STRENGTHENING INFORMATION EXCHANGES BETWEEN HEALTHCARE AND WIC PROVIDERS

National WIC Association

EAST BAY COMMUNITY FOUNDATION

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ACKNOWLEDGEMENTS

The National WIC Association (NWA) is the nonprofit voice for the 12,000 public health nutrition service provider agencies that support over 6.9 million mothers, babies, and young children through WIC. NWA provides education, guidance, and support to WIC staff; and drives innovation and advocacy to strengthen WIC as we work toward a nation of healthier families. For more information, visit www.nwica.org.

In 2024, NWA received a grant from the Kaiser Permanente Fund at East Bay Community Foundation to launch the ***Strengthening Information Exchanges between Healthcare and WIC Providers*** project. This two-year initiative aims to improve the coordination of care for low-income families by enhancing information exchanges between healthcare and WIC providers.

NWA extends its deepest appreciation to the survey respondents and interviewees, including State and Local WIC Agency staff and healthcare partners, who generously shared their time and expertise. Their thoughtful contributions enriched this research and made this report a valuable resource for understanding the current referral and data-sharing landscape, as well as identifying best practices for strengthening coordination with healthcare providers.

NWA is sincerely grateful to the Kaiser Permanente Fund at East Bay Community Foundation for its generous support. This funding has enabled NWA to examine both the challenges and opportunities in WIC-healthcare information exchange and to support WIC agencies in advancing meaningful improvements.
Finally, NWA extends special thanks to Urban Metrics Consultants for leading the evaluation of the landscape survey results, conducting in-depth interviews and data analysis, and providing critical insights that shaped this report. Their expertise and dedication were instrumental in deepening our understanding of the WIC-healthcare information exchange landscape.

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EXECUTIVE SUMMARY

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) plays a critical role in connecting families to nutrition support and preventive health services, yet referral and data-sharing processes between healthcare providers and WIC remain inconsistent across State and Local WIC Agencies. The National WIC Association (NWA) received funding from the Kaiser Permanente Fund at East Bay Community Foundation to strengthen information exchange and collaboration between healthcare providers and WIC agencies. To better understand current practices and identify opportunities for improvement, NWA conducted the *WIC–Healthcare Provider Referrals & Data Sharing Survey* and a series of qualitative interviews with State and Local WIC Agencies.

In-depth interviews and survey responses from more than 200 WIC agencies revealed a landscape characterized by diverse systems, uneven integration, and strong reliance on staff effort, which contributes to operational inefficiencies and inconsistent participant access and experience across communities. Most agencies receive referrals through multiple pathways, including participant-driven referrals, paper or faxed forms, third-party or state-developed platforms, and, less commonly, Electronic Health Records (EHRs) or Health Information Exchanges (HIEs). While electronic referral tools have expanded participant access and improved intake efficiency, the medical and anthropometric data needed for WIC certification are still primarily collected through manual processes.

THE LANDSCAPE AT A GLANCE: FOUR SYSTEM TYPES

Across the country, WIC agencies rely on four primary system types to support referrals and medical data sharing. Agencies rarely depend on a single approach; instead, most operate in hybrid environments, combining multiple tools to meet program needs, staff realities, and participant expectations.

Electronic Health Record (EHR)

EHRs are digital, patient-centered, real-time records containing a patient's medical information and history.

Health Information Exchange (HIE)

HIEs serve as intermediaries that facilitate data sharing among healthcare organizations and, in some cases, public health or social service programs.

Third-Party and State-Developed Platforms

Third-party and state-developed platforms expand referral entry points and support communication[3] and intake. However, they typically offer limited access to medical data.

Traditional and Paper-Based Methods

Traditional and paper-based methods, such as paper forms, fax, email, and participant-delivered documentation, are used to receive referrals and medical data.

WHAT MATTERS REGARDLESS OF PLATFORM

Despite variation in technology, several consistent themes emerged across all system types:

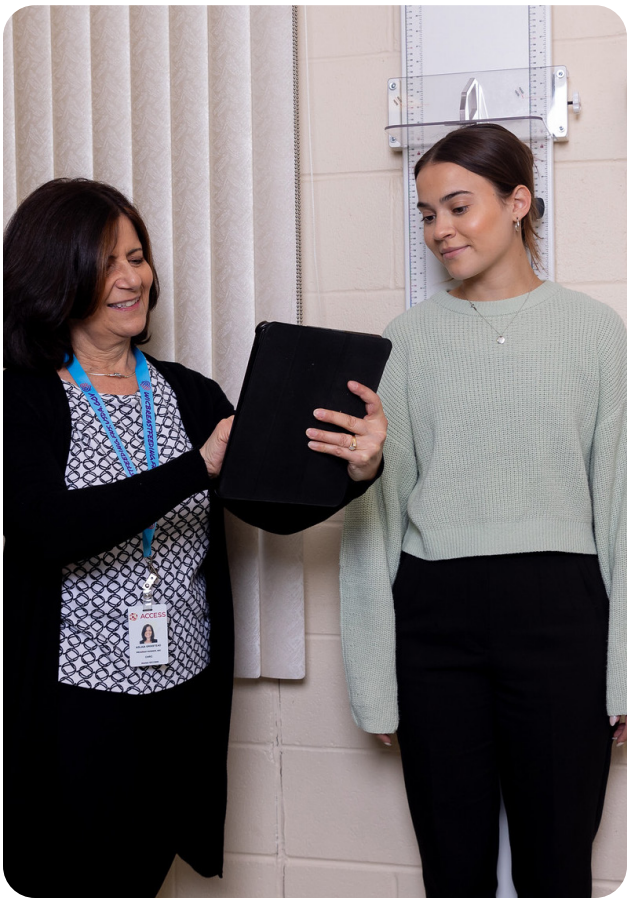
- **Integration matters more than the platform itself.** Systems that connect directly to the WIC Management Information System (MIS) reduce administrative burden, improve follow-up, and support more consistent service delivery. Tools that operate outside the MIS, regardless of sophistication, often increase staff workload through parallel tracking and manual reconciliation.

- **Staff capacity is a defining constraint.** Most agencies rely on a small number of designated staff to manage referrals and retrieve medical data. Turnover, competing responsibilities, and limited staffing may determine which systems can be supported, even when automation is available.

- **Medical and anthropometric data sharing remains the weakest link.** While electronic and third-party/state-developed tools have expanded referral intake, medical and anthropometric data are still most often received through participants or paper-based methods. Direct access through EHRs or HIEs offers clear benefits but remains limited due to legal, technical, and workflow barriers.

- **Relationships and trust drive success.** Strong partnerships between healthcare providers, HIE vendors, MIS vendors, and State and Local WIC Agencies consistently enable progress. Early communication, shared problem-solving, and trust building are critical to implementation and sustainability.

- **Usability and flexibility shape participant experience.** Families benefit most when systems reduce documentation burden and align with how they already interact with healthcare and social services. Complex portals often push participants and staff back toward simpler methods such as phone calls, texting, or screenshots, undermining intended efficiencies.



WHAT THE FINDINGS SHOW

- WIC agencies receive referrals through multiple pathways, including participant-driven referrals, paper or faxed forms, third-party and state-developed platforms, and, less commonly, EHRs or HIEs.

- Agencies using EHRs or HIEs report meaningful efficiency gains but face higher barriers to adoption and maintenance.

- Third-party and state-developed systems and traditional and paper-based methods (e.g., paper forms, fax, and email) continue to play a critical role, particularly where integration is not feasible.

- Across all system types, success is most strongly influenced by direct MIS integration, adequate staffing and role clarity, strong partnerships providers and vendors, and flexible workflows that account for participant needs.

- Interest in streamlining referrals and medical data sharing using electronic methods is high, but agencies emphasize the need for **practical, scalable solutions aligned with staffing capacity.**

LOOKING AHEAD

This landscape analysis shows that meaningful progress is possible across multiple starting points. Agencies using traditional and paper-based methods or third-party and state-developed systems are implementing effective practices within their constraints, while agencies with EHR or HIE access illustrate what modernization can achieve when supported by funding, leadership, and strong partnerships.

Ultimately, successful referral and data-sharing systems depend less on adopting a specific platform and more on intentional system design, clear role definition, sustained investment in staff capacity, and ongoing cross-sector collaboration. By focusing on these foundational elements, WIC programs can strengthen coordination, improve data quality, and better support families; regardless of the systems they currently use.

HOW TO USE THIS REPORT

This report is designed to support decision making across roles and contexts:

- **State WIC Agencies** can identify opportunities to strengthen coordination, technical assistance, and system alignment across Local Agencies.
- **Local WIC Agencies** can compare system types and assess which approaches best fit their staffing, workflows, and participant populations.
- **Healthcare partners** can better understand how referral and medical data-sharing processes affect WIC access and enrollment. They can also identify opportunities to partner with WIC to better coordinate care.
- **Funders and policymakers** can identify where targeted investments may reduce administrative burden and improve equity.

INTRODUCTION

The National WIC Association (NWA) received funding from the Kaiser Permanente Fund at East Bay Community Foundation to strengthen information exchange and collaboration between healthcare providers and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Healthcare providers play a critical role in this effort, as they routinely collect demographic and medical information and serve as trusted points of contact for individuals and families who may be eligible for WIC services.

Because of their regular engagement with WIC-eligible populations, healthcare providers are well positioned to both refer families to WIC and share the medical and anthropometric information needed to support WIC certification and ongoing participation. When referral pathways and data-sharing processes from healthcare providers and systems to WIC agencies are streamlined, WIC programs are better able to reach eligible families, reduce administrative burden on staff, and support more coordinated, person-centered care for participants. It is important to note that WIC agencies do not transmit participant data to healthcare providers unless participant consent has been obtained. Throughout this report, mentions of referral and data sharing refer only to the transfer of information from healthcare providers to WIC agencies.

