys to all 85 State agencies and a nationally representative sample of 300 local agencies. All survey respondents were asked to identify changes that occurred in the service delivery system, administration, and caseload management of WIC since 1988. The focus of the State Agency Survey was on allocation of funding and caseload to local agencies. The Local Agency Survey documented current operations and services and indicates which selected services and operations changed during this period of rapid growth in WIC.

Those agencies that did not return the survey within a specified period of time were sent follow-up postcards, and, if necessary, then received a telephone call to remind them to complete the survey. Responses were received from 77 of the State agencies (91%) and 285 of the sampled local agencies (95%). Once the data were received and entered into a data file, they were compared to an edit program that identified missing data and errors. Surveys with errors were reviewed and follow-up telephone calls were made as necessary to resolve these issues. After the data were edited and errors corrected, the analysis tables were created. These tables are in Volume 2.

Research Objectives 2 and 3 were addressed primarily through case studies of 22 local WIC agencies, although the Local Agency Survey also included some questions relevant to these objectives. The case study local agencies were selected to be as heterogeneous as possible, with local agencies selected from all regions, and with at least one local agency per region that had been included in a prior FCS study (to permit some comparison to earlier findings).[9] Agency growth was also considered in the selection so that agencies with increasing, decreasing, or stable growth were included.

Two-person teams spent 3-4 days on site at each case study local agency in the sample, depending on the size of the site and the number of clinics to be visited. The data collection was comprehensive, including interviews with the WIC director, nutritionist, and other staff members, as well as record reviews of certification and nutrition education data. Interviews were also conducted with public and private health care providers in the community served by the local WIC agency and with agencies that were coordinating some activities with WIC.

[9]Report on Findings and Methodologies of WIC Case Study Analyses, Abt Associates, December 1988.

Exhibit I-1

Study of WIC Dynamics Research Topics

Effects of Rapid Growth and Other Changes on Local Agency Service Delivery	Effect of Increased Participation, Integration, and Coordination with Local Health Care Delivery Systems	Assessment of Nutrition Services	State Agency Administration and Oversight of Local WIC Programs
A. Effects of Changes on Local Agency Service Delivery 1. Nutrition Education Process 2. Space and Facilities 3. Methods for Referrals 4. Types of Referrals 5. Food Package Delivery B. Effects of Changes on Program Administration and Caseload Management 1. Certification Process 2. Operating Procedures 3. Staffing 4. Waiting Lists/Priority Systems C. Effects on Local WIC Programs 1. Staffing 2. In-Kind Contributions 3. Total Resources 4. Overall Integration and Coordination with Other Health and Community Service Programs D. Service Quality and Accommodating Future Growth 1. Quality of Services, Work Environment, Morale 2. Practices to Accommodate Growth	A. Integration and Coordination with Local Health Care Delivery Systems 1. Relationship with the Medical Community 2. Other Maternal and Child Health Services 3. Accommodation by Other Health Care Delivery Systems of Increased WIC Referrals 4. Types of Health Care Providers Accepting WIC Referrals 5. Requirement That Applicants Visit a Physician Prior to WIC Certification	A. Nutrition Services 1. Nutrition Education Services 2. Length of Sessions 3. Attendance Promotion 4. Staff Providing Education 5. Relationship to Medicaid Enhancement Service Packages 6. Relationship to the Frequency and Content of Other Nutrition Education 7. Individual Care Plans 8. Quality and Frequency of Nutrition Education Contacts B. FOM Nutrition Services Standards C. Breastfeeding Promotion	A. Funding 1. Allocation of Funds to Local Agencies 2. Percentage of Administrative Grant Retained at the State Level 3. Conversion of Food Grant Dollars to Cover Nutrition Education and Program Administration 4. Availability or Use of Alternative State Funding B. New Initiatives in Response to Changes in Federal Regulations C. Automation D. States' Capacity to Serve E. State-Level Program Initiatives

For more detailed information on the methodology used and the sampling plan, see the Volumes 2 and 3. Upon completion of each site visit, the site visit team wrote individual case study reports and sent them to a representative from the local agency for review and verification. The information from these reports was synthesized in preparation for this report, using cross-site analysis tables (see Volume 3).

V. Study Limitations

WIC Dynamics focuses on current operations and changes that occurred since 1988. The measures of change and impact of the changes are primarily based on State and local agency staff perceptions. Due to budget constraints and the need to limit the data collection burden, their views were not subjected to independent verification or assessment, although the data were closely examined for consistency in related areas.

VI. Overview of the Final Report

The purpose of this report is to present findings from both the mail surveys and the site visits. The State and local surveys primarily provided the quantitative data in this report. The information obtained during the site visits, along with follow-up telephone discussions with representatives from different local and State agencies, have supplemented the survey data. The core of this report consists of six chapters, each of which addresses a specific set of questions related to the Study Objectives.

- Chapter II—State Agency Administration, discusses funding issues, automation, and other changes occurring at the State level that affect the State's administration of the WIC Program.

- Chapter III—Local Agency Administration, covers the day-to-day operations and procedures followed at the local agencies and the impact of changes in these areas on the local agencies' ability to administer the WIC Program.

- Chapter IV—Nutrition Services, deals with nutrition education, breastfeeding promotion, and food package delivery methods.

- Chapter V—Integration and Coordination with Other Programs, discusses the extent to which local WIC agencies are integrated/coordinated with other agencies, as well as outreach and referral activities.

- Chapter VI—Synthesis of Impact of Changes on State and Local Agency Operations, summarizes the changes in State and local agency characteristics, caseloads, economic factors, program requirements, and other initiatives and factors during the study period.

- Chapter VII—State and Local Agencies' Perspective on Accommodating Future Growth, discusses the issues and local agency concerns related to growth in the program.

Volumes 2 and 3 provide the detailed tables and reports that support the information contained in this final report.

Chapter II

State Agency Administration

Chapter II. State Agency Administration

The WIC Program functions through three levels of management—Federal, State, and local. At the Federal level, the Food and Consumer Service (FCS) and its seven regional offices provide cash grants to State WIC agencies for program administration and operations. FCS also issues regulations and monitors compliance with these regulations. State WIC agencies set nutritional risk eligibility standards, allocate funds to local WIC sponsoring agencies, monitor their compliance with FCS regulations, and provide technical assistance to WIC local agency staff. This chapter focuses on State agency administration. The data used to prepare this report were collected through the State Agency Survey. This State mail survey was sent to the universe of WIC State agencies, which includes the 50 States, Guam, the Virgin Islands, Puerto Rico, Washington D.C., and 31 Indian Tribal Organizations (ITOs). Of the 85 State agencies, 77 responded. Three States—Hawaii, Idaho, and Oregon—and five ITOs—Indian Township (ME), Pleasant Point (ME), Pueblo of Isleta (NM), Santo Domingo Tribe (NM), and Ute Mountain Tribe (CO)—did not respond.

