



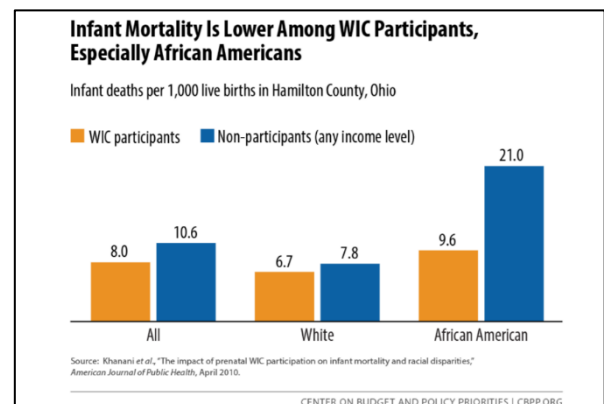
Reinvigorating & Reimagining The Pennsylvania WIC Program

May 16, 2019

The Special Supplemental Nutrition Program for Women, Infants, and Children, known as the WIC Program, has been a cornerstone in efforts to support the health of mothers and babies – physically, socially and mentally – for more than 40 years. By providing nutritious supplemental foods, breastfeeding promotion and support, education on healthy eating, and referrals to health care and critical social services, WIC not only helps to assure healthy pregnancies and birth outcomes for women, it also helps to assure healthy growth and development for infants and children up to age five.

Spanning a woman's pregnancy and continuing support to young children, WIC can be the front door for vulnerable families at critical times and in critical circumstances. It has the potential to reach families living near poverty, women with HIV or opioid or other substance use disorders, those with mental health issues or other complex health challenges, and teen mothers. Finally, many mothers who could benefit from WIC, particularly women of color, are also those who are most at risk for injury or death related to pregnancy; and whose children are more likely to be born prematurely and to die in infancy.

Decades of research have documented WIC's positive impact on birth weight, infant mortality, diet quality and nutrient intake, breastfeeding, cognitive development and learning, immunization, use of health services, and childhood anemia. A recent study found that children receiving WIC services are more likely than eligible children *not* receiving WIC services to eat vegetables, grains and fruits.¹ As shown in the graphic from the Center on Budget and Policy Priorities (CBPP)², infant



¹ Hammer et al, 2019.

² Carlson and Neuburger, 2015.

mortality is also estimated to be lower among WIC participants, particularly among African Americans.³ The program has achieved these outcomes while maintaining stable real per-person costs for the past 27 years, growing only with inflation.⁴

Despite its track record, the WIC program faces declining enrollment in Pennsylvania (as elsewhere in the US). This decline has resulted in budget cuts at a time when staff need to renew recruitment efforts. Declining enrollment has also challenged the program to reimagine and reinvigorate itself. WIC must find ways to make it easier and more relevant for families to participate through their children's fifth birthday. And it must find better ways to make WIC part of an integrated fabric of family supports. Siloed services are always difficult to navigate; for families struggling with poverty and health challenges, it can be impossible. As a stand-alone nutrition program, WIC's value, while important, is nevertheless limited. With the right community partnerships, creative programming, and the right branding and marketing, WIC can achieve a broader, more successful impact.

There is clearly a lot at stake in the Commonwealth. Caring for vulnerable moms and babies early can not only save lives but prevent the need for many services down the road. Mothers who are supported in the universally challenging experience of birthing and raising children are more likely to have the resources to give their children a good start in life. In turn, children who get a good start in life are less likely to fail in school, connect with the criminal justice system, or suffer health and mental health problems. And, healthy families create healthy communities.

Driven by a mission to make sure women have access to appropriate and effective health care for themselves and their families, the Jewish Healthcare Foundation established a supporting organization called the Women's Health Activist Movement Global (or [WHAMglobal](#)). In Pennsylvania, WHAMglobal is pursuing series of strategies in support of better maternity care for women.

We believe that the WIC program is unique in the opportunity it offers to make a permanent difference in women's lives as they form families. More than any other federal program, WIC focuses on nutrition education and breastfeeding in a context that can support personal relationships with families. Pennsylvania can be the best place for a woman to have a healthy baby, but there are important challenges to be overcome to make that happen.

Exploring WIC's potential is the purpose of this White Paper. Consultations with more than 20 people involved directly or indirectly with WIC (see Acknowledgements), analysis of participation data available from the USDA's Food and Nutrition Service, and an extensive literature on WIC provided information not only on the challenges facing WIC in Pennsylvania, but also on best practices from within the state and across the country. The White Paper concludes with a proposal for a partnership between the

³ Carlson and Neuberger, 2015.

⁴ Carlson, Neuberger and Rosenbaum, 2017.

Pennsylvania Health Funders Collaborative and the Commonwealth to reimagine and reinvigorate the Pennsylvania WIC Program.

