



MyWIC: UPDATING WIC FOR A NEW GENERATION

The Millennial Generation has come of age and is now parenting. The diversity and dynamism of this generation pose some unique challenges for the WIC Program in its current format. This brief summarizes current demographic characteristics and market data, provides a glimpse of some recent WIC-related millennial research, and makes recommendations for modernizing clinical WIC services—not including the shopping experience—to add value and increase WIC’s relevance to and impact on this generation of young parents.

MARKET RESEARCH REVEALS UNIQUE ATTITUDES AND BELIEFS

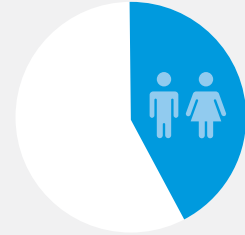
MILLENNIALS (BORN BETWEEN 1980 AND 2000)



COMPRISE
25% OF CURRENT
US POPULATION



1 IN 4
ARE PARENTS



43%
ARE NON-WHITE

Millennials, typically defined as the cohort born roughly between 1980 and 2000, comprise about 25% of the current US population. Already, one in four are parents. Two outstanding and oft-noted characteristics of this generation are their digital connectedness and their ethnic diversity. About 43% of millennials are non-white –the highest proportion of any generation –and their constant engagement with mobile social media is instantly observable on any sidewalk or school campus in the nation.¹

Market research describes a generation that is “self-involved, opinionated, and impatient.” Millennials want to derive personal and emotional benefits from products and services, and they rely heavily on peer influence when deciding to participate or consume. They also seek a feeling of ownership and direct participation. Thanks to the splintering of “mass” media into thousands of smaller channels, reaching this generation involves a more personalized, micro-targeted approach, best described as “viral.”

WIC MILLENNIALS: WIRED

In 2011, USDA Special Project research looked at how WIC households in the Western Region States (including California) used social media and the Internet. Nearly all participants owned cell phones with texting capabilities. The three most utilized technologies were email, Facebook, and text messaging. Not surprisingly, younger participants were more likely to use their phones to connect, while older ones still used computers. More educated WIC moms were more likely to use the Internet to schedule or change WIC appointments or to log on to online nutrition education or videos.

The same research showed very clearly that WIC participants are eager to interact with WIC



online rather than having to use the telephone or schedule in-person appointments at clinic sites. Focus groups also revealed that these participants want to receive more nutrition education via online classes, take-home lessons and video chat; that they perceive WIC counseling via video chat as useful as in-person encounters; and that they are open to connecting with each other via social media. Again, more educated respondents preferred Internet encounters compared to those with less than a high-school diploma. WIC participants reported that they are already using parenting and health sites such as Parents.com and BabyCenter.com.⁵

WIC OUTREACH: CUTTING THROUGH THE CLUTTER



More than 90% of millennials are regular Internet users, using a combination of smartphones, tablets, and laptops to access the Web for everything from shopping to entertainment, news, and social media, and more recently, personal business such as banking.

Because millennials are so tied to their connected devices, some have begun to refer to this demographic as Generation FOMO (Fear Of Missing Out). Contrary to some common assumptions, research shows that current WIC participants—across all income levels and ethnicities—are just as “wired” as the rest of their generation.³

Outreach or marketing WIC benefits and services to new millennial parents is now much more challenging

than simply placing TV/radio spots or buying billboard/ bus placard space. It means penetrating a potential WIC participant’s unique social and cultural bubble via multiple media platforms such as Twitter, Facebook, and Instagram, creating a relationship that will cut through the clutter and engage a new mom or dad in a program that feels individualized.



PERSONALIZED APPROACH TO LEARNING

Given millennials’ digital connectedness and desire for intensely personalized information, supporting them around healthy nutrition and breastfeeding decisions will necessitate new approaches in WIC clinical settings. Market research stresses this generation’s emphasis on peer (friend) support, their belief that parenting is an equal partnership, and their desire for an authentic and useful learning experience. They are early adopters of new technology, but they also like to feel directly involved in their own learning or care, not passive recipients.