Across the country, WIC agencies use a wide range of approaches to receive referrals from healthcare providers and obtain the medical and anthropometric data required for certification when those data are not collected during an in-person WIC appointment. These approaches reflect differences in state infrastructure, local capacity, provider partnerships, and access to technology. Some agencies can leverage Electronic Health Records (EHRs) or Health Information Exchanges (HIEs) to access medical information directly, while others rely on third-party and/or state-developed platforms, or traditional and paper-based methods such as fax or in-person document collection. In practice, most agencies operate within hybrid systems that combine multiple systems to meet program and participant needs.

Recognizing this diversity, this report is organized around four system types—Electronic Health Records, Health Information Exchanges, Third-Party and State-Developed Systems, and Traditional and Paper-Based Methods—to illustrate how referrals and data sharing function across different contexts. For each system type, this report describes how healthcare providers initiate referrals and share medical data with WIC agencies, the staffing and workflow implications, common barriers and facilitators, and practical lessons learned from WIC agencies' real-world experiences. By centering real-life examples of implementation rather than a single "ideal" solution, this report is intended to help State and Local WIC Agencies, healthcare partners, and policymakers identify strategies that align with their capacity, priorities, and participant populations.

METHODS

This landscape report uses a mixed-methods approach to examine how healthcare providers can send WIC agencies referral and medical data, the systems that support data transmission, and the factors that enable or hinder effective implementation. The methods were intentionally designed to prioritize usability and practical insight for WIC agencies, healthcare partners, and policymakers across a range of operational contexts.

DATA SOURCES

National Survey of WIC Agencies

The *WIC-Healthcare Provider Referrals & Data Sharing Survey* was administered by the National WIC Association (NWA) in May 2025 to gather information on how healthcare providers share referral and medical data with WIC agencies. The online survey targeted both State and Local WIC Agencies and the survey link was distributed digitally via NWA newsletters.

A total of **204 individuals** responded, representing **176 Local Agencies** and **28 State Agencies**, covering 47 geographic states, 1 Indian Tribal Organization, and 4 territories. The survey collected information on referral pathways, medical data-sharing practices, system types used (e.g., EHRs, HIEs, third-party platforms, and traditional methods), staffing and workflow implications, perceived barriers and facilitators, and interest in strengthening or transitioning systems.

Key Informant Interviews

To complement survey findings and provide deeper insight into how healthcare provider referral and data-sharing systems function in practice, five key informant interviews and two follow-up interviews were conducted with State and Local WIC Agencies. Interview participants were typically WIC directors or staff directly involved in referral or data-sharing activities.

Interview participants were identified based on survey responses indicating interest in sharing more information about their systems and were selected to reflect:

- A range of system types (EHR, HIE, third-party/state-developed, and traditional)
- Rural and urban contexts
- Representation from State and Local WIC Agencies

All interviews were conducted virtually, recorded with participant consent, and transcribed for analysis.

ANALYTIC APPROACH

Quantitative Analysis

Survey data were analyzed in SPSS using descriptive statistics to summarize healthcare provider referral and data-sharing practices across responding agencies. Cross-tabulations were conducted to examine differences by system type and to compare

how various approaches are used and experienced across agencies. The quantitative results provide an overview of the systems in use, their usage frequency, the types of information shared, and agencies' perceived challenges, facilitators, and areas for improvement.

Qualitative Analysis

Qualitative interview data were analyzed using thematic analysis in MaxQDA. A structured codebook was created from the evaluation questions and participant interview data, then refined through iterative reviews. Multiple consultants analyzed the data to ensure consistency and strengthen the credibility of findings.

Integration of Quantitative and Qualitative Data

This report uses a mixed-methods design approach in which survey and interview data are integrated to form a holistic understanding of WIC agencies' referral and data-sharing systems. Survey findings provide breadth by illustrating overall patterns and prevalence, while qualitative data provides depth by explaining how and why systems work or do not work in real-world settings. Together, these data sources support system-specific insights and practical recommendations.

EVALUATION FRAMEWORK

The evaluation was guided by the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance) (Holtrop et al., 2021), alongside a Diversity, Equity, Inclusion, and Belonging (DEIB) lens (Spurlark et al., 2025). These frameworks informed the development of interview guides and analytic priorities.

The RE-AIM framework provides a structured approach to evaluating the reach, effectiveness, adoption, implementation, and maintenance of referral and data-sharing systems, ensuring that all critical aspects of system impact are considered. Integrating a DEIB lens further ensures that the analysis prioritizes equity and inclusion, helping to identify opportunities to advance fair access and belonging for diverse populations.

Key evaluation questions included:

- **Reach and equity**: How equitably do referral and data-sharing systems reach diverse populations and partner organizations?
- **Effectiveness and inclusion**: How do systems impact WIC enrollment, access, and organizational workflows?
- **Adoption and diversity**: What factors influence different agencies' adoption of specific systems?
- **Implementation and belonging**: How are systems implemented in ways that build trust and mutual benefit?
- **Maintenance and equity**: What supports long-term sustainability while maintaining equitable access?

ETHICAL AND PRIVACY CONSIDERATIONS

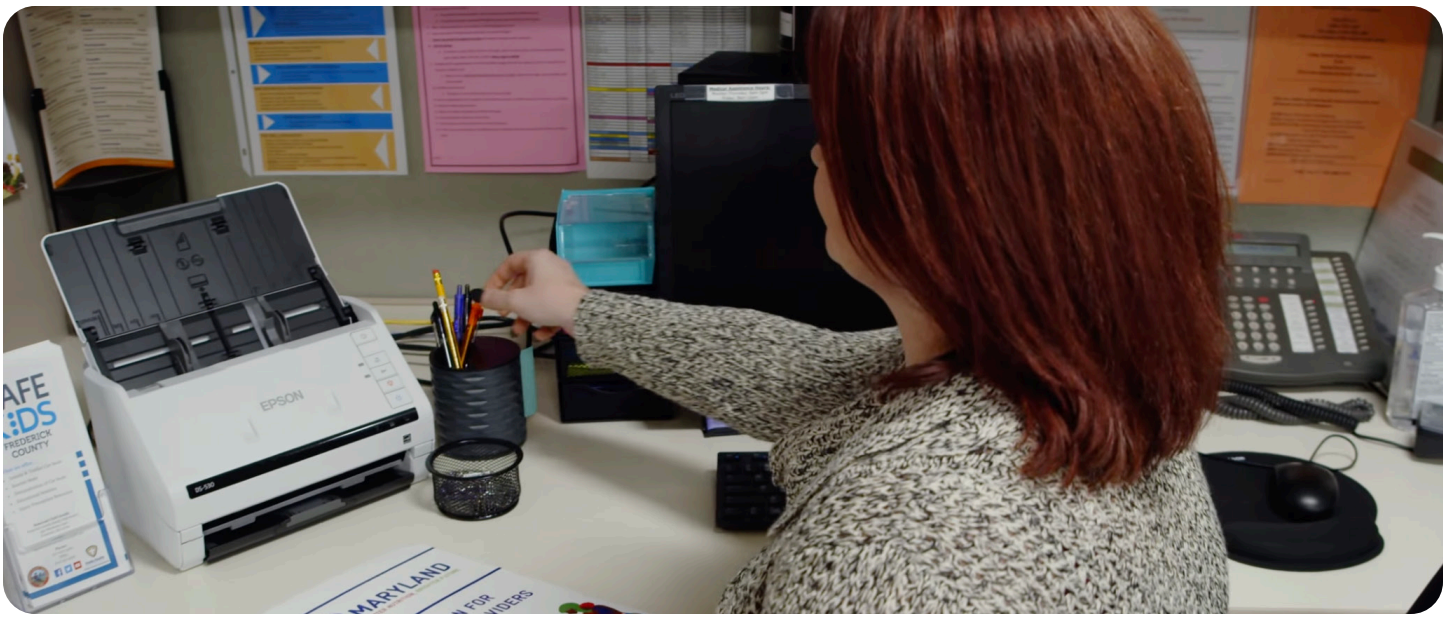
Participation in the survey and interviews was voluntary. Survey responses and interview data were reported in aggregate, and all data used in analysis were de-identified. Formal Institutional Review Board (IRB) review was not required for this landscape assessment; however, informed consent was obtained from all interview participants prior to data collection.

LIMITATIONS

Several limitations should be considered when interpreting findings. The survey sample represents a subset of State and Local WIC Agencies and is not nationally representative of all WIC sites. Data are self-reported and reflect agency perspectives at a single point in time. In addition, system implementation varied widely not only by system type, but also by depth of use, functionality, and local context. Finally, the absence of standardized healthcare provider referral and data-sharing processes across State and Local Agencies limits direct comparison across all settings.

Despite these limitations, the combined survey and qualitative findings offer valuable insight into current practices, challenges, and opportunities to strengthen WIC's ability to receive information from healthcare providers and healthcare systems.

HOW TO USE THIS REPORT



This report is designed to be practical, flexible, and easy to navigate, recognizing that WIC agencies and healthcare partners operate in different contexts and use different systems. This report is organized so that readers can quickly locate the sections most relevant to their current systems, priorities, or planning needs.

WHO IS THIS REPORT FOR

- **Local WIC Agencies** that are seeking to strengthen systems for receiving referral and medical data from healthcare providers, reduce administrative burden, or explore new approaches.
- **State WIC Agencies** supporting Local Agencies across varied contexts and capacities.
- **Healthcare partners** that are interested in improving coordination with WIC agencies.
- **National organizations** and funders that support system-level improvements and technical assistance.