The Pennsylvania WIC Program: Emerging Challenges

The WIC program is funded through the U.S. Department of Agriculture's Food and Nutrition Service, which makes grants to states and territories. States, in turn, select local contractors – usually nonprofit organizations, but also county governments – to manage WIC programs at the local level. In FY2018, Pennsylvania's Department of Health received approximately \$232 million, which it distributed to 24 local agencies in all counties which operate some 270 clinics around the state. Since 2008, between 27% and 32% of the total federal grant for WIC in Pennsylvania has paid for nutrition and breastfeeding professionals, equipment; program administration accounts for only 8% of the budget; and the rest – 68% to 73% – directly pays for food.

To be eligible, a family must be at nutritional risk and have an income less than 185% of

Pennsylvania Enrollment of WIC-Eligible Participants, 2014-2016			
	2014	2015	2016
Pregnant Women	36.9%	47.7%	51.9%
Postpartum Women	74.9%	62.1%	65.7%
Infants	78.2%	83.4%	93.2%
Children Age 1	68.4%	61.6%	58.8%
Children Age 2	47.8%	45.7%	43.5%
Children Age 3	39.0%	35.5%	38.1%
Children Age 4	23.2%	20.3%	20.9%
Source: USDA National- and State-Level Estimates of WIC Eligibility and WIC Program Reach in 2014; 2015; 105			

the federal poverty level (\$46,435 for a family of four, which may include an unborn child). An applicant who already receives SNAP (formerly food stamps), Medicaid, or Temporary Assistance for Needy Families cash assistance is automatically considered eligible. The value of food for the average WIC participant in Pennsylvania is approximately \$51 a month.

In FY 2017-18, 228,455 people participated in the PA WIC program each month, about half of whom were children. On average, Pennsylvania WIC reaches 49.9% of eligible individuals. There are variations within participant groups, however. Using most recently available data on the percentage of eligible people actually enrolled in WIC, Pennsylvania served slightly more than half of eligible pregnant women and 66% of postpartum women (See Table, above). Enrollment of eligible infants was substantially better in 2016 (93%, up from 78% in 2014), but fewer children age one through four than in 2014. (Note: The Appendix shows how Pennsylvania ranked among states showing most improvement in enrolling WIC-eligible participants between 2014 and 2016.)

The WIC program began in 1972 as a discretionary aid (not an entitlement) program. It has been fully funded since 1997 and its budget has been renewed annually with bipartisan support. This means that there are no waiting lists for services and the program can serve all eligible women and children. Nevertheless, WIC caseloads have fallen across the country and in Pennsylvania, after peaking in 2010 during the Great Recession. As of December 2018, the national annual average participation was 6,870,128 and the PA annual average was 218,188 according to the latest USDA data.

However, while it makes sense that program numbers would rise and fall during and after recessions, it is troublesome that not only is participation falling, but so too is the *capture rate*. This means that there are many women and children who are eligible to receive WIC services but who are not enrolled. The USDA estimates that only 60% of WIC-eligible families across the U.S. are participating in the program; and only about one-third of eligible four-year-olds participate.

Since funding is tied to participation, declining enrollment has meant reductions in federal WIC funding to Pennsylvania. The Commonwealth experienced \$2.8 million in funding cuts in FY2018 and \$1.5 million in FY2019. Further federal cutbacks are anticipated. This situation is expected to get worse, as the Trump Administration's 2020 budget proposes an overall 9% cut (11%, if adjusting for inflation) in non-defense discretionary programs (like WIC). The budget projects overall funding cuts in this category by 2029 to be 40% below 2019 funding (adjusted for inflation). The budget imperils programs like WIC, which must compete for funding with a variety of other discretionary programs. After the 2018 cuts, WIC programs across Pennsylvania reduced personnel and/or closed satellite offices – setting up a difficult Catch-22: increase participation, but with smaller staffs and fewer local offices.

Pennsylvania is working to improve WIC participation across the Commonwealth. In an effort to increase the participation of eligible women and children, the Governor's Blueprint for a Hunger-Free Pennsylvania has committed to pursuing the following strategies:

1. Increasing the redemption rate of WIC Farmers' Market Nutrition Program, whereby families have access to fresh fruits and vegetables from local farmers' markets
2. Expanding methods for getting information to people in the state about food assistance options, including WIC
3. Strengthening WIC's role in local agency provider networks
4. Making WIC services more accessible via expanded service hours, Electronic Benefit Transfer, and referral linkages to organizations already in contact with potentially eligible families (e.g., schools, Nurse-Family Partnership home visiting services, Head Start, CareerLink offices, the Department of Military and Veterans

Affairs' Family Service Coordinators, Migrant Service Coordinators, domestic violence service providers, and the medical community)

5. Expanding community opportunities to demonstrate healthy foods via WIC in partnership with the Culinary Institute

These methods align with many key national recommendations from the Center on Budget and Policy Priorities (CBPP) to streamline and simplify WIC clinical processes, improve methods for communicating with applicants and program participants, and strengthen collaboration with other service providers to find WIC-eligible women.⁵ In addition, national recommendations call for providing more accurate data and reports on participation and participation rates and enabling policy flexibility in WIC implementation.