Adjusted analytic procedures were used for those State agencies that do not have traditional local agencies, because their administrative structures made it inappropriate to answer survey questions that referred to local agencies. The State agencies without traditional local agencies are: Delaware, Guam, Puerto Rico, Virgin Islands, Arkansas, Louisiana, and all ITOs. Because of the diversity of these agencies, some questions regarding local agencies could be answered, but not others. For example, Puerto Rico has local administrative agencies, but these agencies do not have separate budgets; Louisiana does not have local agencies, but does contract some services out. These contractors receive budgets and caseload maximums. For purposes of analysis, we used the responses to the questions that referred to local agencies if they were provided by the "State/Local" agency. If they did not respond to these questions, a separate response category called "Not Applicable to ITOs" or "State/Locals" was used.

The topics covered in the State survey were:

- Funding for States and local agencies;
- New initiatives in response to Federal regulations and guidance regarding administration, service delivery, and oversight of local agencies;
- The extent to which automation is used to support WIC administration; and
- States' capacity to serve additional participants.

Findings pertaining to each of these topics are discussed below.

I. Funding for State and Local Agencies

The WIC Program is funded primarily with Federal funds. In FY 1988, Federal funding for this program totaled $1.8 billion, and in FY 1992, approximately $2.6 billion—an increase of 44 percent. In addition to Federal funds, many State agencies support the WIC Program with funds from other sources.

Sources of Non-Federal Funding. Over half of the 77 responding State agencies and Tribal Organizations (57%) reported using non-Federal sources of funding to support WIC Program operations. These State agencies serve 81 percent of the total WIC participants. Twenty-seven percent of the State agencies use State appropriations, and 11 percent of these State agencies are permitted to "carry forward" these funds from one year to the next. Twenty-two percent of the State agencies are using county or other local funds, and about 5 percent use private grants. Sources of non-Federal WIC funding included tribal funds, non-WIC Federal grants, and in-kind services. Some States are using multiple sources of non-Federal funds, as shown in Exhibit II-1.

Exhibit II-1

Current Non-WIC Sources of Funding for WIC

Sources of Non-WIC Funding	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
None	43	24	19
State Appropriations	27	38	39
Private Grants	5	5	4
County or Local Funds	22	45	37
Other Sources	23	22	29

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics Study, 1993.
Note: Totals exceed 100% because more than one funding source could be cited by each agency.

Most State agencies (69%) reported that the availability of non-Federal funds for WIC has not changed since 1988. Those States reporting that additional funding sources had become available had, on average, larger caseloads. The 23 percent of State agencies reporting increased availability of non-Federal sources of funding serve 39 percent of WIC participants and 36 percent of the local agencies. The actual amount of non-Federal funding reportedly remained the same for over half of the State agencies.

Exhibit II-2

Change in the Availability and Amount of Funding from Non-Federal Sources for WIC Since 1988

Availability and Amount of Funding	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
Funding Source			
Additional Funding Sources Became Available	23	36	39
Fewer Funding Sources Were Available	8	15	11
Funding Sources Remained the Same	69	48	49
Funding Level			
More Funding Became Available	22	32	31
Less Funding Became Available	22	35	41
Amount of Funding Remained the Same	56	33	28

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

Funding Allocation to Local Agencies. As shown in Exhibit II-3, the majority of State Agencies (56%) allocate 60 to 80 percent of their nutrition services and administrative funds for local-level expenses. These State agencies serve 74 percent of the participants, and so are, on average, States with larger caseloads. Those States that allocate a lower percentage of administrative funds to local operations appear to be smaller State agencies (20% of State agencies in this category serve 4% of the participants). The study did not investigate the extent to which administration and management of local agencies differ among the WIC State agencies.

Exhibit II-3

Administrative Funds Allocated to Local Agencies

Percentage of Administrative Funds Used for Local Level Expenses	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
0% - 20%	0	0	0
20.01% - 40%	10	0.35	3
40.01% - 60%	10	3	1
60.01% - 80%	56	65	74
80.01% - 100%	24	32	22

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

Average administrative costs per participant are shown in Exhibit II-4. Forty-five percent of the State agencies report using an administrative cost/participant ratio to fund local agencies. These State agencies serve 72 percent of the local agencies and serve 77 percent of the participants. The average administrative grant to local agencies per participant ranges from less than $6 to greater than $20. The largest per-participant reimbursements (more than $15) were in the smallest agencies; 24 percent of State agencies serving less than 2 percent of participants. Conversely, it appears that larger State agencies experience economies of scale and tend to reimburse at a lower rate. The single-most frequently cited range of reimbursement per participant (cited by 21% of the State agencies) is between $8.00-$8.99, affecting 38 percent of the local agencies and 36 percent of the participants. States have, for the most part, been using the same method to compute administrative grants per participant since 1988. Only 17 percent of the State agencies report having changed their method of computation during this period.

Exhibit II-4

Average Administrative Cost Per WIC Participant in 1993

Average Administrative Cost Per Participant	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
Less than $6.00	3	0.12	5
$6.00 - $6.99	13	15	21
$7.00 - $7.99	13	21	21
$8.00 - $8.99	21	38	36
$9.00 - $9.99	8	12	12
$10.00 - $14.99	18	8	4
$15.00 - $19.99*	12	1	0.16
$20.00 or more*	12	5	1

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.
*These are ITOs and other sparsely populated States that experienced higher administrative costs per participant due to the relatively small size of their caseloads.

Note that during this period, the 1989 WIC reauthorization legislation changed the basis for calculating the portion of the total Federal WIC appropriation to be allocated for NSA expenses. Prior to 1989, 20 percent of the Federal WIC appropriation was allocated for NSA expenditures. The 1989 legislation specified that the amount of NSA funds available from the Federal appropriation would be based upon a national average administrative grant per participant (AGP). The AGP was indexed to a 1987 base year and is annually adjusted for inflation, using an economic indicator based upon State and local government personnel costs. The result has been that a larger proportion (25.5% in 1993) of the Federal WIC appropriation is available for NSA expenditures.

The majority of State agencies (53%) consider both the historical performance of the local agencies and factors based on the needs of the population in computing administrative funding for local agencies, while an additional 20 percent use one of these two criteria. However, over 25 percent of the State agencies do not consider either of these factors, but use other measures when computing the administrative funding level. Examples of other criteria reported by States include "number of high-priority participants being served, budget submitted, and available funds," "caseload allocation and inflation," and "staff-to-participant ratio and line-item budget." One-third of the States report that the method for determining large agency administrative grants has been in place less than 4 years; 65 percent have used their current method for more than 4 years.

Caseload Allocation to Local Agencies. In addition to allocating funds to the local agencies, the State agency is responsible for allocating caseloads. State representatives were asked to indicate whether a series of 11 factors were "Important" or "Not Important" considerations in making caseload assignments to local agencies. Exhibit II-5 presents each of these factors and the percentage of State agencies that indicated that this factor was important. The five factors identified as "Important" by most of the State agencies are:

- Local agencies' historical ability to serve the assigned caseload (80%)
- WIC priority groups currently being served (75%)
- The percent of potentially eligible participants being served (72%)
- Management or staffing problems that might hinder the local agencies' ability to serve participants (68%)
- The local agencies' proven ability to grow (67%).