HOW THIS REPORT IS ORGANIZED

Following an overview of the current landscape, the core of this report is organized by information exchange system type:

- Electronic Health Record (EHR)–based systems
- Health Information Exchange (HIE)–based systems
- Traditional and paper-based methods
- Third-party and state-developed platforms

Each system section includes:

- A brief system snapshot describing how the system typically functions.
- A discussion of how referrals and medical data are received in practice.
- Barriers, facilitators, and lessons learned drawn from agency experiences.
- A Keys to Success callout box with practical takeaways and recommendations.

Readers are encouraged to begin with the section that best reflects their current approach. Those planning transitions, managing multiple systems, or scaling across sites should also review the section on Integrating and Scaling Across Systems.

THE CURRENT LANDSCAPE OF WIC-HEALTHCARE INFORMATION EXCHANGE

WIC is one of the nation's most evidence-based public health nutrition programs, supporting healthy pregnancies, infant feeding, early childhood development, and long-term health outcomes. Administered by the U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS), WIC is delivered through a national infrastructure that includes 88 State, territorial, and Tribal Agencies and nearly 1,900 Local Agencies operating approximately 10,000 clinic sites nationwide (U.S. Department of Agriculture, Food and Nutrition Service, 2025).

In an average month, WIC serves more than 6 million pregnant and postpartum individuals, infants, and young children, yet participation represents only about half of those eligible for the program (U.S. Department of Agriculture, Food and Nutrition Service, 2025). Extensive research demonstrates that WIC participation is associated with improved birth outcomes, healthier infant feeding practices, enhanced food security, and reduced healthcare costs (Bitler & Currie, 2025; Hoynes, Page, & Stevens, 2011). Despite these benefits, administrative complexity and fragmented referral and data-sharing processes continue to limit enrollment, timely certification, and continuity of care.

THE ROLE OF HEALTHCARE PROVIDERS IN WIC ACCESS AND COORDINATION

Healthcare providers play a critical role in connecting eligible families to WIC. Pregnant individuals, infants, and young children have frequent contact with obstetric, pediatric, and primary care providers—often at moments when nutrition and breastfeeding support and preventive services are most impactful. As a result, healthcare settings serve as key access points for identifying WIC eligibility, initiating referrals, and sharing medical or anthropometric data required for WIC certification.

However, the mechanisms used to share information between healthcare providers and WIC agencies vary widely across states and local jurisdictions. These mechanisms reflect differences in healthcare infrastructure, technology adoption, policy environments, agency capacity, and maturity of local partnerships. Rather than a single standardized approach, WIC agencies operate within a diverse and decentralized ecosystem of information exchange systems.

A FRAGMENTED AND UNEVEN INFORMATION EXCHANGE LANDSCAPE

The current WIC and healthcare information exchange landscape is best described as fragmented and uneven. While some agencies have implemented electronic healthcare referral or data-sharing systems that reduce manual workload and improve timeliness, many continue to rely on paper forms, fax, email, or participant-delivered documentation. Even when electronic systems exist, they are often not integrated with WIC Management Information Systems (MIS), requiring WIC staff to manually re-enter data to complete certification or follow-up activities.

Several structural factors contribute to this variability:

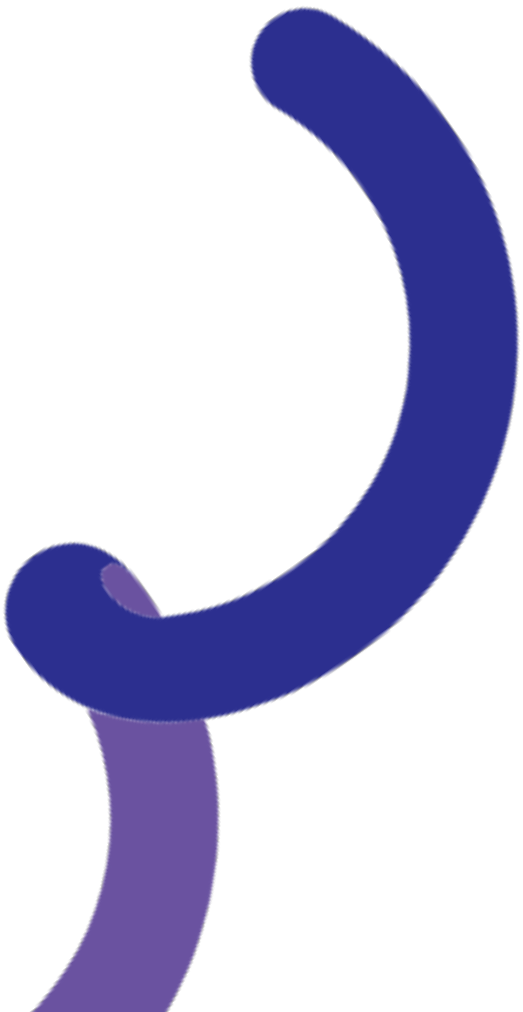
- **Decentralized governance**: While WIC is federally funded, State, territorial, and Tribal Agencies have significant autonomy in program administration, technology adoption, and partnership development.
- **Variation in healthcare infrastructure**: Access to EHRs, HIEs, and referral platforms differs across regions, particularly in rural, tribal, and territorial contexts.
- **Legal and privacy considerations**: Uncertainty related to data-sharing agreements, healthcare provider HIPAA compliance, and state-specific privacy laws can delay or prevent system implementation.
- **Staffing and capacity constraints**: Many WIC agencies operate with limited staffing, making it difficult to adopt, maintain, or scale new systems without additional support.

Federal oversight bodies have noted that administrative burden and technology limitations can create barriers to efficient service delivery in WIC and other safety-net programs, particularly when healthcare referral and data-sharing systems are misaligned with frontline workflows (United States Government Accountability Office, 2019).

WHY SYSTEMS MATTER: BEYOND TECHNOLOGY

Information exchange systems are not merely technical solutions; they shape how WIC agencies and healthcare providers collaborate, how staff time is allocated, and how families experience access to services. Systems that are poorly aligned with workflow can increase administrative burden on both WIC staff and healthcare partners, discourage healthcare provider participation, and delay enrollment. Conversely, systems that are thoughtfully designed, implemented and supported by clear roles, strong partnerships, and adequate resources can streamline processes, reduce duplication, and improve coordination of care.

This report recognizes that there is no single "right" system for all WIC agencies. Successful approaches depend on readiness, relationships, capacity, and local conditions. Accordingly, the sections that follow are organized by system type to help readers quickly identify systems most relevant to their desired approach, learn from agencies operating in similar contexts, and identify practical strategies to strengthen healthcare provider referrals and data-sharing systems.



FOUR PRIMARY INFORMATION EXCHANGE SYSTEM TYPES

Across the country, WIC agencies engage with healthcare providers using four broad categories of information exchange systems. These categories are not mutually exclusive; many agencies operate within hybrid environments, using multiple systems across sites or transitioning between approaches over time.

Electronic Health Record (EHR)

EHRs are digital, patient-centered, real-time records containing a patient's medical information and history.

Health Information Exchange (HIE)

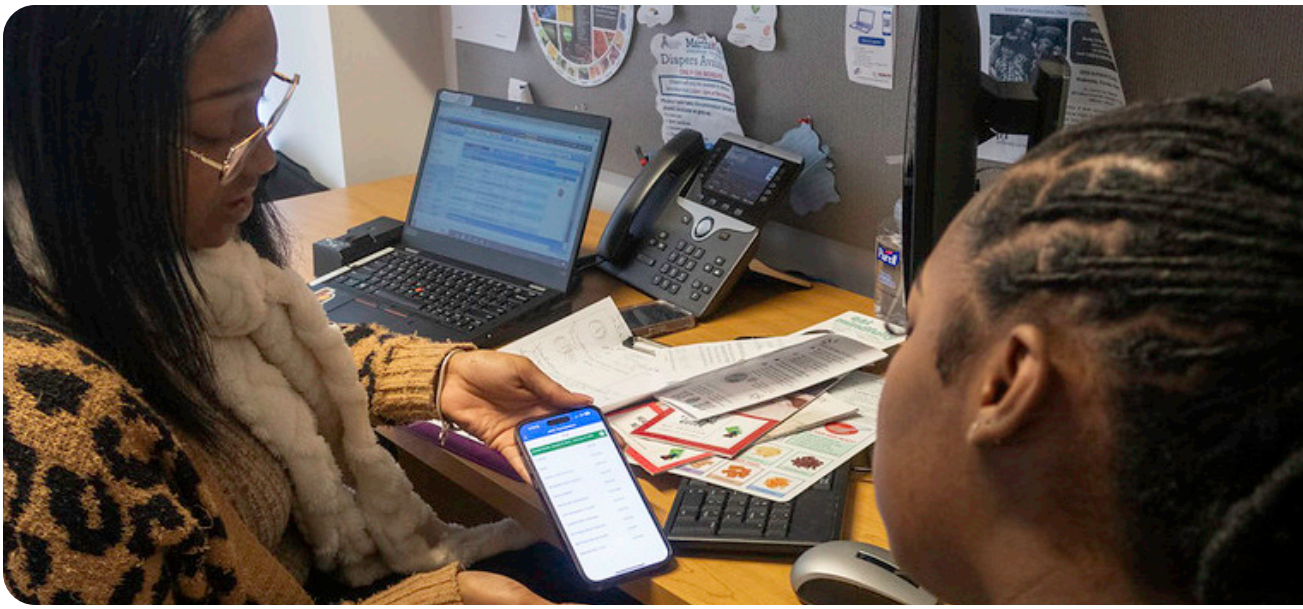
HIEs serve as intermediaries that facilitate data sharing among healthcare organizations and, in some cases, public health or social service programs.

