2. Collaboration promotes health goals

By working together, WIC and managed care organizations contracted with Medicaid can promote better health outcomes for jointly enrolled low-income pregnant and breastfeeding women, infants, and children. For example, MCOs encourage early initiation of prenatal care and compliance with obstetrician recommendations, as do WIC programs. Managed care organizations also seek to increase early childhood immunization rates, and WIC programs provide immunization referrals for infants and toddlers who are not up to date. Collaboration between managed care organizations and WIC has the potential to make breastfeeding promotion initiatives more effective by improving outreach and reinforcing educational messages and services such as lactation consultation. Finally, recent studies and guidelines on early childhood nutrition highlight the need to reduce childhood obesity and educate mothers about infant feeding, an objective that no single program can easily achieve.

WIC can also work with health care providers and public health agencies to achieve national health objectives related to maternal and child health and nutrition. Many of the Healthy People 2010 objectives relate closely to WIC’s mission to assure adequate nutrition for pregnant women, promote breastfeeding, and teach healthy eating habits to mothers with infants and young children. All of the objectives listed in Table 2 are consistent with WIC food benefits and educational activities. Local WIC agencies reinforce the messages given by primary health care providers and public health clinics to their patients.

The following sections describe specific ways in which WIC agencies can work collaboratively with health care to promote healthier outcomes for low-income women, infants, and children. Copies of forms and materials developed by WIC agencies and managed care organizations appear in the final section of this document. Table 3 summarizes the roles of WIC agencies, managed care organizations, and managed care providers for each health objective.

**Enhance prenatal care and decrease likelihood of low birthweight**

There is a well-documented relationship between prenatal care and higher birthweight and lower risk of preterm delivery. Prenatal care ideally includes three important
Low birthweight (LBW) is still a significant problem in the United States. It affected 7.6 percent of all births in 1998, and 13 percent of births to black women. Women with incomes below poverty level and low educational attainment are also at increased risk of having LBW babies. Low birthweight, defined as a birthweight of <2500g (5.5 pounds) is an important public health issue because of the relationship between LBW and infant mortality. LBW is also associated with increased risk of neurological problems, mental retardation, and lower respiratory tract disorders later in a child’s life. In addition to its relationship with infant mortality and morbidity, LBW’s cost to the health care system is significant. In one study medical costs for very low birthweight infants (<1500g) in the first 60 days of life were 9 to 12 times those of normal weight infants (2500+g).

WIC participation has been shown to be associated with reductions in low birthweight. A 1992 GAO report estimated that, for infants born in 1990, provision of WIC services could produce over $423 million in savings to private payers and hospitals, three-fourths of which would accrue in the first year of life. These reductions are due to a lower rate of preterm births as well as lower incidence of small-for-gestational age infants. Women who enroll early in WIC receive the maximum benefit from the food packages provided each month, as well as from the nutritional counseling and education initiated at the first WIC visit. Low birthweight is also associated with maternal behaviors such as smoking, which is one of the risk factors flagged by WIC programs for education and counseling. Women enrolled in Medicaid who are at high risk for low birthweight, and who receive perinatal high risk case management services within a managed care organization, should also be referred to WIC.

Low-income women, such as those served by WIC and Medicaid, and women with limited educational attainment may benefit substantially from early commencement of prenatal care and any associated interventions that can reduce risks to mother or fetus. Prenatal participation in WIC enhances the benefits of early prenatal care for this population. WIC visits reinforce the health promotion messages delivered by health care providers, and alert pregnant women to potential risks or topics they should discuss at their next prenatal care visit. For example, prenatal care providers can refer women at high risk for developing eclampsia or gestational diabetes to the WIC nutritionist for extra counseling about ways to reduce salt or sugar in their diets.
Collaboration between WIC and Managed Care

Perinatal case management is another effective way to improve birth outcomes for women in this population, and women participating in WIC are more likely to receive case management services.\(^ {45} \) A study of a Medicaid-sponsored support service and case management program showed a reduction in low birthweight births among medically high risk women.\(^ {46} \)

Close coordination between WIC and Medicaid managed care organizations can potentially increase the number of women who receive adequate, timely prenatal care through reinforcement of positive health messages and cross-referrals. When pregnant women enroll in WIC before their first prenatal visit, WIC staff routinely offer assistance and encouragement to make sure that they complete their application for Medicaid and obtain an appointment with a prenatal care provider. Similarly, managed care organizations and prenatal care providers need to make sure that all potentially eligible women are referred to WIC and that medical information reaches WIC clinics. Creation of direct links between WIC and the perinatal case management units of managed care organizations can help ensure that women who are at greatest risk for poor birth outcomes are identified and receive needed services.