Exhibit II-5

Factors Used in Assigning Caseloads in Local WIC Agencies

Factor	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
Local Agencies' Historical Ability to Serve Assigned Caseload	80	87	88
WIC Priority Groups Currently Being Served	75	66	78
Percent of Potentially Eligible Participants Being Served	72	75	82
Management or Staffing Problems That Might Hinder Local Agencies' Ability to Serve Participants	68	77	76
Local Agencies' Proven Ability to Grow	67	68	74

Factor	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
New or Expanded Services for High-Risk Maternity Patients at Local Agencies	60	66	62
Local Agencies' Affirmative-Action Ranking	40	52	51
Colocation of Maternity Care	40	40	39
Unserved Areas in the State	35	29	21
Average Food Cost Per Participant	25	14	10
Other Factors	33	34	34

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

The factors considered "Not Important" in assigning caseload increases or decreases to local agencies by most of the State agencies are:

- Average food cost per participant (75%)
- Unserved areas in the State (65%)
- Local agency's affirmative action ranking (60%)
- Colocation of maternity care (60%).

The percentage of States indicating that a factor was important or not important was generally equal (or reasonably close) to the percentage of local agencies and participants served by that State. However, there are a few exceptions to this finding. The local agency's affirmative action ranking is considered important by only 40 percent of the State agencies, but these agencies serve 51 percent of the affected local agencies and serve 51 percent of participants. The State agencies that considered the average food cost per participant or the unserved areas of the State to be important factors were the State agencies with smaller caseloads.

The method for assigning the maximum caseload varied greatly. The most frequently cited method was based on the number of eligibles meeting specific priorities. This was used by 20 percent of the State agencies serving 30 percent of the local agencies and serving 28 percent of the participants. The remainder of the States used a variety of methods, including negotiation with local agencies (10%) or historic levels of caseload (7%). Only 15 percent of the State agencies have changed their methods of allocating caseload since 1988. Fifty-nine percent have been using their current method for 5 to 10 years, and 22 percent have been using their current method over 10 years. It appears that increased funding and participation has had no material effect on the way State agencies allocate caseload to local WIC agencies.

When experiencing rapid growth in caseload, a large proportion of States allocate caseload based on requests from local agencies (30%), or allocate proportionately to all agencies (18%).

Twenty-five percent of State agencies reported not having had rapid participation growth; however, these State agencies only serve 7 percent of the local agencies and serve 5 percent of the participants.

Staff Ratios. The majority of States (51%) report that they have not set participant-to-staff ratios under which local agencies operate. Thirty percent of States noted that they used staff ratios but did not specify that ratio. Only 13 percent of States reported using these ratios for less than 4 years. Of those agencies that reported a ratio, some have separate ratios for professional versus paraprofessional/clerical, while others have a single ratio that encompasses all staff.

II. Practices and Initiatives Affecting Administration, Service Delivery, and Oversight of Local Agencies

As discussed in the Introduction, since 1988, major changes in Federal regulations and program requirements were instituted that directly affected the WIC Program. These include increased emphasis on breastfeeding promotional activities and requirements concerning food issuance practices. While some of the initiatives were Federal requirements, others have been initiated by the States. The effect of each of these changes on State agency administration is discussed below.

Program Performance Standards. Performance standards developed by States address issues such as staffing ratios; staff training and staff qualifications; certification procedures; documentation; voucher preparation and distribution; client flow and waiting times; and nutrition education content, frequency, and quality. In 1987, the Food and Consumer Service (FCS) and the National Association of WIC Directors (NAWD) jointly developed nutrition services standards as part of the "Focus on Management" (FOM) initiative. The purpose of these standards was to provide WIC directors and nutritionists with a method for evaluating the quality of nutrition services and to encourage the use of evaluation information to improve program services. While the State Agency Survey did not specifically ask about implementation of the FOM Nutrition Services Standards, information obtained during case study site visits indicates that many States have developed their own standards, which incorporate and adapt the FOM standards to their particular situations, or build on existing State guidelines.

Sixty-one percent of the State agencies have developed and implemented program performance standards, which affect nearly three-fourths of the local agencies (71%) and participants (71%). Approximately one-fourth of the State agencies (24%), serving 11 percent of the participants, reported that they have not developed performance standards. State agencies that serve a smaller number of participants are using program performance standards to a lesser degree.

States used the performance standards to provide training for local agency WIC staff on topics ranging from administration of WIC services to techniques for providing nutrition education. All case study sites reported State evaluations occurring on at least 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.

Eighty percent of the State agencies reported that their performance standards focus to some degree on nutrition education. Over one-third of the State agencies (35%) reported that their performance standards focus primarily on nutrition education.

State agencies most commonly reported (75%) that their performance standards are used for monitoring local agency performance, evaluation, or both monitoring and evaluation. Exhibit II-6 illustrates the use of performance standards by State agencies.

Exhibit II-6

The Use of Program Performance Standards in WIC

Performance Standards Are	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
Used for Monitoring	25	26	27
Used for Evaluation	11	1	4
Used for Monitoring and Evaluation	39	55	56
Used for Other Activities	3	<1	<1
Do Not Use Standards	22	17	13

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

State Sponsorship of Breastfeeding Promotional Activities. The 1989 reauthorization legislation, P.L. 101-147, specified that $8 million be set aside annually from the NSA portion of the Federal WIC appropriation to fund State breastfeeding promotion and support activities. These funds are allocated to the WIC State agencies based upon their proportion of the national caseload. According to State Agency Survey responses, there are a variety of breastfeeding promotional activities in place. The most common State agency activity is providing printed materials (reported by 99% of the responding agencies), such as pamphlets and posters, for participants. Conducting in-service training programs, cosponsoring local activities with other organizations, and coordinating with hospital maternity wards are promotional breastfeeding activities sponsored by more than half of the State WIC agencies. Exhibit II-7 illustrates the types of activities that State agencies are sponsoring to promote breastfeeding among WIC participants.

Exhibit II-7

State Sponsorship of Breastfeeding Promotional Activities in WIC

Breastfeeding Promotional Activity	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
Providing Materials	99	99	99
In-Service Training Programs	91	95	98
Cosponsoring Local Activities	66	83	84
Coordinating with Hospital Maternity Wards	53	59	54
Peer Counseling Program Training	47	51	70
Public Service Announcements	29	29	31
Hot Lines	16	24	17

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

Various responses, other than those listed above, were given by a small percent of the States. These included coalitions, task forces, lactation consultants, breastfeeding consultants, and general media activities. For all responses included in the "other" categories, less than 10 percent of the State agencies responded for any one of these categories.

Food Instrument Issuance Practices. The most common frequencies of issuing food vouchers or instruments are once per month (43% of State agencies) or once every 2 months (39% of State agencies). A small number of State agencies (6%) reported that they are direct distribution agencies and do not issue food vouchers or instruments to participants. Survey responses indicate that voucher issuance does not vary greatly within State agencies. Only 5 percent of the State agencies reported a significant variation in issuance frequency among their local agencies, whereas 49 percent of the State agencies reported no variation in issuance frequency among their local agencies. Thirty-four agencies were unable to respond to this issue because they were sponsored by Indian Tribal Organizations (ITOs) or State Agencies, which do not have local agencies.