Nevertheless, if the WIC program is to continue to be a premier nutritional program for low income families *and* become an essential part of broader efforts to support the health of women and young children, it will need to attract and retain more eligible families, and it will need to organize itself as part of a comprehensive support system for pregnant and postpartum women. These strategies are intertwined. Even the retention of older children is relevant to maternal *and* child health: *moms who remain in the program so that their two-, three- and four-year-olds can receive WIC services are also more likely to be with the WIC program on subsequent pregnancies.*

Linking WIC to Comprehensive Integrated Support

Beyond these important recommendations, linking WIC to comprehensive, integrated services should be considered seriously – not only as an outreach strategy, but as an opportunity to improve maternal health and reduce preventable deaths and morbidity. A mother who breastfeeds and refrains from smoking is contributing to her children's health; but, if she also lives in substandard housing, is the victim of intimate partner violence, spends two hours a day getting to a minimum wage job, can't afford quality child care, and has untreated hypertension and depression, she and her children will ultimately suffer. Holistic prevention strategies incorporate social, economic *and* physical & behavioral health supports to protect women's and children's lives.

Successful, comprehensive programs that embrace women and children throughout a woman's perinatal period and beyond exist in countries like Australia where midwives conduct a comprehensive prenatal assessment in the 20th week of pregnancy and initiate wraparound services for six weeks to up to one year postpartum, depending on mother and family risk level. Supporting maternal-child attachment is a serious program goal, and parenting training and mental health assessments are built into childbirth classes and home visits.

The American reality is that vulnerability to poverty, disease, health crises, violence, under and unemployment is unequally distributed as a result of "a toxic combination of

⁵ Ambegaokar, Neuberger and Rosenbaum, 2017.

poor social policies, unfair economic arrangements, and bad politics."⁶ As bad as overall American maternal and infant morbidity and mortality rates are, and as challenging as the exposure to HIV and opioid addiction is, with situation is many times worse among poor women, and among women and children of color, especially African Americans, where implicit bias and even explicit racism make the healthcare system even more dangerous.

The WIC program can be an indispensable front door for connecting women to a range of supports – from preparing for childbirth and parenting to helping them advocate effectively on their own and their children’s behalf in hospitals and at doctors’ offices to getting needed health, mental health and social services.

The challenge is that many WIC offices are siloed in their focus on nutrition. Although WIC programs are committed to developing robust referral networks and making appropriate health and social service referrals, the standard WIC intake assesses a limited range of potential needs, and the typical 15-minute appointment rightly necessitates a tight focus on nutrition.

Moreover, funding levels are so tight that only programs that can supplement their WIC services with grant funding can do much more. Beyond lack of convenient access, this may help explain why the program’s value to participants declines as children move out of infancy and the value of subsidized infant formula wanes. This represents not only a missed opportunity to improve children’s health, but also an enormous missed opportunity to support mothers on their subsequent pregnancies.

Despite these logistical and budgetary challenges, a number of WIC programs in Pennsylvania and elsewhere are proactively connecting their participants to other needed, wraparound services. For example, about a quarter of WIC offices in Pennsylvania are co-located or have formal referral arrangements with a range of services critical to family health and safety (e.g., Healthy Start, Inc., Head Start, Nurse-Family Partnerships, medical practices, substance abuse counseling).

In others, the WIC program is part of an array of in-house programs. For example, WIC is part of the MFHS Circle of Care in Scranton which provides comprehensive care for women and children’s health care, including maternity and reproductive health care, and cancer screening. MFHS also houses Healthy MOMS to support pregnant women and moms in addiction recovery. Universal screening enables referrals across a network of health and nutrition centers in 16 PA counties. MFHS features early intervention, care coordination and continuity, with a comprehensive package of services including medical, nutrition, and social services that are tailored to meet individual needs.

Similarly, The Foundation for Delaware County manages a WIC program together with Healthy Start, Inc., a home visiting Nurse- Family Partnership, Cribs for Kids, a Center for Hispanic Resources, substance use prevention services, and Title X services at a school-based health resource center. Universal assessments ensure that income-eligible families can be enrolled in the programs they need and want. One program

⁶ World Health Organization, 2008.

takes the lead in connecting the client to all other internal and external resources to address the client's global needs.

Finally, the Commonwealth is considering changes to its WIC contracting process that would favor local WIC program that are part of ob-gyn and/or pediatric practices (although there is currently no research evidence that favors particular WIC locations). All of these strategies, to varying degrees, can make for silo-breaking opportunities to offer a continuum of care to women and children.

Enrollment & Comprehensive Care: Intertwining Challenges

Declining budgets and enrollment, and the need to connect WIC to comprehensive services, are ultimately intertwined challenges. While acknowledging that federal funding levels are clearly influenced by political considerations, without enrolling more eligible women and children, state and local WIC budgets will continue to shrink. Moreover, the program's biggest cash value to families occurs in the first year of an infant's life with significant subsidies on infant formula, making ongoing enrollment in the program as it's currently structured less valuable.