Third-Party and State-Developed Platforms

Third-party and state-developed platforms expand referral entry points and support communication and intake. However, they typically offer limited access to medical data.

Traditional and Paper-Based Methods.

Traditional and paper-based methods, such as paper forms, fax, email, and participant-delivered documentation, are used to receive referrals and medical data.



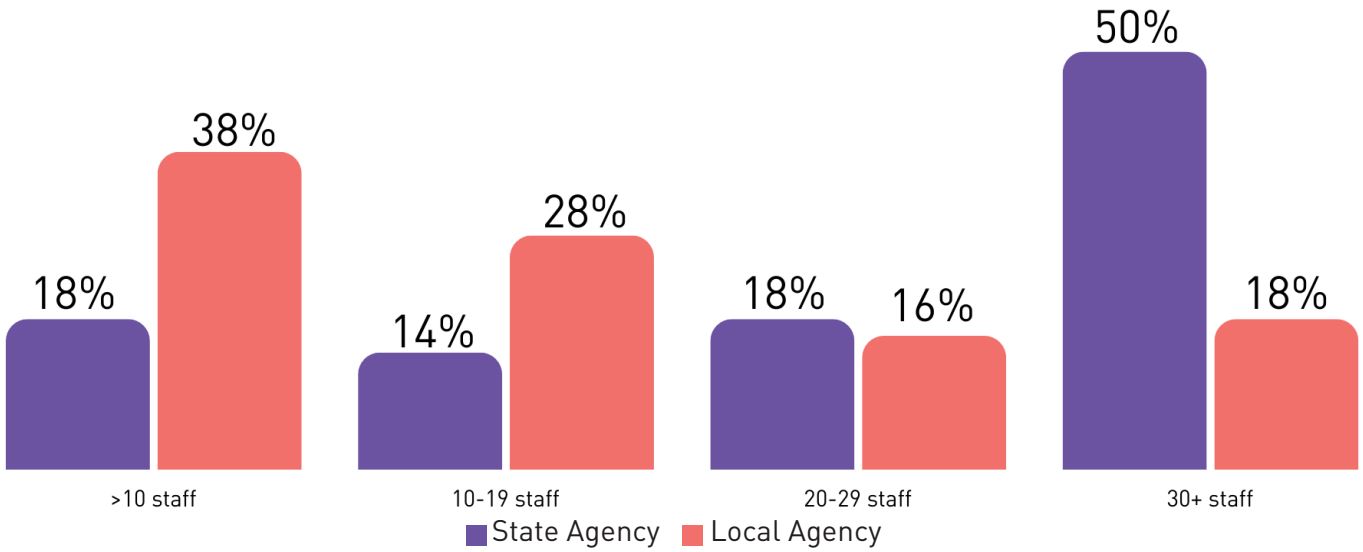
UNDERSTANDING WIC AGENCIES

AGENCY SIZE AND STAFFING CAPACITY

Local WIC Agencies vary widely in staffing size, though most operate with small to mid-sized teams. Among responding Local Agencies, 38% employ fewer than 10 staff, while 28% employ 10 to 19 staff. Nearly 18% report 30 or more staff, indicating the presence of a smaller number of very large agencies alongside many modestly staffed programs.

State WIC Agencies also vary in staffing size, reflecting differences in administrative scope and program oversight responsibilities. Among responding State Agencies, 32% employ fewer than 20 staff, 36% reported 20–39 staff, and 25% employ 50 or more staff.

Figure 1. WIC Agency Staffing, by Local and State Agencies



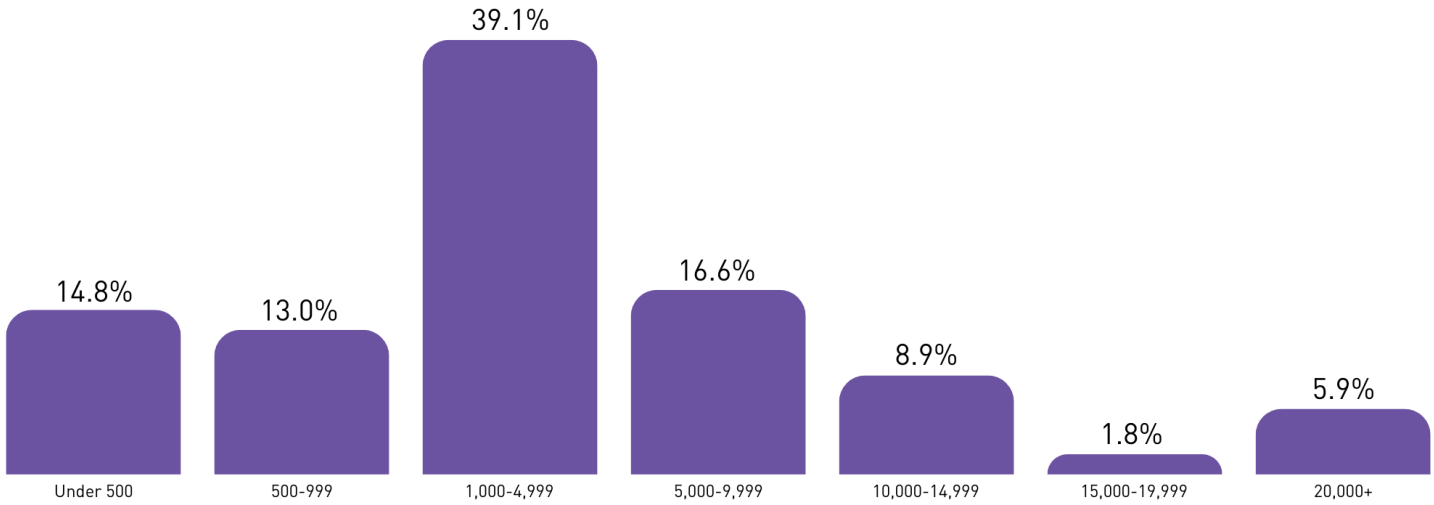
Local Agency n=173; State Agency n=28

These staffing differences shape how healthcare referral systems, data sharing, and follow-up processes are designed and implemented, and help explain variation in efficiency, burden, and scalability across agencies.

CASELOAD SIZE

Most responding Local WIC Agencies serve moderate-sized caseloads, with 39% managing between 1,000 and 4,999 participants per month. An additional 28% serve fewer than 1,000 participants, while about 34% manage caseloads of 5,000 or more. Only a small share of agencies serve very large caseloads exceeding 20,000 participants.

Figure 2. Local WIC Agency Monthly Caseload Size



Local Agency n = 176

The caseload range underscores the need for healthcare referral and data-sharing systems that can function effectively across both low-volume and high-volume environments.

ORGANIZATIONAL AND HEALTH SYSTEM AFFILIATION

More than half of responding Local WIC Agencies (57%) are co-located within local health departments. In addition, 25% of responding Local Agencies operate through nonprofits or community-based organizations, while smaller percentages are affiliated with Federally Qualified Health Centers (8%) or other types of healthcare or hospital systems (7%).

These affiliations influence access to electronic systems and opportunities for WIC MIS integration, with health departments and healthcare-based agencies often having greater exposure to digital infrastructure than community-based organizations.

PARTICIPANT COMMUNITY CHARACTERISTICS

Almost half (47%) of responding Local Agencies describe their participant communities as "majority rural," 34% as "majority urban," and 16% as "majority suburban."

Local Agencies also reported serving racially and ethnically diverse communities. Among the top three race/ethnicity groups served by Local WIC Agencies were White, non-Hispanic (90%), Hispanic or Latino (90%), and Black, non-Hispanic (73%). Smaller but meaningful proportions of the agencies serve American Indian or Alaska Native (14%), Asian (10%), Middle Eastern or North African (6%), and Native Hawaiian or Pacific Islander (5%) communities.

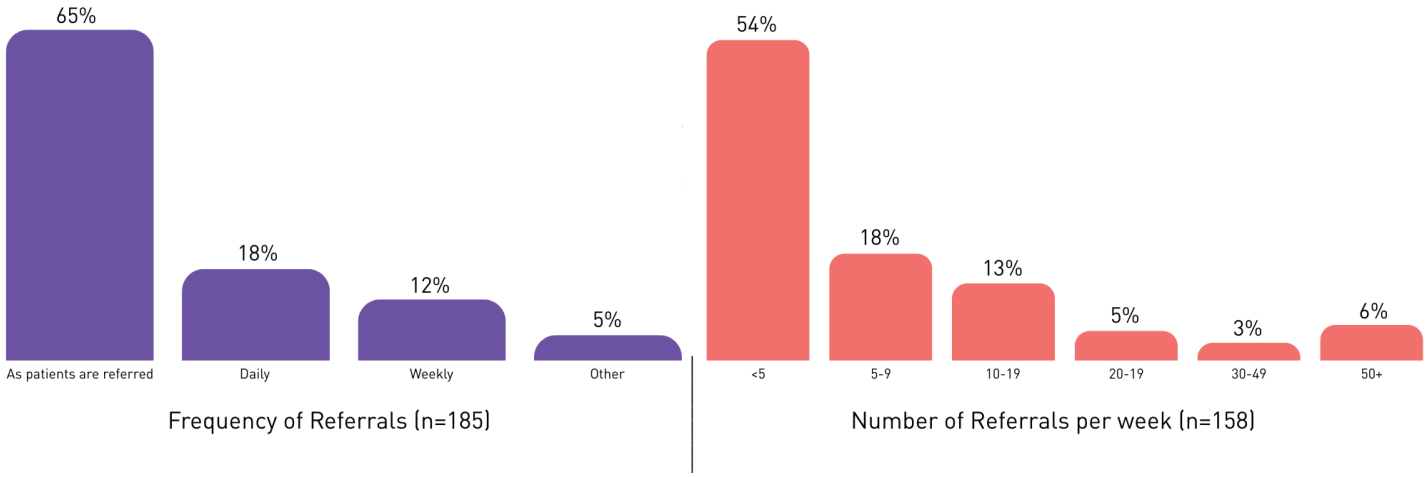
Language diversity is also a defining characteristic of participating Local WIC Agencies. Spanish is nearly universally reported (96%) by Local Agencies as a primary language spoken by participants after English. Other commonly reported languages include Arabic (29%), Haitian Creole (22%), Chinese (18%), and Portuguese (10%), alongside many additional languages.