The majority of State agencies (64%) have had a change in their voucher issuance schedule since 1988. These State agencies serve 68 percent of local agencies and 78 percent of WIC participants. Survey responses indicate a wide variation among State agencies in the number of years they have been using their current issuance policies and procedures. Exhibit II-8 illustrates this variation.

Exhibit II-8

Number of Years that Current Food Voucher Issuance Policies and Procedures Have Been in Place in WIC

Number of Years Using Current Issuance Policies and Procedures	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
1 Year	12	12	18
2 Years	21	11	16
3 Years	14	23	24
4 Years	6	6	4
5 Years	10	6	4
6 to 10 Years	19	21	16
Over 10 Years	14	22	17
Don't Know	3	<1	<1

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

Change in WIC Coordination with Other Programs Since 1988. Because coordination with related services is a major focus of the WIC Program, survey responses indicate that 90 percent of the State agencies have increased their coordination efforts with other programs since 1988. Of these, 52 percent reported a substantial increase in effort. Only 3 percent of the State agencies reported a decrease in coordination efforts.

Program Initiatives and Practices. State agencies reported a variety of programs and activities. The majority of State agencies (97%) reported that they participate in immunization programs. These agencies serve 95 percent of the local WIC agencies and 97 percent of the participants. Survey responses also indicate that 90 percent of the State agencies participate in joint efforts with other agencies to provide services to women and young children. More than half of the State agencies (68%) reported that their State has implemented programs targeted toward low-income women and young children which relate to and coordinate with WIC. These States have, on average, the larger caseloads, in that 83 percent of the local agencies and 86 percent of the participants are located in States that have these new programs in place.

More than one-third of the State agencies (36%), serving 29 percent of the local agencies and serving 41 percent of the participants, reported that prior to certification, participants needed to visit a physician or non-WIC clinic to obtain biomedical and anthropometric data or verify pregnancy. According to survey responses, 16 percent of the local agencies, serving 27 percent of the participants, reportedly use non-WIC-funded medical providers to perform certifications.

The majority of State agencies (79%) reported that their State's Medicaid program does not reimburse for WIC services. However, services such as laboratory work used for WIC certification are covered when provided by a Medicaid participating provider (such as a private physician, hospital, or county health department or health center). In some States, Medicaid also reimburses for enhanced services, such as nutrition counseling and case management, for high-risk pregnant women. Thus, in some States, Medicaid resources are used to fund some WIC service to program participants.

III. The Extent to Which Automation Is Used to Support WIC Administration

The use of computers and the automation of various activities in the WIC Program have increased over the past 5 years. This mirrors the rapid increase in the use of computers in many segments of society. However, the level of automation and the amount of change that occurred since 1988 vary substantially among agencies. The State survey included a number of questions regarding the current state of automation and how it has changed since 1988.

Use of PC or Mini and Mainframe Equipment. State agencies were asked what proportion of their local agencies used PC or minicomputer support and what proportion used a mainframe. Their responses are shown in Exhibit II-9. Forty-five percent reported that all of their local agencies used PCs or minis, while 41 percent reported that all of their locals had mainframe support. Note that the two categories are not mutually exclusive, as an agency could use mainframe support for some functions while using PCs for other activities.

State agencies were also asked whether a shift occurred in the use of PCs or minicomputers since 1988 (Exhibit II-11). Most State agencies reported that more PC or mini-equipment is being used now at the State level, as compared with 5 years ago, and nearly all participants (97%) are in such States. PC or minicomputer usage also increased in local agencies, with two-thirds of the local agencies and three-fourths of the participants in States reporting increased usage at the local level. As mentioned earlier, State responses to mainframe and PC or minicomputer equipment questions are independent, so there may legitimately be an increase in the use of both types within a State.

Exhibit II-9

State Reported Use of Mainframe Computers at Local Agencies

Proportion of Local Using Mainframe Computers	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
All	41	49	55
Most	5	12	7
Some	1	0.87	2
Few	16	16	19
None	36	21	16

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

Some State agencies reported that they had shifted toward more mainframe equipment in the past 5 years, both at the State and local levels (Exhibit II-10). However, the greatest number of State agencies reported no significant change since 1988. Larger agencies tended to report a change in the use, either more or less, as compared with smaller agencies that tended to report no significant change. The responses indicate that mainframe usage occurs in either all or few-to-none of the agencies; very few States reported an intermediate level of mainframe usage among their local agencies.

Exhibit II-10

Change in Use of Mainframe Computers since 1988

Shift in Mainframe Equipment Used Since 1988 at State Level	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
More Used	26	25	42
No Significant Change	61	55	37
Less Used	13	20	22
Shift in Mainframe Equipment Used Since 1988 at Local Level	**State Agencies (%)**	**Affected Local Agencies (%)**	**Affected Participants (%)**
More Used	19	18	29
No Significant Change	71	69	59
Less Used	11	14	12

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

Exhibit II-11

Change in Use of PC or Minicomputers Since 1988

Shift in PC/Mini Equipment Used Since 1988 at State Level	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
More Used	86	97	97
No Significant Change	13	3	3
Less Used	1	0.06	0.01
Shift in PC/Mini Equipment Used Since 1988 at Local Level	**State Agencies (%)**	**Affected Local Agencies (%)**	**Affected Participants (%)**
More Used	63	78	76
No Significant Change	36	22	24
Less Used	1	0.06	0.01

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.

Automation of WIC Activities. Thirty-five percent of State agencies reported a shift from central State processing to more locally based processing; about half of all the agencies (55%) reported no shift between central and local processing. In addition to general issues of recordkeeping, States reported on the level of automation used in three agency functions: enrollment, food instrument production, and appointment scheduling.

Enrollment. Forty-three percent of State agencies have a fully automated enrollment system. Local agencies in these States either enter enrollment information into a micro- or mini-computer and transmit the data to a central database (29%), or else enter data into terminals that are directly connected to a central database (14%). Almost half of the State agencies (44%) reported that locals manually fill out forms for enrollment which are then sent to the State agency for entry into a central database. Only 3 percent of the States serving less than 1 percent of the participants are using all-manual systems.

Food Instrument Production. A variety of levels of automation was reported for food instrument production, as is shown in Exhibit II-12. About one-third of the States reported that local agencies use a variety of automated production methods. Nearly half of the States (45%, serving 56% of participants) use computer-generated bulk vouchers that are hand-customized by local agency staff for each participant. Only 8 percent of the States reported all-manual production. One State reported limited use of an Electronic Benefits Transfer (EBT) card.

Exhibit II-12

Automation for Food Instrument Production

Method of Food Instrument Production	State Agencies (%)	Affected Local Agencies (%)	Affected Participants (%)
On First Visit, Local Agencies Produce Instrument Using On-Line Terminals; on Subsequent Visits, Instruments are State-Produced	10	12	12
Local Agencies Produce All Food Instruments On Site Using On-Line Terminals	23	19	16
Electronic Benefits Transfer Card*	1	0.87	0.19
Local Agencies Hand-Customize Instruments Produced by State	45	57	56
All-Manual Production	8	0.35	0.14
Combination of Above Methods	4	8	13

Source: Based on responses from 77 State WIC agencies; State Agency Survey, WIC Dynamics, 1993.
* EBT used only in one small area of one State.