**Partnerships to enhance prenatal care and reduce the likelihood of low birthweight call for each program or provider to play a role, such as:**

| **WIC** | • Refer uninsured participants to Medicaid and/or SCHIP.  
• Refer participants to managed care enrollment brokers or MCOs as appropriate.  
• Refer participants to perinatal programs for high risk pregnancies, as appropriate.  
• Refer participants to community-based services. |
|---------|--------------------------------------------------|
| **MCO** | • Provide free pregnancy tests and referrals to prenatal care.  
• Conduct orientation sessions at WIC sites.  
• Analyze delays in processing Medicaid applications.  
• Provide case management and home visiting.  
• Share patient information with WIC. |
| **Health Care Provider** | • Refer to WIC if not already enrolled.  
• Refer to WIC for nutritional counseling.  
• Communicate with WIC about nutritional needs of high risk patients. |
Coordination between WIC and health care providers both encourages early prenatal care and helps to reduce delays in processing Medicaid applications and contingent enrollment in managed care plans. In Solano County, California, the Partnership Healthplan of California (PHC) provides the Growing Healthy Together case management program. This program assists PHC members to access early prenatal care through California’s Comprehensive Perinatal Services Program (CPSP) and thereby secure a WIC enrollment appointment. The PHC Growing Healthy Together Program also promotes WIC attendance. PHC and WIC staff are on many committees together to network and coordinate services. In Massachusetts, some WIC sites are located at provider clinics where most patients are enrolled in Medicaid managed care. Prenatal care clinicians encourage pregnant women to visit WIC on the same day of their clinic appointment. The clinicians also give the clients a special referral form indicating all known risk conditions.

**Improve maternal nutrition**

Many WIC participants have inadequate diets or nutritional and health concerns such as obesity, diabetes, and hypertension prior to pregnancy. Poor nutrition during pregnancy is associated with lower gestational weight gain, maternal anemia, neural tube defects, and gestational diabetes, all of which may affect birth outcomes. Anemia during pregnancy is a common and significant problem linked to low birthweight and preterm delivery, though a causal relationship has not been established. Women enrolled in WIC or in Medicaid are at even greater risk for anemia during pregnancy, as approximately 33% of all pregnant low-income women are anemic. WIC staff assess risks to pregnant women for conditions that can be modified through changes in diet and then develop individual care plans. WIC also helps postpartum participants to lose weight by promoting breastfeeding and dietary changes. Although WIC services do not include intensive dietary counseling or “medical nutrition therapy,” as it is termed by health plans, many WIC nutrition professionals are qualified to give this level of care. In some poor communities where medical nutrition therapy may not be readily available as a private service, WIC staff time for this purpose might be able to be expanded through service fee arrangements.

**Providers need continuous education about the health promotion role of WIC.**

Collaboration efforts between WIC and Medicaid managed care organizations can improve overall maternal nutrition by promoting long-term dietary changes that not only improve pregnancy outcomes but also help women attain personal goals of weight loss and reduce the risks of chronic health problems later in life. Managed care organizations can work with WIC agencies on achieving better communication with prenatal care providers to ensure that all pregnant women are screened for nutritional risks and receive appropriate dietary counseling. More than half of all states include nutritional counseling in their Medicaid managed care programs as part of enhanced services for
pregnant women. Health care providers need continuous education about the role of WIC as well as supplies of WIC referral forms and brochures. MCOs can facilitate better access to medical nutrition therapy for WIC participants by developing contractual arrangements with WIC programs and making providers aware of the new service.