Despite its undeniable benefits, it is complicated to enroll – and remain enrolled – in WIC and, at least until electronic benefit transfers have been instituted, it is difficult to use the benefits in grocery stores. Enrolling more eligible women means getting the word out about WIC services and making enrollment and ongoing participation both easier and perhaps more valuable. It also means offering services considered to be valuable to families that are even more likely to be stressed than 'average' American pregnant and postpartum women.

In the next sections we identify states whose WIC programs have had outstanding track records in enrolling eligible women and children and highlight best practices that may contribute to that success.

Outstanding States in Enrolling Eligible WIC Participants

There are variations across states in enrolling WIC-eligible women and children that may point to best practices and improvement opportunities. If Pennsylvania data had been available – at the county level, or by WIC local office – we would have been able to share best practices and characteristics of local WIC programs that have been especially successful. Unfortunately, such data are not available. We instead, focused on the most successful states in the U.S., and explore their best practices.

The USDA annually publishes national and state estimates of WIC eligibility and WIC program reach – for each of the WIC-eligible population groups (pregnant women, postpartum women, infants, and children age 1, age 2, age 3 and age 4). The 2019 report provides data for 2016. Reports from 2014, 2015, and 2016 (the most recent data covering WIC population groups) allowed us to rank U.S. states by their success in enrolling eligible participants.⁷

	Top 5 States in Enrolling Eligible Women in WIC, 2014-2016						
	Pregnant Women Rank (% Served)				Postpartum Women Rank (% Served)		
	2014	2015	2016		2014	2015	2016
Alabama		1 (56%)	2 (64%)				
Alaska		3 (54.5%)					
California	2 (63%)	2 (55%)	4 (59%)		4 (84%)	4 (77%)	5 (84%)
Connecticut			5 (58%)				
Delaware		1 (56%)					
Georgia					2 (91%)	2 (83%)	3 (85%)
Kentucky	3 (61%)	4 (53.2%)					
Louisiana						3 (80%)	5 (83%)
Maryland	1 (67%)	5 (53%)	1 (74%)		3 (88%)		1 (99%)
Michigan		5 (53%)					
Minnesota	5 (56%)				5 (83%)		
Nevada							3 (85%)
Oklahoma	4 (60%)		3 (62%)				
Rhode Island			4 (59%)				
South Carolina						5 (74%)	
Texas					1 (94%)	1 (88%)	2 (97%)
Pennsylvania	37%	48%	52%		75%	62%	66%
US Average	50%	46%	50%		73%	69%	76%

⁷ U.S. Department of Agriculture. National and State-Level Estimates of WIC Eligibility and WIC Program Reach, 2014, 2015, 2016.

We focus first on state success in enrolling pregnant and postpartum women. The table above highlights the 16 states that ranked between 1st and 5th nationally in 2014, 2015 and/or 2016 in enrolling eligible pregnant and postpartum women in WIC.

Several states stand out:

- Maryland ranked 1st in the nation in 2016 in its enrollment of pregnant and postpartum women – and ranked in the top five in five of the six time periods. In 2016, the state's WIC program enrolled an incredible 99% of eligible postpartum women and 74% of pregnant women.
- California consistently ranks in the top five across all years and for both pregnant women and postpartum women.
- Texas was only slightly behind Maryland, enrolling 97% of postpartum women in 2016.

It turns out that many of the states that successfully enrolled eligible women also successfully enrolled eligible children. As the following two tables show, Maryland and California again topped the national ranks in enrolling children:

- California was among the top five states in enrolling children aged one through four.
- Maryland (together with Ohio and Rhode Island) ranked 1st in enrolling infants and 2nd in enrolling two-year-olds.
- Vermont was 2nd in enrolling one-year-olds, and three- and four-year-olds.

WIC Eligible Infants, 2016			WIC Eligible Children Age 1, 2016		
Top States	Percent Served	State Rank	Top States	Percent Served	State Rank
Maryland	100%	1	North Dakota	79.9%	1
Ohio	100%	1	Vermont	76.2%	2
Rhode Island	100%	1	California	68.3%	3
Louisiana	97.5%	2	New York	66.7%	4
Nevada	94.3%	3	Rhode Island	66.6%	5
Oklahoma	94.1%	4			
Delaware	94.0%	5			
Pennsylvania	93.2%	9	Pennsylvania	58.8%	19
US Average	85.9%		US Average	59.2%	

WIC Eligible Children Age 2, 2016			WIC Eligible Children Age 3, 2016			WIC Eligible Children Age 4, 2016		
Top States	Percent Served	State Rank	Top States	Percent Served	State Rank	Top States	Percent Served	State Rank
Vermont	67.3%	1	Rhode Island	58.2%	1	California	44.7%	1
Maryland	65.2%	2	Vermont	58.2%	2	Vermont	43.4%	2
North Dakota	61.4%	3	California	55.8%	3	Hawaii	37.5%	3
California	59.9%	4	Minnesota	54.9%	4	Washington	36.6%	4
Minnesota	56.0%	5	Oregon	51.8%	5	Oregon	36.3%	5
PA	43.5%	30	PA	38.1%	25	PA	20.9%	39
US Average	47.4%		US Average	42.1%		US Average	26.5%	

Recognizing that more recent data may highlight other states, in the next section we explore characteristics of the Maryland and California WIC programs, and highlight a few others that demonstrate innovative efforts to improve WIC relevance, convenience/access, and effectiveness (from the perspective of women's health).