Appointment Scheduling. Sixteen percent of State agencies reported that scheduling is automated at the local level, but that it was not part of a statewide system, while 4 percent reported a statewide automated scheduling system. However, over three-quarters of the local agencies schedule manually (78% of agencies, serving 71% of participants).

Benefits of Automation. While automation is prevalent in many agencies, one cannot assume that the use of computers is always viewed as beneficial. Therefore, we asked State agencies to rate the effect that automation had on both productivity and quality in the WIC Program. A large majority of agencies reported that automation resulted in some or substantial improvement in productivity (83%) and quality (79%), while only 3 percent of agencies reported a decline in either quality or productivity. As more agencies move toward automating their services, these reports of benefits in quality and productivity are encouraging.

Chapter III

Local Agency Administration and Operations

Chapter III. Local Agency Administration and Operations

Most WIC programs are administered by local agencies under the supervision of a State agency. The exceptions to this rule are the six State agencies that also function as local agencies[1] and the 31 Indian Tribal Organizations (ITOs). The funds received by local WIC agencies are used to provide supplemental foods and nutrition education to WIC participants and to pay operating costs. This includes the costs of certifying applicants for eligibility and providing nutrition education and counseling services at WIC clinics and other service sites (e.g., 1-day-a-week voucher distribution in a church basement). During the project development process, the project study team noted that some practices varied by clinic within large agencies. Therefore, local WIC directors were asked to report on up to six of their largest clinics separately (to minimize burden). These are referred to as "principal clinics" throughout this report, and represent the 5,874 largest clinics, up to 6 per agency, in local WIC agencies nationwide. This chapter addresses local agency administration of WIC-selected operations and changes that have occurred since 1988. It includes results from the nationally representative Local Agency Survey and findings from the 22 case studies.

I. Number of Local Agencies and Distribution of Clinics

In 1992, there were 1,777 local WIC agencies providing services at 8,992 sites to an average of 5.4 million participants monthly. This is a participation increase of 45 percent compared to 1988, when there were 1,719 local agencies serving 3.7 million participants at 7,890 sites. Between 1988 and 1992, the total number of WIC local agencies increased by 3.4 percent while the number of clinic sites increased 14 percent. Of the 1,777 local WIC agencies in 1992, the majority have three or fewer clinic sites. Exhibit III-1 lists the distribution of service sites by local WIC agencies.

Exhibit III-1

Number of Service Sites in Local WIC Agencies

1 Site (%)	2–3 Sites (%)	4–5 Sites (%)	6–10 Sites (%)	11–25 Sites (%)	Over 25 Sites (%)
29	30	15	16	10	1

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

II. Certification and Scheduling Procedures

Respondents reported that certification services were provided in the majority of the service sites supported by these agencies; however, there are a few service sites that provide only food

[1]The six State agencies are Arkansas, Louisiana, Delaware, Puerto Rico, Guam, and the U.S. Virgin Islands.

issuance or nutrition education services. For example, one local agency reported one of their sites was open 1 day per week for issuance of vouchers only. Exhibit III-2 shows the amount of participant time spent waiting for and receiving services. The waiting time in clinics for certification services is less than 15 minutes in 75 percent of the agencies; however, these agencies serve only 51 percent of the participants. Twenty-six percent of the participants are served by the 12 percent of agencies where average waits in WIC clinics are longer than 30 minutes for certification. These findings indicate a tendency toward longer waits in larger agencies. Reported waiting time ranged from 0 to 150 minutes, and the average waiting time was 22 minutes.

Exhibit III-2

Time Spent Waiting For and Being Certified For WIC Benefits

	1. Less Than 5 Minutes		2. Less Than 15 Minutes (Includes Column 1)		3. Less Than 30 Minutes (Includes Columns 1 and 2)	
	Agencies (%)	Participants (%)	Agencies (%)	Participants (%)	Agencies (%)	Participants (%)
Waiting	24	12	75	51	88	74
Certification	2	7	21	30	67	77

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

Case study observations found that scheduling procedures, voucher preparation procedures, clinic staffing, and provision of integrated services had the greatest impact on waiting times. For example, in Long Beach, CA, recertification appointments are scheduled at 8:00 am and 9:30 am only, with afternoons reserved for group classes and voucher distribution. This contributes to long patient waiting times (as long as 2 hours in some clinics) as participants wait to see the next available CPA. In San Antonio, TX, waiting times between "stations" in the certification process were attributed to staffing limitations, inefficient scheduling of clients within a day, and uneven distribution of appointments throughout the month. In Martinsville, VA, the clinic with three WIC clerks and one nutritionist often had participants waiting for nutrition education/counseling after the completion of income, anthropometric, and hematologic measurements. Client flow at a second site in Martinsville, with one clerk and one nutritionist, was much smoother. The use of preprinted vouchers was reported to be a time saver in Salt Lake City, UT, reducing the time required for a client certification visit by about one-third. Integrated services were associated with increased time spent at the clinic, but not necessarily increased waiting time. In Tangipahoa Parish, LA, and Delaware, for example, WIC services were fully integrated with maternal and child health services without increases in client waiting times between services or providers.

Other sites, such as Montgomery County, MD, reported bottlenecks in providing integrated services due to the limited number of WIC staff available to see referrals from maternal and child health clinics.

During the study period (since 1988), local agencies reported making changes in the certification and scheduling processes. The most frequent changes in certification practices were:

- Scheduling less certification time per participant (57% of the agencies, serving 63% of the participants), and
- Limiting participation to certain priorities (43% of the agencies, serving 54% of the participants). This practice was also in place in local agencies prior to 1988.

The major changes in scheduling practices were:

- Overbooking participant appointments (71% of the agencies, serving 84% of the participants),
- Implementing or rigorously holding to an appointment system (55% of the agencies, serving 58% of the participants), and
- Extending the clinic days of service (51% of the agencies, serving 57% of the participants).

While only 44 percent of the agencies extended clinic hours beyond regular hours, these agencies serve 64 percent of the participants, indicating that the larger agencies made more changes in hours of operation than the smaller agencies. Exhibits III-3 and III-4 present the percentage of agencies that implemented these changes and the proportion of participants these agencies serve.