REFERRAL MANAGEMENT

Staffing capacity and referral volume vary widely across Local WIC Agencies, shaping how agencies receive, process, and follow up on healthcare provider referrals. Forty-three percent (43%) of participating agencies rely on two to three staff members to manage referrals, while 14% rely on a single designated staff person. Only 26% of reporting Local Agencies involve more than five staff in referral management.

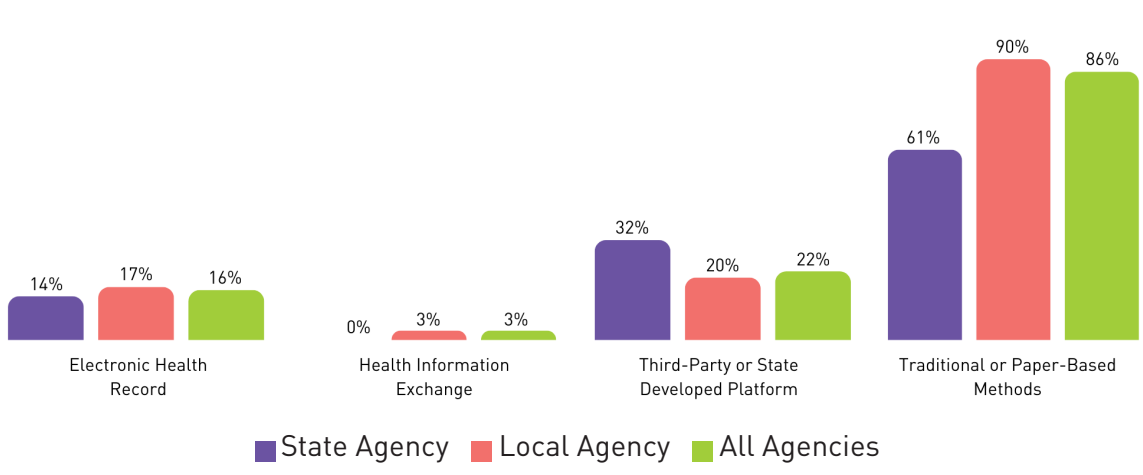
Most agencies receive healthcare provider referrals irregularly; 65% of participating agencies receive referrals individually, as patients are referred. Over half receive fewer than five referrals per week, while 31% receive between five and nineteen referrals weekly. Only a small percentage receive 20 or more referrals per week.

Figure 3. Frequency and Volume of Provider Referrals Received



Most reporting agencies continue to rely on participant-driven referrals (78%) and/or paper or faxed forms from healthcare providers (57%). Electronic pathways, such as EHRs, HIEs, or third-party referral platforms, are used by a relatively small share of agencies. Nearly 87% of agencies manually enter referral information into their WIC MIS, and 78% follow up with referrals by contacting families individually.

Figure 6. How Agencies Receive Referrals from Participants or Healthcare Providers, by Agency Type



Nearly 70% of agencies express interest in electronic referral systems, even if most have not yet started the transition.

Most reporting agencies report readiness at the "interest" or "early planning" stage, signaling a strong demand for practical guidance, infrastructure support, and scalable implementation pathways.

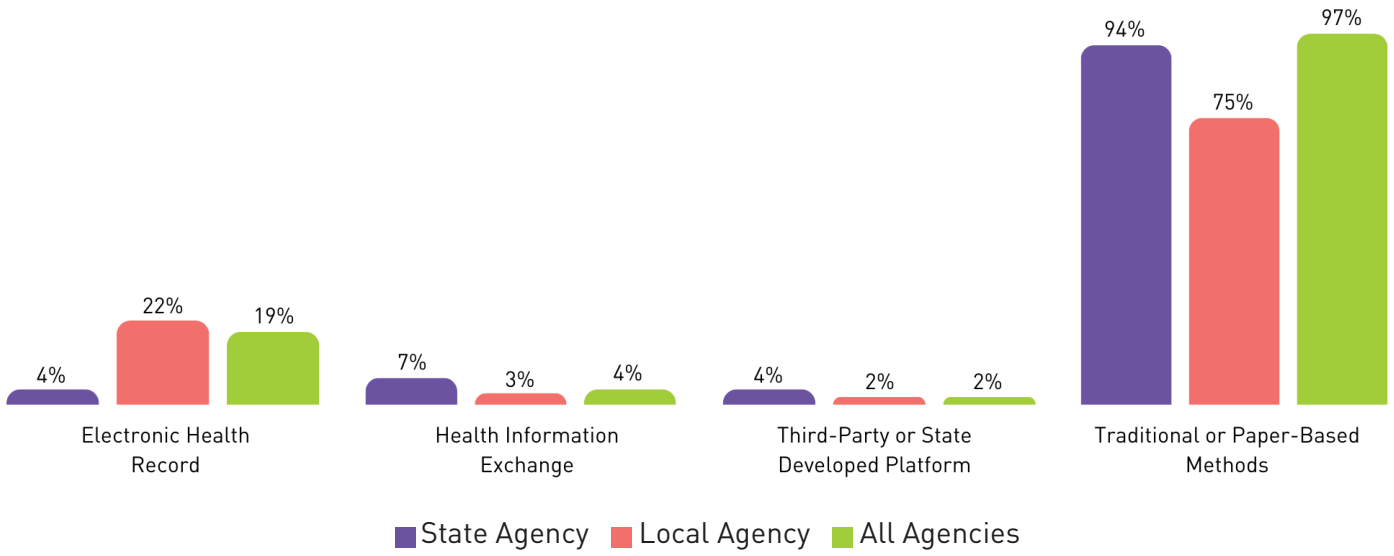
State Agency n=28; Local Agency n=176; All Agencies n=204

Agency perceptions of referral ease are mixed, with only 17% strongly agreeing that their current process is easy to use. Reported challenges reveal that staffing capacity—not system usability alone—is a primary barrier. Nearly half (45%) of agencies cite time-consuming processes for limited staff, and nearly one-third (31%) report dependence on a small number of staff.

MEDICAL DATA SHARING MANAGEMENT

Across participating agencies, medical and anthropometric data are most often received through manual, participant-mediated pathways. Nearly 90% of agencies receive medical data from participants, such as paper forms or screenshots from patient portals, and 74% receive paper or faxed forms directly from providers. Fewer than 20% receive data electronically through secure email, EHR access, or third-party platforms, and access via HIEs remain rare. Among agencies receiving medical data electronically, 81% use EHRs.

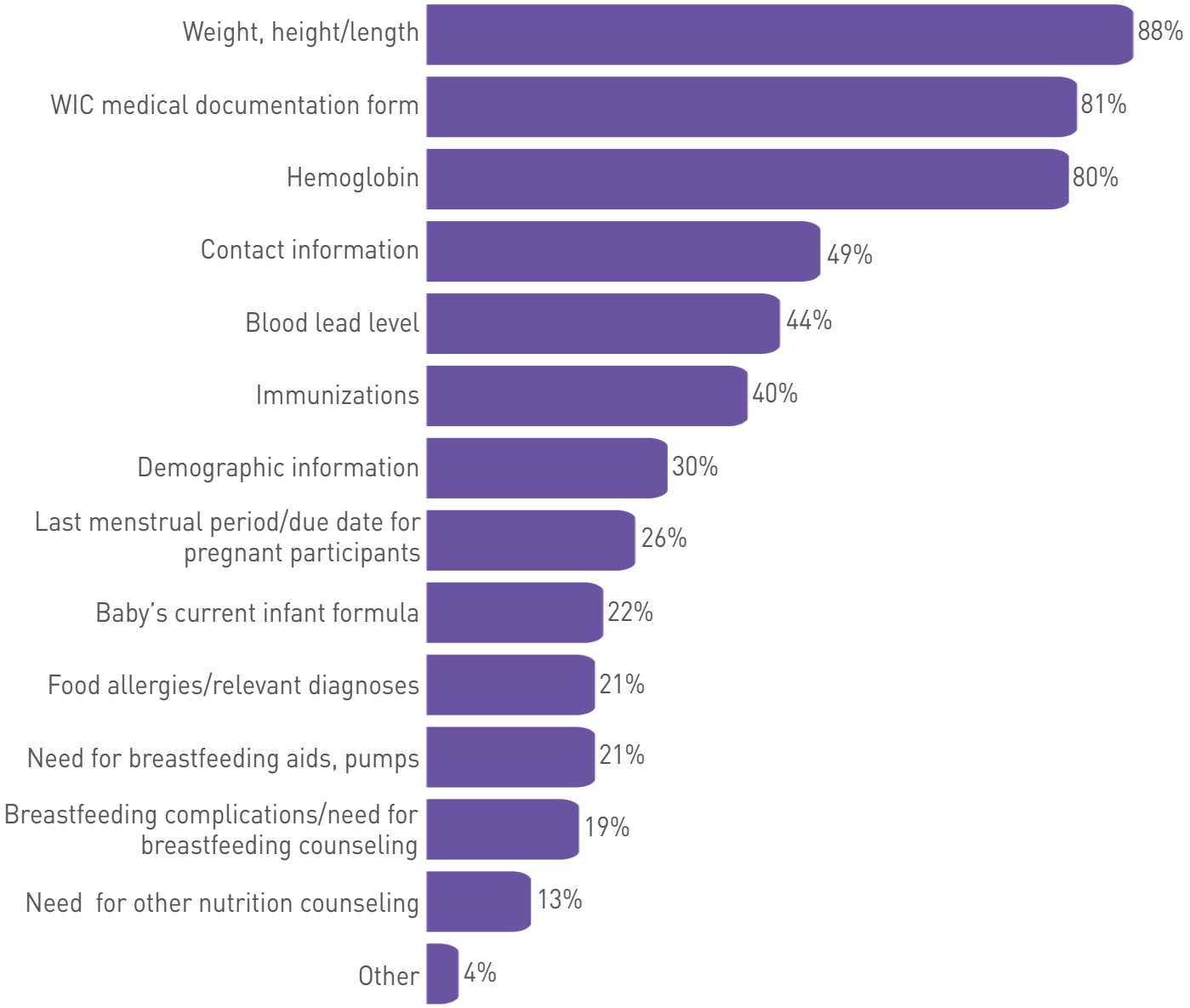
Figure 7. How Agencies Receive Medical Data from Participants or Healthcare Providers, by Agency Type