**Partnerships to support better maternal nutrition could work like this**

<table>
<thead>
<tr>
<th><strong>WIC</strong></th>
<th><strong>MCO</strong></th>
<th><strong>Health Care Provider</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Conduct nutritional risk assessment and make referrals based on nutritional risk determination.</td>
<td>▪ Promote patient information sharing between providers and WIC through special forms and provider education.</td>
<td>▪ Conduct case conferences with WIC staff.</td>
</tr>
<tr>
<td>▪ Schedule participants for nutritional counseling as needed.</td>
<td>▪ Support WIC-based interventions with pregnant women at risk.</td>
<td>▪ Schedule frequent prenatal visits.</td>
</tr>
<tr>
<td>▪ Provide nutritional counseling and communicate with prenatal care providers.</td>
<td>▪ Reimburse medical nutrition therapy for high risk conditions.</td>
<td>▪ Prescribe nutritional counseling and/or nutrition therapy and refer to WIC.</td>
</tr>
<tr>
<td>▪ Develop individual care plans according to need and participant wishes.</td>
<td></td>
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</tbody>
</table>

**Reduce smoking and substance abuse**

Substance abuse is a risk factor in pregnancy identified through routine WIC certification. For this reason WIC programs often include prevention messages along with nutrition education. Excessive alcohol consumption during pregnancy is associated with poor fetal outcomes. Drug use is also a concern. In Solano County, California, WIC staff, with support from a special project grant awarded by the Partnership Healthplan of California, were trained to screen pregnant participants at each certification visit for problems and concerns related to use of illicit substances in their household. Women identified with problems were linked to treatment programs.
Smoking cessation is another common objective of WIC and Medicaid managed care organizations. For example, Contra Costa County WIC Program and Contra Costa Health Plan established a smoking cessation education program with funding from California's Proposition 10. When county WIC staff looked at health risk data from their participants, they discovered that smoking rates were higher than the average for California. WIC offered classes to pregnant participants and to any family member who smoked, and the Health Plan supplied nicotine patches and water bottles (for oral gratification) at no charge. WIC used its own data systems to evaluate the results of this intervention, and documented decreases in smoking. This collaboration is also an example of a joint health promotion effort between WIC and MCOs that has been established through letters of agreement that explicitly delineate expectations and provisions.

**Partnerships to reduce smoking and substance abuse, when support for interventions is available, might work like this:**

| WIC | • Screen for smoking and substance abuse.  
• Train staff and offer classes such as smoking cessation to WIC participants and family members if program funding is available.  
• Schedule visits for high risk women on a monthly basis.  
• Refer women for counseling and treatment for substance abuse when appropriate and contact MCO and providers as needed. |
|---|---|
| MCO | • Support WIC-based interventions to reduce smoking.  
• Inform providers about WIC educational activities in newsletters and memos. |
| Health Care Provider | • Screen patients and refer to perinatal case management programs.  
• Encourage patients to attend smoking cessation classes at WIC when available. |
Contra Costa Smoking Cessation Program: Project Summary

A Smoking Cessation Program was initiated in 1998 by the WIC Program in Contra Costa County, CA, to reduce the rate of tobacco use and exposure to second-hand tobacco smoke among WIC participants and their families. Analysis of WIC Information System data had shown that 33% of WIC participants in the county were exposed to smoke, compared to an average of 24% statewide. The WIC agency received support from state Proposition 10 funds to launch a smoking cessation program in collaboration with the nonprofit, county-government-based Contra Costa Health Plan (CCHP). A smoking cessation curriculum and clinical support and encouragement from health care providers constituted the primary interventions. WIC staff screened all WIC participants for tobacco exposure, prepared individual treatment plans, and scheduled them for a series of six smoking cessation classes at the time of their monthly food voucher pickups. CCHP marketed the program to its Medi-Cal members and providers, and added nicotine patches and nicorette gum to its benefit package. Program evaluation after 17 months showed that the proportion of WIC participants who smoked was cut in half, and the proportion of those exposed to second-hand smoke had decreased as well. The total program cost to WIC was approximately $16,000 for each of the two years funding was available.

Contact: Beverly Clark, WIC Director, Contra Costa Public Health Division, 925-646-5376

Promote breastfeeding

Breastfeeding is considered the best source of nutrition for infants, providing nutrients needed for development and antibodies that protect against infection early in a child’s life. In addition to enhancing the closeness of mother and infant, infants who are breast-fed have lower rates of infant illness. A study of the health care costs of formula feeding in a managed care setting found that formula-fed infants experienced more episodes of otitis media and higher rates of respiratory and gastrointestinal illness, compared to breastfed infants. Investigators concluded that MCOs could improve infant health outcomes and also realize substantial cost savings by supporting and promoting exclusive breastfeeding. Breastfeeding advice and support from professional and peer counseling sources are important factors in the initiation of breastfeeding.