Exhibit III-3

Changes in Local WIC Agency Certification Practices

Changes Implemented	Agencies (%)	Participants (%)
Scheduled Less Time Per Certification	57	63
Limited Caseload to Certain Priorities	43	54
Added Priorities Served	43	44
Reduced Priorities Served	38	48
Started Doing Walk-In Certifications	26	28
Stopped Doing Walk-In Certifications	21	26

Changes Implemented	Agencies (%)	Participants (%)
Conducted Group Certification	16	24
Replaced Interview with Self-Administered Forms	14	22
Scheduled More Time Per Certification	14	20
Dropped Group Certification	7	7

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

Exhibit III-4

Changes in Local WIC Agency Scheduling Practices

Changes Implemented	Agencies (%)	Participants (%)
Overbooked WIC Participant Appointments	71	84
Implemented/Continued Appointments	55	58
Extended Clinic Days of Service	51	57
More Flexible Clinic Activity Schedules	46	50
Extended Clinic Hours Beyond Regular Hours	44	64
Less Flexible Clinic Activity Schedules	37	42
Cut Back on Days of Service	8	15
Shortened Clinic Hours	1	2

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

Determination of Nutritional Risk. As part of performing a certification, a nutritional risk determination is conducted. This risk determination can be made by a competent professional authority such as a nutritionist, nurse, physician, or other State or local medically trained officials, and is based on Federal guidelines. Three major types of nutritional risks are recognized:

- Medically based risks (designated as "high priority"), such as anemia, low birth weight, maternal age, history of pregnancy complications, or poor pregnancy outcomes;

- Diet-based risks such as inadequate dietary patterns determined by a 24-hour dietary recall, food frequency, or a diet history; and

- Conditions that predispose persons to medically based or diet-based risks, such as alcoholism or drug addiction.

Each risk criterion is specifically coded and corresponds to a priority level. The priority levels are not only based on the risk criteria, but also vary on the participant category. For example, an infant or pregnant woman with a low hemoglobin count is considered to be in the first priority category, compared to a child who would be in the third priority level. A lactating or pregnant woman at dietary risk would be in the fourth priority level. While the risk assessment is used to determine program eligibility, the priority level is most important when, due to resource constraints, agencies must limit the number of participants. Exhibit III-5 describes the WIC priority groups.

Exhibit III-5

WIC Priority Groups

Priority	Description
I	Pregnant and breastfeeding women and infants, at nutritional risk as demonstrated by anthropometric or hematological assessment or by other documented nutritionally related medical condition.
II	Infants up to 6 months of age of mothers who participated in WIC during pregnancy, or who would have been eligible to participate under Priority I documented medical condition. This priority may also be assigned to a breastfeeding mother of an infant who is classified as Priority II.
III	Children at nutritional risk, as demonstrated by anthropometric or hematological assessment of other documented medical condition. Can also include high-risk postpartum women.
IV	Pregnant and breastfeeding women and infants, at nutritional risk as demonstrated by inadequate dietary pattern. Can also include high-risk postpartum women.
V	Children at nutritional risk due to inadequate dietary pattern. Can also include high-risk postpartum women.
VI	Postpartum women, not breastfeeding, at nutritional risk on either medical or dietary criteria.
VII	Previously certified participants likely to regress in nutritional status without continuation of supplemental foods.

The measures that are used to determine the risk status are often taken from the medical history provided on a participant's record or from the anthropometric measurements that can be taken by WIC or non-WIC staff. Data collected from the case study sites indicate that among WIC staff, nutritionists are most likely to take these measurements (13 of the 22 sites), while among non-WIC staff, equal numbers of sites reported using physician- or nurse-generated information. This information may be sent to the WIC Program as a result of visits by the participant with the medical provider. If information is taken from patient medical records, there is generally a time period within which the measurements must be taken (e.g., 60 days prior to certification).

The method for obtaining hematological measurements differs among clinics in local agencies. The survey responses indicated that at least 71 percent of the principal clinics conduct blood tests on site. This figure includes principal clinics where the hematological work is conducted on site by WIC staff or by non-WIC staff. The responses also indicated that 52 percent of the principal clinics accept hematological reports prepared off site by health care personnel. Thus, hematological data may be obtained through both on-site and off-site measurements.

During the case study site visits, it was found that although many WIC clinics take their own anthropometric and hemoglobin/hematocrit measurements, others rely solely on outside providers to provide this information. Case study information indicated that New York State tends to rely on medical providers to do all the blood work for their participants. In addition, the sites visited also relied on those providers to complete medical forms prior to certification that specified participants' anthropometric measures. In fact, the medical form required for certification also includes information on other measures that might be used in the risk assessment (e.g., developmental disorders, chronic medical conditions, emotional/psychological problems, or substance abuse). Staff at one of the New York case study sites were concerned about relying on outside providers, particularly private providers, to obtain this information. Often, there appeared to be little, if any, contact between WIC staff and private providers. The staff felt that private providers are reticent about divulging what may be considered "confidential" information about their patients to WIC offices. They do not perceive WIC staff to be fully part of the health system, but rather as part of the welfare system; therefore, they are uncomfortable about sending forms that include such "private" information.

III. Local Agency Operations

Both the survey responses and the site visits indicated that many agencies have changed the day-to-day operations of their programs since 1988, as illustrated by Exhibit III-6. Some of these changes could be considered beneficial changes (they tend to make the process run more efficiently), but others may be detrimental. For example, about one-half of local agencies streamlined their recordkeeping. Sixty-two percent of the agencies, serving 68 percent of the participants, delayed the completion of paperwork or reports. In addition, 59 percent of the agencies, serving 64 percent of the participants, reportedly increased the amount of paperwork. This finding by itself is interesting because 68 percent of the agencies, serving 80 percent of the participants, made greater use of computers. Exhibit III-6 details administrative changes reported by local agencies.

In addition to the changes shown in Exhibit III-6, the majority of the local agencies initiated some type of special project (51% of the agencies, serving 68% of the participants), and planned or held regular staff meetings (59% of the agencies, serving 76% of the participants). However, 43 percent of the agencies, serving 56 percent of the participants, postponed or canceled special projects.

Exhibit III-6

Administrative Changes Reported by Local WIC Agencies

	Agencies (%)	Participants (%)
Made Greater Use of Computers	68	80
Delayed Completion of Paperwork/Reports	62	68
Increased Paperwork	59	64
Streamlined Recordkeeping	51	58
Expanded Case Management	46	52
Postponed or Canceled Special Projects	43	56
Limited Caseload to Certain Priorities	43	54
Added Priorities Served	43	44
Streamlined Case Management	35	40
Decreased Paperwork	17	22
Other	1	1

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

IV. Staffing of Local WIC Agencies

Local WIC agencies have three categories of staff: professional (e.g., licensed nutritionists, nurses), paraprofessional (e.g., nutrition assistants), and clerical/support. The Local Agency Survey found that all but 3 percent of the local agencies use professional staff, and only 8 percent do not use clerical/support staff. Paraprofessional staff are not as widely used, in that 49 percent of the local agencies do not have paraprofessionals. Exhibit III-7 illustrates that the majority of local agencies reported an increase in the use of all three types of staff since 1988. For each of these staff categories, local agencies serving a large number of participants more commonly cited an increase in the number of staff.

Exhibit III-7

Local Agency Current Staffing and Growth in Staff Since 1988

Staff Type	Local Agencies Using This Staff (%)	Local Agencies Reporting Staff Increase Since 1988	
		Agencies (%)	Participants (%)
Professional	97	53	69
Paraprofessional	51	39	55
Clerical/Support	92	61	75

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

It is interesting to note agency responses to the sufficiency of their staff numbers and skills. When asked about their current sufficiency, 53 percent reported having sufficient numbers of professional staff and 9 percent reported having less than sufficient staff with appropriate skills in providing nutrition services. When asked to compare sufficiency now to the situation in 1988, 69 percent reported professional staff numbers as sufficient as or more sufficient than in 1988, and 88 percent reported having equal or more sufficient nutrition skills. The responses indicate that for the majority of agencies staffing is sufficient, though there is still room for further improvement with respect to the number of professional staff. These response patterns indicate that a proportion of the respondents viewed the number of professional staff in 1988 to be insufficient. During the follow-up calls, one agency director noted that while she had increased her staff size, the workload had outpaced her hiring ability, so the staff's burden was still too heavy.