Best Practices in Outstanding States and Beyond

Recognizing that overall participation in the WIC program since 2016 has declined in Maryland and California, as it has nationally, we share some promising WIC practices in these states. Both have made concerted efforts to improve outreach, enrollment and ongoing WIC participation; we briefly describe some of these strategies. Beyond these examples, we focus on models – in California, Maryland and elsewhere – that seem mostly likely to enable WIC to be part of efforts to address maternal mortality. These include:

- Services, supports and/or information – beyond nutritional and breastfeeding support – that can help to retain women in the WIC program as their children age (increasing the odds that they will be already enrolled in WIC during subsequent pregnancies)
- Program provisions or linkages that provide women access to a network of comprehensive, integrated services, including WIC efforts explicitly related to maternal mortality

Making Outreach, Enrollment and Engagement/Retention Easier

While outreach strategies can be customized in accordance with the socio-demographic characteristics of the participants in particular WIC programs, implementing high-level strategies for finding eligible families is critical. For example, families eligible for Medicaid, SNAP, and TANF are automatically eligible for WIC in most states; however, using this information to link Medicaid, SNAP, and WIC data systems requires overcoming information-sharing and privacy obstacles. Nevertheless, there are practical strategies for pursuing these arrangements⁸; and, multiple states are working to link their Medicaid, SNAP, and WIC data systems.

In Maryland, Medicaid is required to refer families who are potentially WIC-eligible to the WIC program; WIC then makes contact, while respecting federal information-sharing regulations. Similarly, Vermont WIC receives a list of Medicaid eligible children from the state's department of health for follow-up outreach to the families. With guidance of the Benefit Data Trust, Colorado began piloting in September 2018 a texting service to SNAP enrollees in six counties who have children under age five encouraging them to apply for WIC. Although California is actively exploring ways to integrate multiple federal programs (including WIC), information-sharing is not yet a reality. Nevertheless, the state analyzes Medicaid data and provides to local WIC agencies 'hot spot' maps of small geographic areas in which there are a lot of WIC-eligible people so that targeted outreach strategies can be deployed.

The Center on Budget and Policy Priorities' 2017 paper on modernizing and streamlining the WIC program provides a comprehensive set of strategies for improving enrollment and engagement. Here we highlight several efforts shared by our contacts primarily in Maryland and California.

- Maryland WIC employs an auto-dialer system which contacts a family the day before a scheduled appointment (by text or phone call, depending on participant's preference). The family can also cancel the appointment on that call, freeing up staff time to make other follow-up calls – including to all participants who missed appointments.
- To enable immediate receipt of WIC benefits, Maryland WIC provides a short-term, one-month WIC certification for a family who can't provide all of the many required eligibility documents on the first visit. It also utilizes its MIS to keep track of and remind families when the short-term certification is about to expire (preventing the family from having to start the enrollment process over again).
- In both Maryland and California, families can choose WIC program sites if, for example, a location near their job is easier than a location near home. In addition, clinics offer flexible scheduling, including weekend and evening hours. In both states, walk-ins are accepted.

⁸ Ambegaokar, Neuberger and Rosenbaum, 2017.

- In California, there are grocery stores in which more than 50% of sales are made by WIC participants; these stores specialize in WIC food so there is no confusion about what to buy. Often they are located next to WIC clinics. Although these stores make up about 10% of stores, they account for 40% of WIC transactions statewide.
- Online nutrition education is available in both states. In Maryland, online nutrition education is available for low-risk participants, obviating the need for a clinic visit to receive education that is mandatory for ongoing receipt of benefits. Some local WIC programs are also using texts to send nutrition information. Likewise, the largest WIC program in California (and in the country) is PHFE WIC, a program of Heluna Health, serving nearly 200,000 participants (approximately the number of Pennsylvania's WIC participants). PHFE WIC provides online nutrition education programs in four modules (prenatal, breastfeeding, infants, family).
- Maryland WIC implemented a mobile WIC app to help make grocery shopping easier. Participants can scan items to see if they are covered by WIC (rather than having to ask the cashier at checkout). A participant can also send a request, via the app, that a particular food item be considered for future WIC inclusion. (Pennsylvania recently launched the same WICShopper mobile app.)
- California WIC has provided staff training in two areas that WIC leaders believe have improved the program. First, a number of years ago, the program overhauled its approach to nutrition education by replacing long dietary questionnaires and classroom-type education with motivational interviewing and participatory approaches to education. More recently, all staff received training in baby behavior – extended in the last year and a half to include training about behavior issues related to feeding older infants and toddlers. (The training is now a requirement for all new staff.) Staff reported increased knowledge and confidence in supporting moms. The program is modeled on an Arizona WIC program which found that implementing sites had better retention of mothers, reduced maternal stress, and altered parenting styles.⁹
- It shouldn't be hard for mothers or caregivers to get children to *want* to go to WIC appointments. Maryland: works to make clinics clean, appealing, and friendly. In addition, it has replaced finger sticks for hemoglobin testing with a non-invasive test, to decrease children's fear of going to the WIC clinics. More ideas for making WIC clinics inviting for children (and by extension to their mothers) may be found in a guide prepared by Nevada WIC.¹⁰
- Georgia: The WIC program in Georgia began utilizing telehealth services ('teleWIC') in county health departments and WIC clinics in 2011, enabling staff, including the breastfeeding coordinator who can connect to women to provide lactation education and individual and group nutrition services. There are also

⁹ Arizona WIC Training Baby Behavior Course.