Women enrolled in WIC who wish to breastfeed are likely to need extra support. Prenatal WIC participation has been found to increase the initiation of breastfeeding, but to date WIC participation has not been shown to increase the duration of breastfeeding. Low-income women nationally have much lower rates of sustained breastfeeding, when
compared to those with higher incomes and/or education. Possible deterrents include lack of flexible employment schedules and support at home. Women enrolled in WIC who wish to breastfeed are thus likely to need extra support through activities such as lactation referrals and access to consultants. A 1997 study found that about 45 percent of women enrolled in WIC initiated breastfeeding after their babies were delivered.\(^{62}\)

The new Healthy People 2010 goals include several breastfeeding objectives. They call for increasing the percentage of women who initiate breastfeeding from the 1998 benchmark of 64% to 75% in 2010, and for increasing the number who are still breastfeeding after 6 months to 50% from the current 29%. Women and children with higher levels of health risks have shown some of the greatest increases in breastfeeding rates over the past decade. Rates of initiating breastfeeding among African American women increased 65 percent, as did rates among women aged 20 years and under.

WIC programs encourage mothers to breastfeed, and breastfeeding mothers receive enhanced food packages for up to a year. Many local WIC programs have greatly increased their activities in support of breastfeeding over the past decade. WIC staff have actively promoted breastfeeding by training peer counselors, organizing support groups, offering special classes, and presenting written and audiovisual educational materials. They have also screened out materials and activities that would encourage bottle feeding from the moment of delivery. In many states, WIC staff have taken leadership roles in organizing coalitions to advocate policies that favor and promote breastfeeding and educate health care providers. Collaboration activities focusing on breastfeeding promotion have the potential to benefit both the WIC program and managed care organizations.

**Partnerships to promote breastfeeding could work like this:**

<table>
<thead>
<tr>
<th>WIC</th>
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</thead>
<tbody>
<tr>
<td>• Offer pregnant women group and individual breastfeeding education.</td>
</tr>
<tr>
<td>• Sponsor breastfeeding hotlines.</td>
</tr>
<tr>
<td>• Offer lactation consultation and referrals.</td>
</tr>
<tr>
<td>• Provide breast pumps purchased with WIC food funds (new USDA policy).</td>
</tr>
<tr>
<td>• Participate in and sponsor breastfeeding coalitions.</td>
</tr>
</tbody>
</table>
| MCO | • Issue policy on breastfeeding and educate providers.  
     • Participate in community breastfeeding coalitions.  
     • Make breast pumps and lactation consultants available.  
     • Provide prompt case management support, including home visits, to breastfeeding mothers with problems. |
| Health Care Provider | • Educate patients about breastfeeding and refer to WIC for additional education and support.  
     • Refer patients to lactation consultants when needed.  
     • Prescribe breast pumps for lactating mothers. |

The California Health and Welfare Agency issued a “Policy Letter” on breastfeeding to clarify the contractual responsibilities of managed care MCOs regarding breastfeeding education, counseling, and services. The letter states, “MCOs must refer all Medi-Cal eligible… members to… (WIC)… Breastfeeding promotion, education, and counseling services and/or activities must be coordinated with the local WIC agency.” In addition, MCOs are also required to ensure that postpartum women receive necessary breastfeeding counseling and support after delivery, including professional services when needed. They are encouraged to participate in local breastfeeding coalitions, many of which are based at WIC agencies. The letter requires MCOs to supply breast pumps and breast pump kits, and special infant formulas when deemed medically necessary (although WIC was recently authorized nationally to supply breast pumps).63

Within the state, there are several examples of collaborative activities already in place. 

**In Solano County**, WIC initiated a county-wide breastfeeding task force. The Partnership Healthplan of California (PHC) Growing Healthy Together perinatal case manager participates on the breastfeeding task force and works with WIC to develop PHC policies on breastfeeding, including the provision of breast pumps. Contact: Denise Blunt, 707-421-7231.

**In Contra Costa County**, the Contra Costa Health Plan began a pilot test of hiring a lactation consultant and later began an initiative to further encourage breastfeeding by supplying free breast pumps to lactating mothers and by paying for postpartum home visits between 24 and 48 hours after birth. (Contact Beverly Clark, 925-646-5376). The Plan’s written agreement with WIC has specific language with respect to breastfeeding promotion, including the following:
1. Plan will include in Medical Policy for all Providers: Artificial baby milk and/or coupons for this are not to be routinely distributed to pregnant or breastfeeding women. No member names will be distributed to manufacturers of artificial baby milk.