A similar pattern emerged for clerical staff. Responses from 55 percent of the local agencies indicate a sufficient (or more than sufficient) number of clerical/support staff, and 42 percent of the local agencies stated they have less than sufficient number of clerical/support staff. More than one-half of the local agencies (69%) reported that in comparison to the number of clerical/support staff in 1988, the current level is as sufficient or more sufficient. Paraprofessionals are present in just over half (51%) of the local agencies, and about half of these agencies (27% of all agencies) found the number of paraprofessionals to be insufficient.

Local agencies report that all three types of staff have the appropriate level of skills/experiences to provide both nutrition education and non-nutritional referral services. Exhibit III-8 summarizes the sufficiency of number of staff and staff skills by percentage of local agencies.

Exhibit III-8

Percentage of Local Agencies by Sufficiency of Number of Staff and Staff Skills

	More Than Sufficient	Sufficient	Less Than Sufficient
PROFESSIONAL			
Number of Staff	20	34	44
Nutritional Skills	43	45	9
Non-Nutritional/Referral Skills	36	52	9
PARAPROFESSIONAL			
Number of Staff*	5	25	27
Nutritional Skills	12	25	11
Non-Nutritional/Referral Skills	13	29	9
CLERICAL/SUPPORT			
Number of Staff	11	44	42
Nutritional Skills	17	37	12
Non-Nutritional/Referral Skills	20	51	15

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

* Only 51 percent of the local agencies have paraprofessional staff. Responses add up to more than 51 percent, because some agencies that have no paraprofessionals considered none to be sufficient.

Note: Excludes percent non-responding.

Staff Funding. Survey responses indicate that 90 percent of WIC staff are funded by the WIC program, and the remaining 10 percent are funded by non-WIC sources. The majority of local agencies (69%) reported that they were currently receiving more WIC funding for staff currently than in 1988. This is expected, since administrative funds increase when participation increases.

Almost half of the local agencies (47%) use non-WIC funded staff to some degree. Fifty-two percent of these agencies report that the level of funding for these staff has remained about the same since 1988, while 37 percent of these local agencies report an increase in funding.

Augmenting Staff. According to survey responses, 16 percent of the local agencies, serving 27 percent of the participants, reported that they use non-WIC funded medical providers to perform certifications. The use of contract or consulting staff to provide WIC services is found in 28 percent of the local agencies. This characteristic is more common among the larger agencies. In Long Beach, CA, most of the staff are either part-time (39 hours per week or less) or contract staff, because WIC staff are Long Beach City Health Department employees and the WIC Program budget cannot support the city's high fringe rate for full benefits. A 1987 site visit to Long Beach (Abt Associates, 1988) also reported a large number of part-time staff and the requirement that WIC follow the city's civil service procedures in hiring staff.

One-third of the local agencies cited an increase in the use of contract/consulting staff since 1988. This is a method for local agencies to fulfill staffing requirements during periods of growth and/or contraction.

Itinerant Staff. The use of itinerant staff at local agencies was commonly found, primarily in larger agencies and agencies with 50 to 100 percent growth since 1988. The majority of local agencies, 69 percent, use at least one itinerant professional staff member to travel from clinic to clinic, and 48 percent use at least one itinerant clerical/support staff. According to the survey responses, 42 percent of the local agencies increased the use of itinerant staff.

Based on case study site visit information, itinerant staff permit local agencies to offer more convenience to participants. The Temple, TX, local agency uses traveling staff teams who are responsible for operating multiple part-time clinic sites. At the Hudson, NY, local agency, all staff, with the exception of one or two individuals responsible for staffing the main office, travel several days each week to part-time clinics. The San Antonio local agency, which does not regularly assign staff to travel between clinics, will occasionally need staff to travel to other clinics to fill in for staff temporarily out of the office. These examples indicate that local agencies use itinerant staff to fulfill a variety of needs.

Staff Vacancies. The majority of local agencies (70%) cited that they did not have any vacant professional staff positions. Larger agencies cited more vacant positions than the smaller agencies. At 42 percent of local agencies, there were no vacant paraprofessional positions. Note that 49 percent of the local agencies do not use paraprofessionals; thus, the majority of agencies that use paraprofessionals do not have vacancies for this staff position. In addition, 73 percent of agencies did not have clerical/support vacancies. This information does not imply that local agencies do not perceive a need for additional staff, but there are no funded positions available. As noted earlier, 44 percent of local agencies perceived their current number of professional staff to be less than sufficient.

About one-half of the local agencies (52%) with vacant professional positions cited that it is difficult to recruit professional staff. Nearly three-fourths of the local agencies report about the same level of difficulty in recruiting staff now, compared to 1988. Agencies perceived much less difficulty recruiting for clerical/support positions (14% reported difficulty) and paraprofessional positions (15% reported difficulty). According to survey data, larger agencies find it more difficult to recruit professional staff. They also find it less difficult to recruit clerical/support staff and paraprofessionals.

The survey revealed that several barriers exist when attempting to fill staff vacancies. Fifty-eight percent of the agencies cited salary and benefits as the most problematic barrier. Shortages of certain types of staff are also problematic; 21 percent of the local agencies cited a shortage of nutritionists and 14 percent cited a shortage of dietitians as reasons for not filling vacant positions. Follow-up telephone conversations with local agency respondents revealed that many local agencies in rural settings confront difficulties attracting nutritionists and dietitians. This was also found to be the case during the case study site visits. Hudson, NY, which operates in a rural area, reported that it attempted to fill a nutritionist position for over 6 months before

finding a qualified candidate. Sixteen percent of the local agencies cited hiring freezes as the reason for not filling vacant positions.

Staff Retention. About one-third, thirty-four percent of local agencies, serving 47 percent of participants, report that retaining professional staff is difficult. Only 13 percent of the local agencies find it difficult to retain paraprofessional staff and 18 percent find it difficult to retain clerical/support staff. Salary and benefits are reported by 43 percent of the local agencies as a factor contributing to poor staff retention, and just less than one-third (32%) of the local agencies report workload as affecting retention. Low morale is cited by 18 percent of the local agencies as a factor contributing to high turnover, and 17 percent of the local agencies cite "staff attitude and turnover" as a factor that hinders high-quality WIC services.

Nearly two-thirds (65%) of the local agencies report no change in the level of difficulty in retaining staff positions since 1988. This characteristic is more prevalent among the smaller agencies.

The majority of local agencies perceived the staff at their agencies to be the primary contributor to high-quality WIC services. More than half (53%) of the agencies report that they have qualified, well-trained staff that contribute to high-quality services; 60 percent of the respondents attribute high-quality WIC services at their agencies to their staff. Staff turnover was perceived by 39 percent of agencies to be a barrier to providing high quality services.