State Agency n=28; Local Agency n=176; All Agencies n=204

Regardless of data source, agencies collect a broad range of medical data for WIC enrollment and certification. The most collected medical data is weight and height/length (88%), followed by the WIC medical documentation form (81%) and hemoglobin (80%). In addition, agencies often collect data on contact information, blood lead levels, and immunizations. Other less frequently collected data includes demographic information, last menstrual period/due date, baby current formula, food allergies, breastfeeding needs and complications, and need for nutrition counseling.

Figure 8. Medical Data collected from Participants or Healthcare Providers



State and Local Agencies (n=172)

Among the 47 agencies reporting receipt of medical data through EHR, HIE, or third-party platforms, 87% reported receiving both weight, height/length and hemoglobin through those systems, followed by blood lead level (60%), contact information (53%), and immunizations (43%).

Most (56%) agencies receive less than 10 participant medical and anthropometric records on a weekly basis, with 67% of agencies also reporting that these records are received on an individual basis. Only 2% of agencies automatically receive medical data into their WIC MIS systems with minimal staff input.

Only 14% of agencies reported that they "strongly agreed" that their current system for receiving medical and anthropometric data from healthcare providers makes it easy to collect necessary data for certification. The most reported challenge with receiving medical data was that the systems were time consuming for WIC staff with limited capacity (53%).

Nearly three-quarters of agencies are interested in or working toward streamlined electronic data-sharing processes.

Though fewer agencies are in the mid-stages of establishing electronic data-sharing processes, 61% are interested and 9% are in the early planning stages of implementing electronic data-sharing activities.

INFORMATION EXCHANGE SYSTEMS REVIEW

This section provides an overview of the information exchange systems used by WIC agencies to support referrals, enrollment, and the sharing of medical and anthropometric data. The systems reviewed vary in complexity from fully electronic platforms to paper-based processes, but they all play a role in how agencies connect families to services.

This report reviews the following system types:

- **Electronic Health Records (EHRs)**
- **Health Information Exchanges (HIEs)**
- **Third-party or state-supported systems**
- **Traditional or paper-based methods**

To support clear comparison and consistency, each system type is reviewed using the same structured framework. This approach allows readers to understand how systems function today, how they affect staff and workflows, and where opportunities for improvement exist.

Readers can use the sub-sections to compare approaches, identify patterns, and understand how agencies can move from current practices toward more streamlined and sustainable information exchanges.

ELECTRONIC HEALTH RECORD (EHR)–BASED SYSTEMS

SYSTEM SNAPSHOT: ELECTRONIC HEALTH RECORDS

Electronic Health Record (EHR)–based systems support the receipt of referrals and/or medical and anthropometric data directly through healthcare providers' EHR platforms. In these models, WIC staff access select medical data (often read-only) or providers may transmit referral and medical information to WIC through EHR-based workflows such as referral modules or secure messaging.

EHR-based systems are most common where WIC agencies have established partnerships or affiliations with hospitals, healthcare systems, Federally Qualified Health Centers (FQHCs), or large provider networks that already use EHRs for medical documentation and care coordination. These approaches are often pursued to improve efficiency, reduce duplicative data entry, and support timely WIC certification and follow-up (Office of the National Coordinator for Health Information Technology, 2025).

When effectively implemented, EHR-based systems can streamline workflows and strengthen coordination between healthcare providers and WIC agencies. However, they typically require substantial upfront planning, including data-sharing agreements, workflow alignment, and technical configuration. Variability across EHR platforms, limited interoperability, and staffing constraints can affect how seamlessly data flow into WIC operations, particularly when EHR workflows are not integrated with the WIC Management Information System (MIS) (United States Government Accountability Office, 2019).

ABOUT THIS SECTION

This section describes how WIC agencies and healthcare providers use **Electronic Health Records (EHRs)** to support referrals and receipt of medical and anthropometric data needed for certification. Use of EHRs within the WIC ecosystem can vary widely, from highly streamlined workflows where providers send referrals through the EHR and WIC staff can easily access the necessary information, to more fragmented approaches that require WIC staff to retrieve much of the data themselves.

Findings in this section are grounded in qualitative interviews with State and Local WIC Agencies using EHR-based workflows. These interviews illustrate how EHR approaches can reduce provider, WIC staff, and participant burden and improve operational efficiency, while also highlighting challenges related to confidentiality constraints, system fragmentation, provider engagement, and double documentation. Where available, survey findings will be used to contextualize these experiences and describe broader patterns across agencies.

WHO IS USING THIS SYSTEM

Overall, 25% of participating WIC agencies reported using EHRs as part of their referral and/or data-sharing processes. EHR use was more commonly reported by agencies affiliated with larger health systems or health departments. Among agencies reporting EHR use, 65% used EHRs to support referrals and 76% used EHRs to retrieve medical and anthropometric data such as height/length, weight, and hemoglobin.

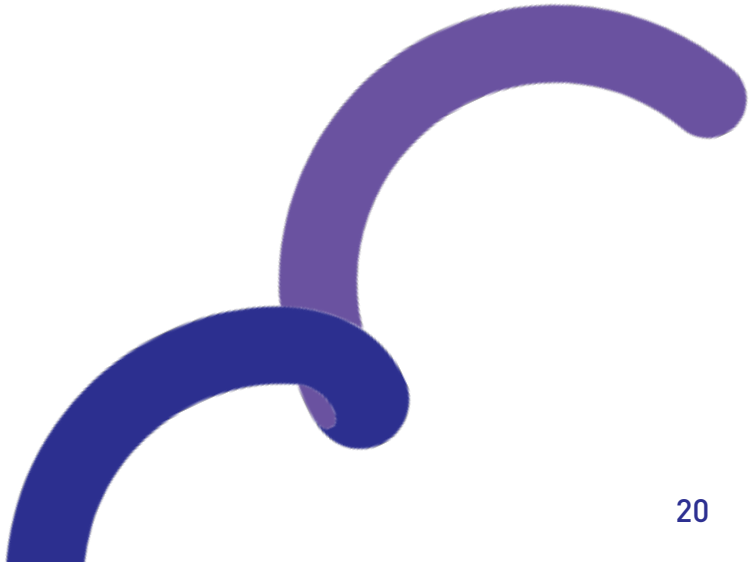
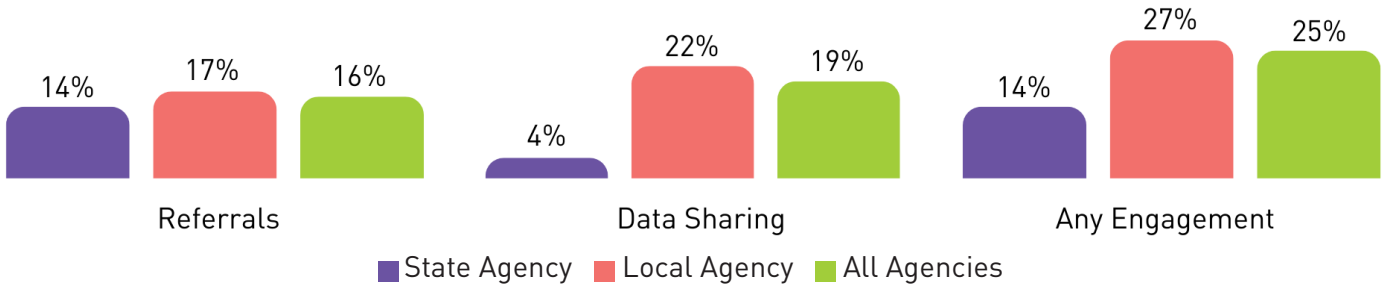


Figure 9. Electronic Health Record (EHR) Reported Utilization among State and Local WIC Agencies



State Agency n=28; Local Agency n=176; All Agencies n=204

EHR use frequently occurred alongside other methods, including paper, fax, email, or third-party and state-developed platforms, reflecting hybrid, multi-system workflows rather than single-system implementation.

HOW REFERRALS WORK USING THIS SYSTEM

Agencies using EHR-based systems, indicated that referral workflows rely on healthcare providers initiating a referral within the EHR using mechanisms such as referral modules, secure messaging, or WIC-specific workflows.