2. Providing continuing breastfeeding education and training to providers and health educators employed by the plan.

8b. Plan will collaborate with State and local WIC to provide (search out, review, modify or develop) culturally relevant breastfeeding materials. Text of any new material developed with WIC staff time will not be copyrighted nor proprietary.

**Clinica Sierra Vista** in Kern County, California, serves approximately 27,000 women, infants and children in its WIC program. A Breastfeeding Peer Counseling Program is available to help pregnant and breastfeeding moms. The Clinica WIC Program also employs 43 Certified Lactation Educators to encourage and assist breastfeeding moms, including two who work in the hospitals where WIC clients deliver their babies. The breastfeeding promotion activities receive partial support from California’s Comprehensive Perinatal Services Program. Clinica Sierra Vista WIC staff also participate actively in the Kern County Breastfeeding Promotion Coalition. Contact Leah Carter, 661-326-6490.

**Improve infant feeding practices**

Many new mothers do not have basic infant feeding information, as demonstrated by a recent study. They may erroneously believe, for example, that young infants need fruit juice in addition to formula, that sugar should be added to bottles, or that solids should be given to infants younger than four months of age. Although most mothers rely on their pediatricians or family physicians for definitive advice on infant feeding, time constraints and cultural barriers may not permit a full discussion of beliefs and family customs. WIC nutritionists, in contrast, have an explicit mandate to educate women about infant feeding, can give them attractive informational materials, and can refer caregivers with special concerns back to the infant’s health care provider.

Mothers and caregivers of infants enrolled in WIC are especially likely to benefit from education about infant feeding. Mothers who report receiving information from WIC about infant feeding are less likely to give cereal too early. A focus group study of low-income mothers enrolled in WIC found that many mothers believed that having a heavy baby was a sign of health, and they often feared that their infants were not getting enough to eat. Misconceptions such as these can lead to inappropriate feeding habits and eventually to childhood obesity. In some cases, WIC-enrolled mothers rely on their own mothers as their main source of information about infant feeding.
feeding. Educating both mothers and grandmothers with consistent messages can also improve infant nutrition.

Educational interventions are needed to prevent common practices not in accord with recommended guidelines, including giving cereal, fruit juice, and sweets or snack foods to infants younger than 4 months of age. Efforts to create materials and messages to be delivered and reinforced by both WIC and pediatric providers would help to ensure appropriate education on infant feeding practices.

**Partnerships to improve infant nutrition and infant feeding practices could work like this:**

<table>
<thead>
<tr>
<th>WIC</th>
<th>MCO</th>
<th>Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reinforce breastfeeding routinely.</td>
<td>Inform providers about infant formula policies of WIC.</td>
<td>Contact WIC regarding prescription of infant formulas when special formulas are needed.</td>
</tr>
<tr>
<td>Provide anticipatory guidance on infant feeding.</td>
<td>Reimburse medical nutrition therapy either at a WIC site or another location.</td>
<td>Refer infants to WIC for nutrition education and management when high risk conditions require individual care plan.</td>
</tr>
<tr>
<td>Refer high risk infants and toddlers to primary care providers, and contact providers directly if appropriate.</td>
<td></td>
<td>Refer infants with very high risk conditions for medical nutrition therapy by a registered dietician.</td>
</tr>
</tbody>
</table>

**Increase immunization rates**

In the past century, universal childhood immunization has been crucial to the reduction of morbidity and mortality due to vaccine preventable diseases. It is a cornerstone of primary preventive services for infants and children. WIC has been an active partner in raising and sustaining immunization coverage rates in the U.S. since the measles outbreaks of the late 1980s and early 1990s. Although childhood immunization rates have improved, constant efforts are needed to educate new generations of mothers and caregivers about the importance of complying with immunization schedules and of obtaining newly recommended vaccines. Interventions such as screening and referral for immunizations and monthly voucher pickups have
been successful, when used in demonstration projects, in getting WIC-enrolled infants and children the vaccinations they need.\textsuperscript{71,72}

The federal government has recognized WIC as a major focus of efforts to increase immunization rates among low-income preschool children. Federal immunization funding supported WIC-based immunization screening and referral projects over a period of several years, many of which documented successes. A December 2000 White House directive\textsuperscript{73} asked USDA and DHHS to develop a strategic plan that would assure immunization screening and referrals for all infants and children at WIC certification visits. In response, a public/private work group is elaborating action steps to train staff in all WIC agencies in standardized procedures for immunization assessment, education of caregivers, and referral to health care providers.