Keeping WIC relevant and appealing to this group could mean moving service delivery beyond the traditional fixed WIC clinic—the medical outpatient model—to a more individually tailored “MyWIC” experience in the virtual space. An online application and eligibility determination process, such as is now used for the SNAP program (CalFresh in California) would enhance access. Online options are already being used for nutrition education and breastfeeding support, but can be augmented with virtual counseling sessions using video chat (Skype or FaceTime, for example) interspersed with text or Twitter reminders and other digital interaction.

MODERNIZING WIC

To continue to attract and retain participants from this tech-savvy generation, WIC will need to consider major transformations to its current business model.

By 2020, all state WIC programs will have transitioned to Electronic Benefits Transfer (EBT) cards as the only platform for provision of WIC food benefits redeemed at local grocery stores and farmers' markets. The WIC EBT rollout is the perfect time for other parts of the program to modernize as well.



A WIC REDESIGN SHOULD FEATURE THREE MAIN COMPONENTS:

- 1. ADDITION OF** options for secure online, virtual WIC enrollment, certification, and benefits issuance to the existing brick-and-mortar service delivery infrastructure;
- 2. CREATION OF** Internet-based nutrition education and breastfeeding support technologies that reach WIC participants in their homes, on their phones, and when they need it; and
- 3. TRANSFORMATION OF** the current WIC workforce to provide WIC benefits and nutrition services in the virtual world as well as in person.

Building an online WIC platform does not mean abandoning the traditional in-person service delivery model. Personal contact between participants and staff is a hallmark of WIC and should continue to be an option. Private interviews usually take place when WIC mothers enroll or receive periodic screening and counseling in local clinics. These brief conversations are a chance for young parents to share intimate concerns or worries and for staff to visually, as well as clinically, evaluate their individual health status or that of their children, provide specific advice, and offer referrals for additional mental health or social services supports if needed.

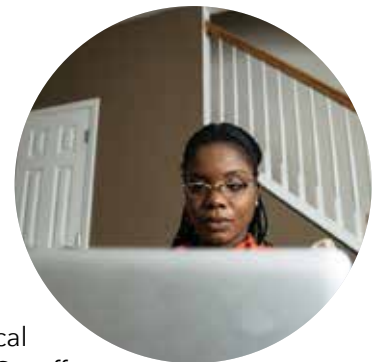
This personal aspect of WIC service can literally be life-saving, as when a WIC practitioner notices that an

infant is dangerously dehydrated, a child is bruised, or a mother is severely depressed. Moreover, many WIC participants still prefer to come in for appointments and talk to their WIC counselors in a safe and personal environment. Others do not have access to the technology needed for online contacts.

For the majority who do have online access, WIC communication can enhance important in-person dialogue by allowing further contact and follow-up between clinic visits, enabling WIC to keep up an ongoing dialogue with parents using teaching videos, personalized messages, and a way to answer questions in real time.

STREAMLINING WIC APPLICATION, ENROLLMENT, AND CERTIFICATION

Today, WIC serves millions of participants from a base of thousands of local clinic sites across the country using the traditional outpatient medical model. With rare exceptions,⁷ WIC requires that participants come to local clinics in person, present their income and medical eligibility documentation to WIC staff, and be assessed for weight gain, dietary intake, and anemia status. After initial enrollment, most mothers must come in every six months for in-person "recert" appointments, annually bringing in infants and children who have previously been enrolled.



WIC can learn from innovations already implemented in SNAP (CalFresh), which has greatly streamlined the eligibility process using telephone interviews and uploading required identification, income, and medical documentation to a secure website. Any requirements that could be completed via smart phone would enhance the user experience.⁸ Horizontal integration⁹ using shared Electronic Medical Record (EMR) information to obtain iron deficiency anemia test results would greatly expedite one of WIC's most cumbersome eligibility requirements. HIPAA¹⁰ and WIC confidentiality rules¹¹ should not hinder innovation in this area. Health care has moved ahead in use of telemedicine and successfully overcome these perceived barriers.¹²

A VIRTUAL OPTION FOR WIC NUTRITION AND BREASTFEEDING SERVICES



Beyond certification, the minimum requirement for contact to provide individualized WIC nutrition education is four times per year,¹³ but more frequent exposure is common, especially among pregnant or breastfeeding women. Many of those WIC participants visit their clinic sites every month to have their progress checked and to attend group classes or receive individual counseling or personal support from WIC staff or peer counselors. Other women, particularly post-partum non-breastfeeding women with older children, often get three months' worth of food benefits at a visit and come in only for recertification and required nutrition education contacts.