Figure 10. Common EHR Referral Mechanism Descriptions

Secure Messaging

Providers send a secure in-system message to designated WIC Staff, triggering follow-up.

EHR Referral Modules

Providers use a WIC module that auto-populates referral information from the patient chart.

Work Flow Standardization

Referral workflows are standardized to establish consistent processes for consent and data access.

Across these models, agencies emphasized that the most successful EHR referral processes are those that are simple for providers, require minimal additional time, and clearly communicate what happens after referrals are sent. WIC agencies used outreach strategies such as newsletters, provider meetings, and individualized support to build provider awareness and confidence. Many agencies also relied on champions within partner organizations to sustain engagement and normalize use of EHR referral workflows.

HOW MEDICAL AND ANTHROPOMETRIC DATA ARE SHARED

Agencies reported that EHR systems are also used to support access to WIC-relevant medical information. The most common model described was read-only access to specific data elements after participant consent is obtained. This access allows WIC staff to retrieve essential information such as height/length, weight, and hemoglobin, directly from the medical record, reducing reliance on faxed forms, participant-provided documentation, or follow-up calls to providers.
Some agencies described EHR features that improve both accuracy and efficiency, including:

- Auto-populated referral forms that pull patient data directly from the participant chart.
- Ability for WIC staff to view select chart elements to verify anthropometric data.
- Secure EHR messaging to request missing information or obtain WIC-related documentation.

Even when EHR access is available, agencies noted that medical and anthropometric data collected through the EHR may still require manual entry into the WIC MIS when systems are not integrated.

WORKFLOW, STAFFING, AND SYSTEM INTEGRATION

EHR-based workflows can improve operational efficiency by reducing paperwork, accelerating participant contact, and supporting remote service delivery.

Agencies described benefits such as:

- Earlier participant outreach, especially for pregnant people and infants.
- Reduced documentation burden for families, by allowing WIC staff to pull what information they need.
- Streamlined certification and recertification when recent measurements are available.

At the same time, agencies repeatedly noted a key constraint: WIC confidentiality requirements often limit direct system-to-system integration between WIC MIS and EHRs. As a result, many EHR-based approaches are "highly connected but not fully integrated." This reality creates operational challenges, including duplicate documentation, manual data entry, parallel tracking systems, and ongoing staff time devoted to troubleshooting and follow-up.

Agencies described strategies to manage these realities, including:

- Centralized triage (e.g., routing referrals by zip code or clinic site).
- Use of EHR features (e.g., unread message alerts) to reinforce accountability.
- Rotating staff coverage for EHR referrals to maintain continuity.
- Supplemental tracking systems (spreadsheets, printed logs) when integration does not exist.

BARRIERS, FACILITATORS, AND LESSONS LEARNED

Key Barriers to System Use

Across agencies, challenges to using electronic systems generally fall into three main areas:

- **Rules and legal requirements**: WIC privacy rules often require signed consent forms and limit what information can be shared. These rules can slow down the process and make it hard to fully connect systems.
- **Disconnected systems and limited support**: Many agencies use multiple systems that do not talk to each other. This leads to extra paperwork and repeated data entry. Limited IT support and uneven funding also make it difficult to keep systems updated and working well over time.
- **Staff time, training, and day-to-day challenges**: Heavy workloads, staff turnover, training needs, and limited time can slow system use. In some cases, providers do not enter complete information, and some participants have trouble using online tools, which affects how well systems work for everyone.

Key Facilitators of System Use

Agencies also shared factors that help electronic systems work better. These fall into three main areas:

- **Strong leaders and system champions**: Having dedicated staff who support the system, encourage partners, and help solve problems makes a big difference in adoption and long-term use.
- **Clear benefits for everyone involved**: Systems are more successful when agencies and providers see clear benefits, such as faster enrollment, less paperwork, and better coordination of care.
- **Flexible and step-by-step implementation**: Rolling out systems in phases, adjusting workflows to fit staff capacity, and learning from other agencies help make new systems easier to adopt and maintain.

WIC Agency Spotlight:

Forsyth County Health Department WIC Program and Atrium Health's Electronic Health Record Workflow

In North Carolina, the Forsyth County Health Department (FCHD) WIC Program integrated access to a local health system's electronic health record (EHR) to enhance its referral and data collection processes. This initiative was supported by a research grant led by several physician champions from the Atrium Health medical system who facilitated collaboration between WIC and several pediatric practices within the health system.

Healthcare providers at participating clinics can now initiate referrals to FCHD WIC directly in the EHR by asking families if they would like a WIC referral. If the patient consents, the referral appears as an EHR in-basket message for designated WIC staff based on the patient's county of residence. FCHD WIC maintains this workflow alongside other referral pathways (phone, email, fax, walk-ins, and a state website referral link) to preserve multiple access points for families.

The FCHD WIC nutritionists and supervisors also have read-only access to the EHRs of their clients for participating healthcare clinics, enabling them to retrieve essential data (e.g., weight, height/length, and hemoglobin) directly from patient records. This supports certification and recertification, including remote service delivery, and reduces the need for families to provide documentation for appointments. When participants receive care outside of clinics in the partnering health system, WIC staff must collect measurements at an in-person appointment or obtain data through secure email or other methods. These processes are often less efficient and can create uneven experiences for families.

FCHD WIC manages referrals across multiple staff roles: two staff handle EHR-based referrals, while three staff, plus the director, handle referrals from other sources. Staff rotate responsibility to maintain coverage and increase confidence in referral management. EHR-based referrals are tracked using spreadsheets, while other referrals are logged using printed sheets with notes on outreach attempts and outcomes. Training on how to use the EHR is provided by the healthcare system's team, and internal peer training supports onboarding. The Local WIC Agency director oversees systems to ensure timely processing and accountability across referral channels. Next steps for this project include integrating a similar process within the health system's obstetric clinics to try to improve rates of WIC referrals for pregnant patients.

For questions about this system, please contact Mayte Grundseth, Nutrition Program Director at Forsyth County Department of Public Health (grundsma@forsyth.cc).

LOOKING AHEAD: OPPORTUNITIES FOR STRENGTHENING EHR USE

Opportunities to strengthen EHR-based systems identified by some agencies included establishing secure EHR communication channels (e.g., in-baskets), creating standardized EHR referral templates, improving automated routing to the correct WIC locations, enhancing WIC-specific training for staff and providers, and developing centralized referral tracking to measure effectiveness across referral sources.

In addition, agencies identified the need to strengthen interoperability between EHR and WIC systems, expand local partnerships to include OB/GYN providers, pediatricians and labor and delivery hospitals, and improve alignment with other state services to create a more seamless experience for families.

RE-AIM SNAPSHOT: SYSTEM-LEVEL INSIGHTS

This snapshot synthesizes key findings across the RE-AIM framework to illustrate how this system functions in real-world WIC settings and where agencies may encounter opportunities or constraints.

Figure 11. RE-AIM Assessment of EHR Systems for WIC Agencies

R REACH	E EFFECTIVENESS	A ADOPTION	I IMPLEMENTATION	M MAINTENANCE
Reach grows through provider training, simplified workflows, and internal champions, yet uptake can be uneven.	EHR workflows can increase timely referrals and reduce documentation burden, but fragmentation limits full efficiency.	Adoption is often driven by modernization goals, external mandates, and shifts to remote services.	Implementation works best when WIC is involved early to align confidentiality requirements and refine workflows through feedback.	Sustained performance depends on formal agreements, accountability tools, and ongoing partnership and training.
Outreach and one-on-one support increases provider confidence and use.	Earlier outreach and easier verification when WIC can access needed data.	Local and State EHR rollouts can increase system buy-in and adoption.	Early engagement prevents legal and confidentiality missteps.	MOUs and consent processes define access and protect privacy.
Adoption may vary based on provider time, interest, and capacity.	Double documentation and incomplete provider data can reduce gains.	COVID-19 accelerated demand for electronic documentation processes.	Iterative design improves referral templates, consent, and WIC-specific views.	Tracking logs, message alerts, and periodic review ensure follow-through and continuity.

KEYS TO SUCCESS FOR EHR-BASED SYSTEMS

What this system does well:

- Enables faster, more consistent referrals when provider workflows are simple.
- Reduces documentation burdens for providers and families when WIC can access needed data.
- Strengthens care coordination through more timely information exchange.

Common challenges to plan for:

- Confidentiality limitations that prevent integration with WIC MIS.
- Double documentation and manual data entry when systems remain separate.
- Uneven provider engagement and inconsistent data availability.

What makes this system work:

- Early engagement of WIC in system design (to define boundaries and workflows).
- Champions within healthcare organizations and WIC agencies.
- Ongoing training and troubleshooting support.
- Clear consent processes and legal agreements (e.g., MOUs).

Actionable tips for WIC agencies:

- Make provider workflows as close to "one-click" as possible (templates, in-baskets, auto-populated forms).
- Establish clear tracking and accountability, especially in hybrid environments.
- Pilot with a high-volume partner, refine the process, and then scale
- Design for accessibility by offering alternatives when WIC participants face technology barriers.

Best fit for programs that:

- Have established healthcare partnerships using a shared EHR and capacity to support ongoing training and workflow alignment

HEALTH INFORMATION EXCHANGE (HIE)–BASED SYSTEMS

SYSTEM SNAPSHOT: HEALTH INFORMATION EXCHANGE

Health Information Exchanges (HIEs) are organizations or networks that facilitate the electronic sharing of health information across multiple healthcare entities within a region, state, or network. In the WIC context, HIE-based systems are primarily used to retrieve medical or anthropometric data required for certification, and in some cases, to support broader care coordination efforts between healthcare providers and public health or social service programs. HIEs are typically governed at the state or regional level and operate within established legal and policy frameworks (Holmgren et al., 2023).