¹⁰ Nevada WIC, Engaging Children, 2013.

“breastfeeding bootcamps” offering six 30-minute workshops on all aspects of breastfeeding. Additional states using telehealth include Arizona, Texas, Nevada, Mississippi, West Virginia, Virginia, Oregon, and Massachusetts.

Connecting WIC to Comprehensive, Integrated Care

Despite severe time constraints (typical WIC clinic visits are scheduled for 15 minutes) and limitations of the WIC assessment tool for uncovering a variety of health and health-related family issues, the WIC Program emphasizes its mission to provide referrals to health and other services. It does this by negotiating MOUs with referral agencies, conducting multi-agency staff trainings, co-locating its program with related organizations (e.g., Head Start, community centers, medical practices) and/or bringing a WIC Program in-house, together with a variety of other maternal-child health programs (e.g., the Foundation for Delaware County in Pennsylvania).

For example, the structure of Maryland’s WIC program may at least partially explain its success. Fifteen of the state’s 18 district programs are located in health departments; two are part of FQHCs, and one is operated as part of the Johns Hopkins Health System in Baltimore. With the exception of very small local health departments, all of its WIC offices are located or have easy referral relationships with a multitude of other health and social services.

California: PHFE WIC has offered enhancements to core WIC services, although these are typically time-limited and grant funded, and include or have included parenting cases and support groups, a prenatal alcohol prevention and interconception care, and an early childhood literacy and cognitive development program offered in 10 WIC sites in Los Angeles County (serving more than 60,000 participants) called *Little by Little*. In addition, PHFE WIC piloted a program that helped parents discuss their child’s health and development with their doctors called *Talking with Your Doctor*. Pediatricians trained WIC nutritionists to conduct classes with WIC parents. The program may be a model for helping pregnant and postpartum women talk with their obstetric providers.

Maryland: Like many WIC programs across the country, Maryland WIC offers a Breastfeeding Peer Counselor Program. The program helps to establish strong support and rapport with WIC families; and is often the only place families can go for free breastfeeding support. This peer counselor program may hold promise as a more broadly-targeted Community Health Worker strategy.

Texas: WIC is participating as subject matter experts together with 100 other stakeholder organizations as part of a non-profit coalition called the Health and Wellness Alliance. Incubated by the Children’s Health System of Texas, its goal is to build “beyond the medical home into the broader health neighborhood,” taking on the health of children in surrounding counties with inadequate food and nutrition. To the extent that the program brings more eligible families into WIC, it increases the opportunities to improve mothers’ health as well.

Comprehensive Care and Maternal Mortality

Because maternal and infant mortality are critical problems in the US, we highlight here several examples of WIC involvement in this issue. The WIC program has been part of collaboratives that seek to address the multiple reasons underlying both maternal and infant mortality.

Ohio: For example, WIC has been part of Cradle Cincinnati, a program initiated by physicians at Cincinnati Children's Hospital, but built in collaboration with the community residents and providers, to reduce infant mortality. Resources are available for both moms and the agencies that seek to ensure that women get the support they need (including WIC services) during the entire perinatal period. Among its many activities, Cradle Cincinnati works to create calming spaces for moms and babies – a goal that motivated a team of interior designers to donate their services and materials to transform a WIC clinic in one neighborhood.

The National WIC Association (NWA), a policy and advocacy organization working on behalf of WIC, has noted that, in serving almost two million low-income pregnant and postpartum women each month, WIC “has an indispensable role to play in helping mothers recognize key factors associated with maternal and infant mortality”.¹¹ To explore WIC's role – especially in protecting black women and children – the NWA organized a one-day conference on maternal mortality in September 2018 and, building on the conference, convened a Task Force on Maternal Mortality early in 2019.

The Task Force's mission is “to examine available evidence regarding WIC participation and maternal mortality to identify promising practices for helping to address the issue in WIC;” its recommendations will be presented in a forthcoming position paper. In particular, it will examine ways through which “referrals and education around birth” can be provided in WIC appointments to increase knowledge surrounding maternal mortality. Given the unequal rates of infant and maternal mortality, the NWA is particularly concerned about reproductive and birthing justice.