Surveys and focus groups suggest that the majority of WIC participants have mobile phones or computers and there is interest in having more online options available, such as a WIC-related app.¹⁴ In recent years, recognizing the growing computer literacy and Internet access among WIC households, WIC programs around the country have developed evidence-based online nutrition education platforms, which most states now offer to participants as an alternative to the required quarterly in-person classes or counseling. Participants can choose to log on and work their way through learning modules on a large variety of topics, from breastfeeding to salt intake. They then take and submit a post-test online.¹⁵ These online offerings have been well received by participants, with studies showing high acceptance and equivalent effectiveness.¹⁶

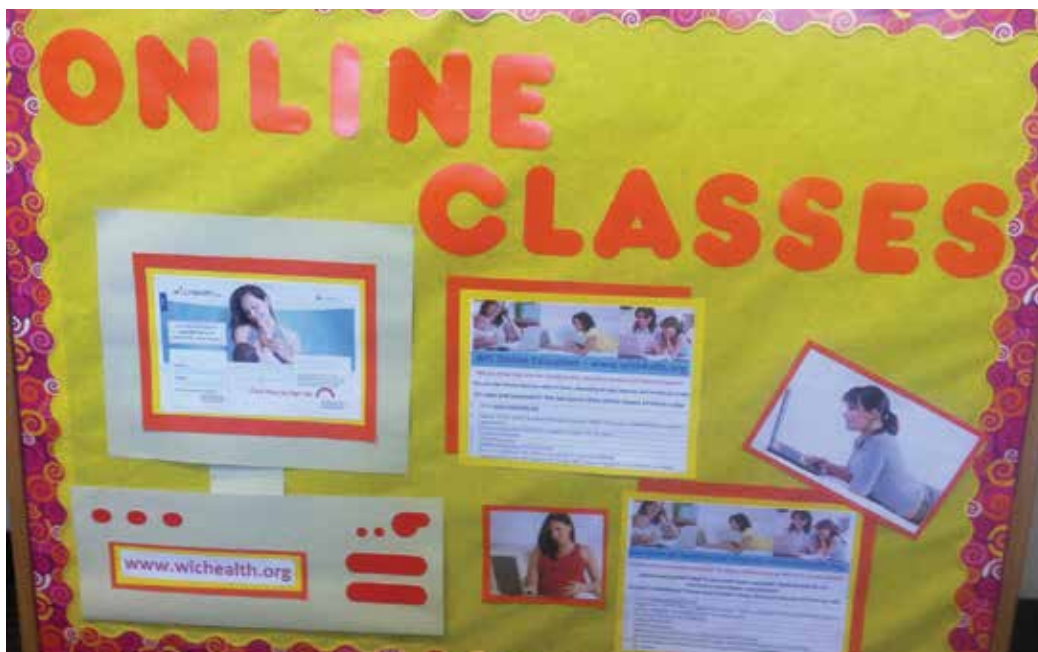
Online interventions in WIC populations have been linked with improvements in nutrition knowledge and nutrition-related behaviors;¹⁷ some studies have shown Internet interventions to be actually more effective than in-person education.¹⁸

In addition to nutrition interventions, research has shown effectiveness of online interventions in efforts to improve exclusive breastfeeding rates, physical activity in children and adolescents, and smoking cessation.¹⁹

An increasing number of local WIC agencies are experimenting with additional ways to connect with families beyond seeing them in clinic. HIPAA-compliant secure texting of WIC appointment reminders²⁰ and well-timed nutrition or health tips²¹ are on the rise, and some WIC providers are experimenting with telephone consults, videoconference meetings, and using Skype or FaceTime for WIC counseling.²² An updated WIC program could further include targeted group support for prenatal or breastfeeding moms coordinated via Facebook, or even through Twitter meet-ups. Specialized applications to support moms with breastfeeding challenges have already been developed and are used by many tech-savvy WIC moms.²³