Managed care organizations can both contribute to and benefit from WIC’s activities to assure childhood immunizations. WIC screening and referral activities in connection with immunization can assist with applications for eligible children for Medicaid or SCHIP, where in many cases the parent must select a managed care plan and primary care provider. In addition, WIC immunization screening and referral can help MCOs meet quality assurance objectives. There are several means by which WIC programs and managed care organizations and providers can work together to ensure that all children jointly enrolled in WIC and Medicaid receive required vaccinations.

\textbf{Partnerships to increase immunization rates could work like this:}

<table>
<thead>
<tr>
<th>WIC</th>
<th>MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen for immunizations at each certification visit.</td>
<td>Reimburse WIC for immunizing children on site.</td>
</tr>
<tr>
<td>Refer newly enrolled infants and children to health care provider for needed immunizations.</td>
<td>Facilitate WIC linkage to an immunization registry.</td>
</tr>
<tr>
<td>Provide immunizations on site, with reimbursement, in coordination with primary care providers.</td>
<td>Contribute to the training of WIC staff in immunization screening and referral procedures.</td>
</tr>
</tbody>
</table>
### Health Care Provider

- Screen for immunizations and provide immunizations.
- Reduce missed opportunities for immunizations.
- Document immunizations and update the patient’s history at each visit, including registry information.
- Provide immunization records to patients and WIC staff as appropriate.

Some WIC clinics are co-located with medical providers, and routinely refer clients to them for immunizations. Others have staff on site, usually from the local health department, who immunize children at the time of WIC visits when they are not up to date. If a managed care plan reimburses WIC for providing immunizations, several benefits can be realized. First, a child can be brought up to date as soon as it is clear that he or she lacks required immunizations. The child would not have to wait for an appointment at the provider’s office. Also, if a managed care plan reimburses WIC for administering shots, it can receive credit for giving the immunization in quality assurance audits, thus raising the MCO’s overall performance in administering childhood immunizations to its enrolled population.

Information sharing is another important area in which WIC has experience, particularly regarding referrals of clients to health and social support services. In some communities, WIC is linked to the immunization registry, which facilitates screening for immunization status at the WIC site. In areas without well-developed registries, information sharing between a Medicaid managed care organization and the WIC program could serve the same function.

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Optimal results occur when WIC programs receive dedicated resources for screening, outreach, services, and referrals.

Reports from demonstration programs suggest that optimal results occur when WIC programs receive dedicated resources for screening, outreach, services, and referrals. While the federal funding invested in these WIC enhancements has identified successful strategies for improving immunization compliance, sustained attention and resources are needed to apply them more widely. Initiatives to begin information sharing, for example, would require funding to put necessary infrastructure in place. Additional sources of funding and building capacity are other important issues to consider when building collaboration efforts.

Currently, there are several coordination efforts between WIC and Medicaid managed care organizations that illustrate how collaboration can improve immunization outcomes for this population.
In Tarrant County, Texas, WIC and MCO providers frequently cosponsor events to promote immunization compliance through the Tarrant County Immunization Collaboration.

In Rhode Island, the KIDSNET enhanced immunization registry (linked to some WIC sites) has information on immunizations, lead screening, and other public health preventive service data for children born from 1997. Improved linkage with MCOs results in coordinated quality assurance reviews to identify children behind in preventive services. Currently, all of the children in WIC born in or after 1997 are in KIDSNET. This represents 80% of WIC’s childhood population.

The Wellness Plan in Detroit responded to low immunization rates by enlisting the WIC program operating at its clinic sites. This managed care plan contracted with Medicaid added walk-in primary care and immunization services for children coming for regular WIC visits, and used the CASA software to track immunization records. As a result of coordination between WIC and Wellness, immunization levels increased 14.8% within six months.75

Improve early childhood nutrition

The nutritional status of children ages 1 through 4 has improved significantly for all racial and ethnic groups in the past two decades.76 National surveillance has documented a decrease in growth stunting and iron deficiency anemia, accompanied by improvements in diet. Proper nutrition for young children is still a concern, however, as recent findings of diets deficient in iron, zinc, and vitamin E demonstrate.77 Risks for poor nutrition remain greatest in low-income children. Some studies suggest that parents who know more about proper nutrition can help their preschool children eat and enjoy healthful foods, a finding that increases the argument for educating parents through WIC nutrition education.78 More recently, an increase in the proportion of overweight children, especially in Hispanic and Native American populations, has been widely recognized.79