A session at NWA's April 2019 annual conference, “How WIC Can Make Progress Against Maternal Mortality” highlighted some compelling models:

New Jersey WIC is part of a coalition of organizations working to reduce the state's particularly high and unequal rates of infant and maternal mortality (black infants are three times more likely to die than white infants, and black women four times more likely to die from pregnancy-related complications as white women). Championed by New Jersey First Lady Tammy Murphy, The Healthy Women Healthy Families (HWHF) Initiative awarded grant funding to six maternal and child health agencies across New Jersey. Each is now working with many partner organizations, including WIC.¹²

The aim of HWHF is to provide “a collaborative coordinated community-driven approach” to care, using Community Health Workers and a Central Intake Hub – a

¹¹ Eppes and Dittmeier, 2018

¹² New Jersey Department of Health, 2018.

single point of entry for referrals to community resources. Participating organizations complete, with their program participants, a simple one-page *initial referral form* that acts as the front door for referrals to a broad range of community resources, medical care, home-visiting programs, doula programs, CHWs through HWHF and social support agencies – spanning preconception, prenatal, interconception and postpartum care, and case management services.

Arizona WIC is part of a statewide Severe Maternal Morbidity and Mortality partnership, sponsored by the Arizona Department of Health, March of Dimes and the Arizona Perinatal Trust. Its immediate goal is to initiate the application process for the Alliance in Innovation on Maternal Health (AIM) which promotes standard practices for safe maternity care.

In one of the earliest collaborative efforts to involve WIC in addressing maternal mortality, WIC was involved beginning in 2008 with the American Indian Health Commission for Washington State to develop *Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan* in December 2010.¹³ Pregnancy-related deaths and infant mortality are much higher for American Indians/Alaskan Natives in the state. The plan set a foundation guiding state agencies to see the tribal population's maternal and infant health as symptoms of adverse childhood events, discrimination, historical and intergenerational trauma, trauma-informed care, toxic stress, epigenetics data and data misclassification, and tribal food sovereignty. The plan called for, among other things, concerted efforts to integrate tribal with federal and state programs, to prepare staff culturally, and to increase efforts to enroll eligible families in WIC.

¹³ American Indian Health Commission for Washington State, 2010.

Reimagining & Reinvigorating WIC in Pennsylvania: A Proposal for a State-PHFC Partnership

The months during and immediately after pregnancy and childbirth are critical for mom and baby; early childhood is critical for the whole family. If all goes well, a lifetime of health and productivity are possible. If a family fares poorly, there is preventable suffering, distress, and cost. Caring for vulnerable moms and babies early can prevent the need for many services down the road. With good reason, Governor Tom Wolf proclaimed May as WIC Month. Spanning a woman's pregnancy and continuing support through early childhood, WIC can reach vulnerable families at critical times and confronting critical health, economic and social circumstances.

Although the services offered by WIC are determined by federal law, states vary in the creativity and skill with which they reach out to eligible families and manage their programs. In Pennsylvania, the program faces declining participation: only half of those who are eligible to receive WIC services are actually enrolled in the program. Further, without comprehensive and robust relationships with other programs and services that support mothers and young children, the value of WIC begins to decline after an infant reaches her first birthday – making the program's challenging enrollment rules and the stigma some feel harder to bear.

We can protect Pennsylvania mothers, babies and young children much better. Funders from the Pennsylvania Health Funders Collaborative (PHFC) share concerns about reducing maternal and infant morbidity and mortality, enhancing mother-baby attachment, ensuring both mother and infant physical and mental health. They recognize now that many families could be dramatically helped with early intervention and with efforts to personalize approaches depending on specific family challenges (e.g., addiction, homelessness, AIDS, etc.). PHFC stands ready to help, but progress and improvement depend on vigorous leadership from the Governor and at the highest levels of the Departments of Health and Human Services.

Together we can learn from best practices in other states, and even in other countries! We can make WIC a beneficial program for all young families. Even without significant new resources, the Wolf Administration can leave its mark on WIC, making it one of the most important programs for a successful pregnancy and early child development

The Commonwealth has a lot at stake. Children who get a good start in life are less likely to fail in school, enter the criminal justice system, or experience health and mental health crises. Appropriate support goes beyond nutrition. The WIC program may have limited resources but, with the right community partnerships, with creative programming, and with the right branding and marketing, WIC can achieve a broader, more successful impact. Reimagining and reinvigorating this effective program will take a broader vision, momentum from the "top" of government, new partnerships, and empowered staff.

Here's how we can get started:

Shore Up the Program

Because Pennsylvania's WIC enrollment has been steadily declining, this year the state is receiving \$3.7 million less than in FY 2014. This downward decline in federal WIC funding can be turned around if Pennsylvania invests limited, one-time state funds to modernize the WIC program and support outreach. This would result in increased federal funds for next year.

We recommend an investment of \$7.5 million in state funds for FY 2019-20. This will allow WIC providers to staff up to FY 2014 levels, increase outreach and enrollment to get back to FY 2014 federal funding levels, and link families to robust services networks. Without this infusion of funds, our WIC program will continue to hemorrhage federal funding and lose WIC enrollees, needlessly resulting in unnecessary health challenges and costing the state hundreds of millions dollars in the future.