Although busy and stressed WIC parents and caregivers have responded favorably to these virtual health education options, the WIC organization (often, the

sponsoring agency) itself can often be the biggest barrier to innovation because of rules—often from the parent agency—prohibiting employees to use social media (Facebook, Twitter, etc.) or fears of violations of confidentiality. However, many hospitals and community health providers have found ways to comply with strict HIPAA rules around patient confidentiality and still take advantage of these innovative communication technologies to streamline and simplify interactions.²⁴





REACHING FAMILIES WHERE THEY WORK AND SHOP

Over the years, data have consistently shown that the WIC participation rate drops sharply after WIC infants turn one year old.²⁵ At that point, the household transitions to the child food package, which carries a much lower retail value than the infant formula package, a change that likely plays a substantial role in the drop-off rate among WIC families with older children. In addition, in a 2010 USDA WIC attrition study, 26% of households exiting the program reported that it requires too much effort and time for the value of the benefits received, and nearly 10% of those exiting cited scheduling and transportation problems, suggesting that overall “transaction costs” (the overall hassle) of WIC participation may be a barrier.²⁶

Once WIC EBT cards are universally available, WIC can focus on overcoming these transaction barriers by testing ways of providing benefits and services where parents work, shop, or spend time together instead of in fixed, stand-alone WIC clinics. Less cumbersome and more mobile technology will make it easy to issue benefits, allowing flexible and innovative alternatives to current operations.

At the same time, providing and documenting WIC nutrition and breastfeeding services to participants could be liberated from being solely offered at the WIC office, using technology or creative community partnerships. Many WIC sites are already co-located with community or public health clinics, but city parks, day care centers and school health clinics, grocery stores, pharmacies, or retail outlets might also be attractive as places for young families to receive WIC benefits and nutrition services. WIC providers could issue food benefits at grocery stores, malls, or factories; work with breastfeeding moms in pharmacies (where breast pumps could be issued); or share nutrition education messages and cooking classes at day care centers or playgrounds. Simultaneously, WIC participants could use personalized WIC apps and other social media platforms to shop for WIC food, get help with breastfeeding, or discover new ways to feed a picky eater.

TIME TO PLAN FOR MyWIC!

To be appealing to the population of young parents it is seeking to serve, WIC needs to reposition itself as a high-tech, high-touch program. WIC managers and advocates must begin the process of updating WIC to meet the needs and aspirations of the Millennial Generation. This is a tall order, one that will take many years of innovative state-level WIC modernization pilots, considerable federal regulatory overhaul, and enhanced federal funding for systems redesign.

The process can begin with pilot testing using federal waivers and public-private funding partnerships. Pilots that evaluate well can be scaled up using policy proposals during the next (2020) Child Nutrition Reauthorization debate.

Failure to take action will result in an increasingly outdated and unpopular program with dwindling utilization and political support –an unacceptable outcome.



POLICY ACTION RECOMMENDATIONS

1. USDA and State WIC programs should include redesign of WIC nutrition services, breastfeeding support, and nutrition education at the same time as they plan and implement new MIS and EBT system rollouts.
2. USDA and State WIC programs should review and update WIC eligibility regulations and guidance to reflect cutting-edge technological advances in secure document handling, database linkages, and other online identity and income verification applications in order to streamline the WIC certification process and decrease the number and length of required in-person clinic appointments.
3. USDA and State WIC programs should review and update WIC regulations and guidance to allow for innovative online and social media approaches that are as effective as personal counseling and group classes –and easier to access –in order to create virtual options for nutrition education and breastfeeding support for busy working families.
4. WIC advocates should work with USDA and State WIC programs to ensure that the pending Child Nutrition and WIC Reauthorization statute is passed with language allowing pilot programs testing new approaches to WIC education and service delivery using innovative and emerging technologies.
5. Based on the outcomes of pilots, WIC advocates should work with USDA and State WIC programs to seek more substantive changes in the 2020 Child Nutrition and WIC Reauthorization statute that will allow states to re-design basic WIC services to include both in-person and online options for certification, benefits issuance, nutrition education, and breastfeeding support.
6. USDA and State and Local WIC agencies should begin rethinking and redesigning staff recruitment and training programs to reflect the new skill base needed for a “high-tech, high-touch” WIC program.

NOTES

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