V. Space and Facilities

Currently, only 23 percent of local agencies exclusively fund their space from their WIC budget, indicating that space is a major benefit of resource sharing for WIC. Approximately the same proportion of agencies fund their space exclusively by non-WIC government agencies or private sources. About half the local agencies receive funding from a combination of WIC and non-WIC sources for their space and utilities. Exhibit III-9 presents local agency funding sources. The availability of space and facilities to support the WIC Program, and the funding for such, was cited as a major area of concern for further growth of the WIC Program. If local WIC agencies' space requirements increase with caseload growth, they may need to seek increases in the level of non-WIC funding or devote more of their WIC funds to cover space costs.

Local agencies most often reported that WIC funding allocated by their State agencies for both space (41%, serving 29% of participants) and utilities (48%, serving 32% of participants) remained at about the same level in comparison to 1988. Local agencies serving a larger number of participants reported an increase in WIC funding for space and utilities more often than smaller agencies.

Exhibit III-9

Percent of WIC Local Agencies Reporting Funding Sources for Non-Labor Items

Non-Labor Item	Supported Exclusively by WIC Funds (%)	Supported Exclusively by Non-WIC Gov't Funds (%)	Supported Exclusively by Charitable Funds (%)	Supported by a Combination of Funding Sources (%)
Space	23	20	4	53
Utilities	24	19	5	52
Computer Equipment	54	10	less than 1	24
Medical Equipment	49	9	less than 1	38
Education Equipment	62	3	less than 1	34
Other	3	1	less than 1	4

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

Local Agency Equipment. According to survey responses, WIC most often exclusively funds equipment. As Exhibit III-9 indicates, 62 percent of local agencies exclusively fund educational equipment, 54 percent fund computer equipment, and 49 percent fund medical equipment exclusively from WIC grants. Many local agencies (49%) perceived an increase in the level of exclusive WIC funding for computer and education equipment over the last 5 years. The level of medical equipment funding was reported to have remained at about the same level by 46 percent of the agencies in comparison to funding in 1988. Large local agencies indicated an increased level of funding in these areas more often than smaller agencies.

While the local agencies are clearly less dependent on other funding sources for equipment than for space and facilities, a small proportion of local agencies rely exclusively on non-WIC government or private funding for equipment. The following list displays the percentages of local agencies receiving equipment that is exclusively funded by non-WIC sources. These figures combine both charitable and non-governmental sources as indicated in Exhibit III-9:

- Computer Equipment 11 percent
- Medical Equipment 9 percent
- Educational Equipment 4 percent.

Vans or Mobile Units. According to survey responses, 7 percent of local agencies, serving 11 percent of participants, reported using vans, mobile units, or other motorized facilities. Clearly, the majority of local agencies do not have this equipment; however, case study site visits revealed that there are agencies where this type of equipment is needed. Hudson, NY, an agency with 10 service sites located in a rural, sparsely populated area, expressed the need for a "WIC Mobile" to store and transport all WIC files, materials, and equipment needed at the agency's nine part-time sites. Agency staff explained to the case study team that they currently load and unload their personal vehicles when traveling to each clinic site. The agency director reported that the use of a van would create greater operating efficiency for the agency by decreasing the time staff spend loading files and supplies to transport to the next site. Conceivably this would free up staff time to devote to direct client services.

Adequacy of Space at Local Agencies. The Local Agency Survey included the following questions regarding space and facilities: "In your opinion, is your local agency's **current space** adequate for the number of staff, participants, and program responsibilities?" and "Do you think the adequacy of your space and facilities has changed since 1988?" The majority of local agencies (67%), serving 82 percent of the participants, perceive their current space to be inadequate. This perception is supported by the large number of respondents (65%) who indicated that high-quality WIC services were hindered by inadequate facilities and materials. These reports of inadequacy coincide with case study findings in which many staff cited concerns regarding waiting areas, space for individual and group sessions, and food instrument pick-up space. While this perception was more prevalent among larger agencies, small agencies also voiced this concern. For example, in Hudson, NY, the facilities lacked privacy for individual sessions, were not conducive to conducting group sessions, had crowded and/or chaotic waiting areas, and lacked adequate areas for children to play. At several of the case study sites, some nutrition counseling areas were too small to accommodate an observer from the study team.

Based on the mail survey response, 39 percent of the local agencies perceived a decrease in adequacy of their current space in comparison to 1988. The majority (72%) of local agencies reported making more efficient use of space over the last 5 years.

Elimination, Addition, and Movement of Clinic Sites. Sixteen percent of the local agencies, serving 30 percent of the participants, reported the elimination of clinic sites during the last 5 years. Elimination appears to be a characteristic of larger agencies. Observations from the case study at Wilkes-Barre, PA, support these findings. In the past 5 years, this large agency has consolidated several clinic sites in order to make agency operations more efficient. This was necessary because of the large geographic area covered and the growing number of participants served.

During the last 5 years, 48 percent of local agencies, serving 66 percent of the participants, reported that they moved to new facilities (Exhibit III-10). Forty percent of local agencies, also serving 66 percent of the participants, cite that they have added new facilities. It is interesting to note that 67 percent of the local agencies characterize their current space as inadequate. This indicates that, despite changes, facilities remain inadequate. It could also indicate that agencies have moved into new facilities or added sites that are less adequate than their previous sites. Of

the case study sites, 17 of 22 reported a change in space or facilities since 1988. Yet, most case study sites found their existing space to be inadequate. Some case study sites, such as York, PA, moved specifically to provide more space and privacy for WIC staff and participants. In other sites, such as Montgomery County, MD, changes in location reflect efforts to accommodate demographic changes in the county.

Exhibit III-10

Percent of Agencies and Participants by Specific Changes in Facilities

Specific Change in Facilities	Local Agencies (%)	Affected Participants (%)
Moved to New Clinic Sites	48	66
Added New Clinic Sites	40	66
Eliminated Clinic Sites	16	30
Made More Efficient Use of Space	72	78
Colocated with Health Care Provider	32	44
Other	less than 1	2

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

Staff interviewed at most of the 22 case study sites were concerned about space and their ability to grow further. Between 15 and 18 sites mentioned waiting room space, individual or group nutrition education space, or voucher distribution space as issues that might be problematic given future growth. For example, at the case study site in San Antonio, TX, the majority of this agency's facilities are colocated or receive space funding from other sources. As the program continues to expand, it is outgrowing many of its current facilities. Plans are underway to establish three new clinic sites. The program director reported that these sites will be funded exclusively by WIC funds. He indicated that this is an expenditure that the agency never really encountered until now.

Another example of this is the case study site in Atlantic City, NJ. This agency houses its clinics and administrative offices in space provided by the municipal government, which is the largest space the city government has available. This WIC site will soon exceed its current space (a situation noted by the WIC director and confirmed by on-site observation). Further expansion will mean seeking space from other sources and, for the first time, using WIC funds to rent space.

As the preceding discussion indicates, local agencies have undertaken various steps to increase their clinic space or use their current facilities in more efficient ways. While these efforts may have helped to absorb the caseload growth, there remains concern about the adequacy of their existing space to serve current caseloads or accommodate future growth.