With this funding, PHFC will work with the DOH to initiate action at the state and regional levels:

Initiate Action at the State-Level:

1. DOH and DHS leaders, with support from PHFC, convene a strategy planning session to identify and engage key partners and stakeholders (including WIC families) who will create a roadmap for modernizing the WIC program in Pennsylvania. Bring model programs and best practices from around the country for working with specific populations and work with PA WIC to inform the development of the roadmap.
2. DHS and DOH make inter-agency data sharing possible in order to target outreach efforts and increase enrollment.
3. Stimulate a branding and messaging campaign to reduce WIC stigma, positioning participation in WIC as an emblem of maternal strength and providing the best for the baby
4. Revisit the design and 'child-friendliness' of WIC centers. Parents whose children want to go to the WIC clinic may be more likely to remain engaged as their infants become young children. Clinics that are clean, appealing to children and friendly help. Including a play area and perhaps a toy-lending library may not only attract children, but also create informal socializing and learning opportunities for parents.

Initiate Action at the Regional-Level:

5. Engage (and inform) WIC providers on how to extend the reach of their services through strategic partnerships.

6. Design, at the regional level, a model of an integrated, comprehensive service network for different populations.
7. Enact multiple strategies to reduce the burden of participation for already-extended families – from flexible hours, walk-in appointments, automatic phone reminders, teleWIC, and online nutrition education to reduce the need to make frequent clinic visits
8. Provide training opportunities for staff on how to deliver best practice care for different populations, including connections to appropriate community services.
9. Activate volunteer networks of moms (based on excellent models) to provide support and friendship to new mothers.
10. Train WIC Breastfeeding Peer Counselors on Community Health Worker functions (e.g., helping women and children enroll in other programs, serving as a liaison between the community and agencies, and advocating for the health of the individual and community).
11. Actively engage a network of healthcare providers (e.g., pediatric practices, FQHCs, clinics), and community agencies (e.g., Healthy Start, Head Start, Nurse-Family Partnerships, Family violence counseling agencies, and substance abuse services) to understand and support WIC.
12. Experiment with new models of service delivery, such as group/peer support sessions, volunteer matching, and home-visiting.

The evidence that WIC works is abundant and consistent: this cost-effective, decades-long program has a consistently positive impact on mothers, babies and young children. Our job as concerned community members, funders and public servants is enviable: to ensure that eligible families know about and can participate in a responsive WIC Program integrated with a mosaic of mother and family supports. With state leadership, we are prepared to step up and help.

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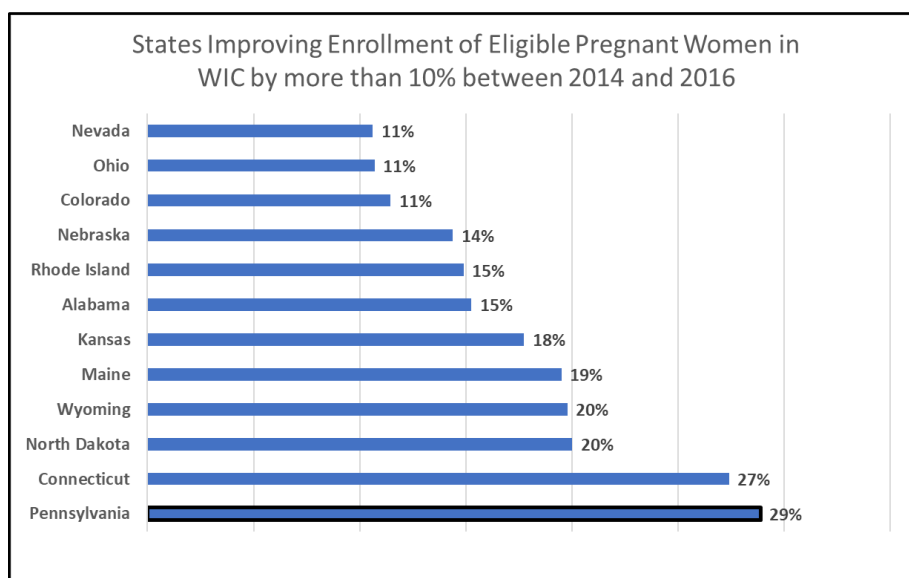
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APPENDIX

Changes in Pennsylvania Enrollment of Eligible Women, 2014-2016

Pennsylvania was first in the nation in the level it improved its enrollment of eligible pregnant women between 2014 and 2016. On the other hand, the Commonwealth's enrollment of eligible postpartum women dropped by 14.1% between 2014 and 2016 – the third largest decline in the country.



Number of States Improving between 2014 and 2016				
	Number of states improving	Avg change	States with Biggest improvements	
Infants	40	-6.9%	29%	Wyoming
Age 1	17	-15.2%	41%	N Dakota
Age 2	25	-1.5	34%	N Dakota
Age 3	24	-0.2%	26%	S Dakota
Age 4	21	2.3%	36%	Oklahoma
Pregnant	25	0.2%	29%	Pennsylvania
Postpartum	37	4.2%	37%	Wyoming

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