WIC screens infants and young children for nutritional risks and gives high priority to those with documented medical conditions that affect nutrition. WIC staff educate their caregivers about feeding small children in accord with the latest dietary guidelines, following national recommendations such as those issued by USDA (www.usda.gov) and DHHS (e.g., www.brightfutures.org). In addition, WIC food packages supplement the diets of targeted participant groups with needed nutrients and limit ingredients that should be curtailed.80 Young children who consume WIC food packages have higher intakes of protein, calcium, iron, folic acid, and vitamin E, compared to low-income children who do not receive WIC.81 Fat, sugar, and sodium content in food packages
available through WIC are limited, in accord with concerns about their contribution to health and nutrition problems.

**Partnerships to improve childhood nutrition could work like this:**

<table>
<thead>
<tr>
<th>WIC</th>
<th>MCO</th>
<th>Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Complete dietary histories for toddlers.</td>
<td>▪ Inform providers about the WIC role in child nutrition.</td>
<td>▪ Refer high risk children to WIC for individual care plans.</td>
</tr>
<tr>
<td>▪ Monitor height for weight at each visit.</td>
<td>▪ Reimburse WIC for medical nutrition therapy when needed.</td>
<td>▪ Prescribe medical nutrition therapy for children with very high risk conditions.</td>
</tr>
<tr>
<td>▪ Develop individual care plans for high risk children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Notify primary care providers about high risk children.</td>
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</table>

*In Solano County,* California, the Partnership Healthplan of California (PHC) has created a medical nutrition therapy benefit in which the county’s Clinical Nutrition Services Program registered dietitians provide medical nutrition therapy for women and children. Young children diagnosed with conditions such as diabetes, lead poisoning, obesity, severe anemia, and failure-to-thrive are covered for medical nutrition therapy. Women who are compromised due to cancer, heart disease, diabetes, obesity, substance abuse and HIV are covered for medical nutrition therapy.

*In Contra Costa County,* California, representatives from WIC and Contra Costa Health Plan serve on an obesity task force. They also collaborate closely to make sure that families bring children in for preventive health examinations.

**Reduce risk of lead toxicity**

Lead toxicity, or lead poisoning, is recognized as one of the most serious environmental health risks facing children today. Lead poisoning affects the brain and nervous system tissues of children and can cause learning and developmental disabilities. Young children, those below the age of 5, are at particular risk because of their frequent hand-to-mouth activity. In 1991, CDC published a statement defining the maximum acceptable blood concentration of lead at 10 micrograms/dl. CDC also recommended at that time that all children under the age of 5 be screened for lead
toxicity. In 1997, however, CDC revised its recommendation to acknowledge that the scope of the problem of lead toxicity can vary by region and locality. The new recommendation is for state health officials to develop statewide plans for childhood lead screening and better target children who are known to be at increased risk.83,84,85

Although all children are at risk for lead poisoning, a greater proportion of those in low-income families have higher blood lead levels.86 National Health and Nutrition Examination Survey (NHANES 3) data from 1991-94 show that lead toxicity is a significant problem for children receiving care under Medicaid, and that Medicaid-eligible children constitute the majority of children with elevated blood lead levels.87 In February 1998, the GAO released a report documenting that, despite HCFA’s lead screening requirement for children enrolled in Medicaid, 81% of Medicaid children in the NHANES had not been previously screened for lead.88 As a follow-up, the GAO released another report in January 1999 highlighting possible reasons why Medicaid enrolled children are not being screened.89 To address these shortcomings, the GAO made several recommendations to the Secretary of DHHS, including coordinating lead screening and treatment activities among federal agencies, including Medicaid and WIC, that serve at-risk children.90 Coordination activities between Medicaid managed care organizations and WIC directly follows this recommendation, and they can have a positive impact on lead screening in this population.

In states that target low-income children for lead poisoning prevention efforts, local WIC programs may already participate in screening children for high blood lead levels. According to local WIC directors who responded to a recent survey, 19 percent of local WIC agencies currently screen children for lead exposure. Most of these agencies are affiliated with local health departments and work closely with the state lead poisoning prevention program. WIC agencies that play an active role in testing children’s blood lead levels often require additional funding and support. The National Association of WIC Directors (NAWD) recently published a position paper on lead screening that highlighted some of the costs and concerns associated with lead screening and tracking by WIC programs. The paper also recognized the indispensable role of a child’s primary health care provider.
In states with active programs to reduce lead exposure, partnerships involving WIC could work like this:

<table>
<thead>
<tr>
<th>WIC</th>
<th>MCO</th>
<th>Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ask whether participant was screened for lead and make referral if needed.</td>
<td>- Promote universal lead screening and/or verification by provider.</td>
<td>- Conduct lead testing on all children referred by WIC.</td>
</tr>
<tr>
<td>- Provide information about lead poisoning prevention to participants.</td>
<td>- Notify enrolled patients about need for lead testing and availability of service.</td>
<td>- Verify blood lead screens conducted elsewhere.</td>
</tr>
<tr>
<td>- Develop individual nutrition care plans for children with high blood lead levels.</td>
<td>- Establish program to reimburse WIC for drawing blood for lead testing if feasible and needed.</td>
<td>- Notify state and local lead programs about children with high blood lead levels and refer them to WIC or registered dieticians for development of an individual care plan.</td>
</tr>
<tr>
<td>- Draw blood for lead testing, with reimbursement, in coordination with programs established by public health departments and MCOs.</td>
<td></td>
<td>- Share results of blood lead (and iron) test with WIC to expedite certification.</td>
</tr>
<tr>
<td>- If services offered in setting that conducts blood lead testing, WIC can reimburse the testing program for the cost of drawing blood for WIC iron screening to determine anemia</td>
<td></td>
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</tr>
</tbody>
</table>

State health officials may find that WIC involvement in lead screening can be useful both in assisting parents to obtain appropriate interventions for affected children and in targeting communities that are more likely to have lead exposure problems. For example, while Rhode Island’s WIC Program formerly conducted routine lead screening for young children at risk, pilot sites will soon be assessing the child’s lead screening status through KIDSNET. This change in strategy was due to two factors:
93% of RI WIC participants have health insurance and access to health care providers, and the availability of KIDSNET at WIC sites. Instead of WIC staff performing lead screenings, they now ensure access to health care through screening and referrals to Rite Care (RI’s managed care Medicaid Program), educating parents on the importance of lead screening, referring participants’ to their health care providers and providing follow-up. Coordinated quality assurance initiatives between WIC, the lead program, MCO’s and KIDSNET monitor compliance with screening requirements, and locate areas with higher or lower than expected rates of lead exposure. Consequently, they can target lead poisoning prevention initiatives in communities with the greatest need.

Recently WIC (using KIDSNET data) analyzed lead screening information for each WIC site. Overall, 75% of all WIC children had received lead screening, and 8% had blood lead levels greater than 10 µg/dl detected. According to the report, lead screening could be promoted at two or three of the WIC sites with screening levels at 65% or less. This type of quality assurance, when shared with providers and MCO’s, could focus efforts in underserved communities.
Lead Poisoning Prevention Program in Wisconsin

The Wisconsin Childhood Lead Poisoning Prevention Program (WCLPPP) and WIC Program has recently begun an initiative to promote collaborations between WIC, MCOs, and the WCLPPP. This effort was prompted by the realization that Wisconsin’s children have higher rates of lead poisoning (10.1%) compared to the national average of 4.4 %, that low-income children enrolled in Medicaid and WIC have the highest rates, and that more than one-third of infants and children are not being screened for lead poisoning. Lead screening in Wisconsin is done by private health clinics, public health departments, and WIC clinics. The WCLPP and WIC Programs are seeking ways to promote dialog and partnerships between MCOs and WIC in order to promote screening for lead for all children enrolled in WIC and managed care organizations. The Program is addressing issues that could pose obstacles including:

▪ Billing and information sharing practices between public health departments, providers, and MCOs.

▪ Reimbursement mechanisms for lead screening services.

▪ Outreach and referral for WIC services.

▪ Roles and relationships of managed care, WIC, and public health in conducting lead screening.

The Wisconsin WIC Program Director, Immunization Program Director, and WCLPP staff have jointly made numerous presentations to managed care organizations in Wisconsin and explained the benefits of collaboration with WIC on lead screening and immunization. The Wisconsin Public Health Division prepared a document titled “Partnerships for Healthy Kids” to aid this process.

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COLLABORATION BETWEEN WIC AND MANAGED CARE


Collaboration Between WIC and Managed Care


Ball (1999). Ibid. ??


COLLABORATION BETWEEN WIC AND MANAGED CARE


87 Kaufmann R (2000), ibid.


90 Ibid.