For WIC agencies, HIE-based systems can offer the potential to access standardized medical data without relying on one-to-one connections with individual healthcare providers. At the same time, participation in HIEs often involves complex governance structures, varying levels of access, and different functionality across jurisdictions. These factors can influence whether HIE-based approaches are practical or sustainable for WIC agencies, particularly in settings with limited resources or uneven healthcare participation (Vest & Gamm, 2010).

ABOUT THIS SECTION

This section describes how WIC agencies use **Health Information Exchange** (HIE)–based systems to obtain referral and medical and/or anthropometric data needed for WIC referrals, certification, and service delivery. HIEs are different from EHRs because HIEs do not generate their own clinical data. Instead, an HIE is comprised of data collected and combined from different healthcare providers, clinics, and hospital systems. Each of those organizations may use their own EHR system with its own forms, workflows and documentation rules. Therefore, data accessed through an HIE may be incomplete, inconsistently updated and less standardized than data extracted directly from EHRs. Accessing this system has the potential to reduce the amount of paperwork families must gather and make recertifications faster, more accurate, and less burdensome for WIC staff and families.

Specifically, findings are drawn from survey data of twelve agencies. Four Local Agencies reported receiving referrals from an HIE system and eight WIC agencies (two State Agencies and six Local Agencies) reported having direct access to medical and/or anthropometric data using an HIE system. Findings are also extrapolated from an in-depth qualitative interview with one State WIC Agency that has implemented both medical portal access and Application Programming Interface (API)-based integration between the HIE and their WIC MIS. These findings illustrate how HIEs can support streamlined certification workflows, reduce administrative burden, and improve participant experience, while also highlighting challenges related to data completeness, equity, and long-term sustainability.

WHO IS USING THIS SYSTEM

Use of HIE systems was very limited among survey and interview respondents, with a small number of agencies reporting access to HIE platforms for retrieving referral and medical and/or anthropometric data. However, the experiences documented provide insight into what is possible when governance, partnerships, and technical infrastructure are aligned. Given the small number of respondents reporting HIE use and the qualitative data from one State WIC Agency, **findings for this system should be interpreted as illustrative of emerging practices** rather than representative of widespread adoption.

Among the four responding agencies that received referrals from HIEs, three (75%) also received referrals through traditional methods, and one reported receiving referrals by HIE only.
Among the eight responding agencies that received

medical data from HIEs, five (62.5%) also received medical data through both traditional and paper-based methods, one (12.5%) also received medical data through traditional methods and EHR, and two reported only receiving medical data through an HIE. Through these electronic methods, all were able to receive weight, height/length, and hemoglobin. Most (87.5%) were able to receive blood lead levels. Two reported full integration, indicating that medical data is automatically received into the WIC MIS system with minimal staff input.

HOW REFERRALS WORK USING HIE-BASED SYSTEMS

Because only a small number of agencies reported in the survey and interviews that they receive referrals through HIEs, this report cannot offer a comprehensive picture of WIC agency practices related to HIE-based referrals.

However, findings from NWA-funded pilots conducted by the California WIC Association illustrate how HIEs can help Local WIC Agencies receive referral information for WIC-eligible individuals more efficiently (National WIC Association, 2024). Two Local WIC Agencies affiliated with Federally Qualified Health Centers in Los Angeles implemented a system to receive referrals, along with medical data, through a regional HIE. Each week, the health center sent a roster of patients seen for prenatal and well-child visits to the HIE. The HIE then made the roster available to WIC staff through a dedicated "WIC view," which included contact information and relevant medical data. WIC staff compared the roster to participant records in the MIS and conducted outreach to enroll or recertify eligible families. This process streamlined referrals, reduced administrative burden, and helped families access WIC services earlier.

HOW MEDICAL AND ANTHROPOMETRIC DATA ARE SHARED

HIE-based systems are primarily used to retrieve medical and anthropometric data necessary for WIC certification. Commonly accessed data includes height/length, weight, hemoglobin levels, date of birth, and immunization records. This approach significantly reduces reliance on faxed forms, follow-up calls to medical offices, or participant-provided documentation. Staff described the ability to retrieve recent, valid measurements with a single action as a substantial improvement in workflow efficiency and participant experience, particularly for young children with recent well-child visits.

An HIE system can operate using an opt-out or opt-in consent policy, with opt-out meaning that patients must actively decline to share their data with the system and opt-in meaning that patients must actively approve the sharing of their data with the HIE system (Office of the National Coordinator for Health Information Technology, 2016).

Interview participants noted that HIE data quality and consistency remain a persistent challenge. Some records may only contain data required by state policy (e.g., immunizations or lab results), omitting measurements critical for WIC certification. While HIEs include analytical tools that can identify geographic areas or health systems with limited data contribution, these features were not yet fully utilized by Local WIC Agencies, suggesting opportunities for more strategic use of system analytics.

However, HIE data availability varies by region. In areas with lower health system participation or limited data, staff may still need to rely on traditional methods for gathering medical data, resulting in uneven experiences for both participants and staff.

WORKFLOW, STAFFING, AND SYSTEM INTEGRATION

Integration between the HIE and the WIC MIS represents a promising opportunity and significant shift in workflow. Automated data transfer reduces manual entry and allows staff to focus more on participant engagement and service delivery rather than administrative follow-up. One example of HIE-MIS integration can be found in the Vermont State Agency Spotlight below.

BARRIERS, FACILITATORS, AND LESSONS LEARNED

Key Barriers

Agencies shared several challenges when using HIEs. These challenges generally fall into three main areas:

- **Data quality and technical issues**: Patient data in HIEs can be incomplete and inconsistent across records. This can make it hard for WIC staff to find the right information. Matching errors, formatting differences, and system glitches can also slow the process.
- **Limited staff time and IT support**: HIE integration can be complex and requires ongoing technical support. Central IT teams often have many competing priorities, which can delay system updates or troubleshooting.
- **Privacy and communication challenges**: Initial concerns about privacy and access to non-WIC data required careful policy review and legal approval. In some cases, highly technical discussions made it harder for program staff to stay fully engaged without extra support and clear communication.

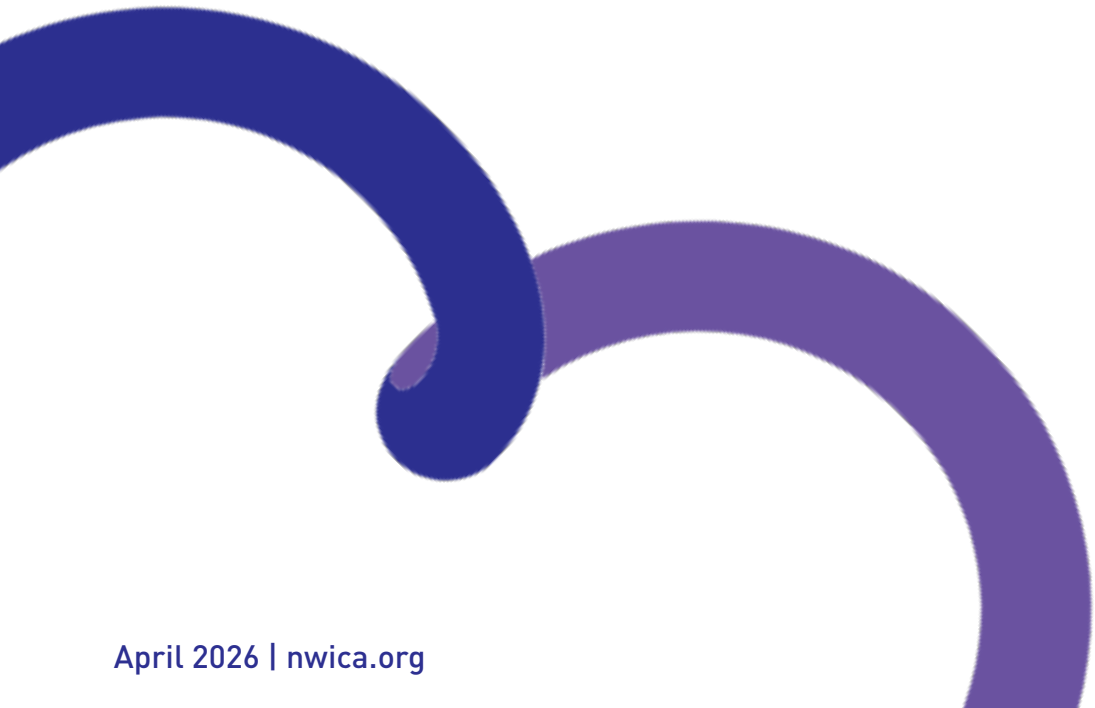
Key Facilitators

Agencies also identified several factors that helped make HIE implementation successful:

- **Strong leadership and clear purpose**: Framing WIC access to HIEs as a public health priority and a way to improve population health outcomes helped secure leadership support and legal approval.
- **Dedicated funding and partnerships**: Special funding, such as ARPA modernization grants, and strong partnerships with HIE organizations helped move projects forward.
- **Step-by-step implementation and shared learning**: Starting with HIE portal access and ensuring viability before moving to system integration makes the process more manageable. Learning from other states and reusing system integration templates also reduced time and cost.

LOOKING AHEAD: OPPORTUNITIES FOR STRENGTHENING HIE USE

The interviewed State WIC Agency identified opportunities to strengthen HIE-based systems, including centralized tracking of referral effectiveness, deeper integration with other state benefit programs, improved automation of data retrieval, expanded partnership with healthcare and community organizations, and enhanced data measurement strategies to assess impact over time.



WIC Agency Spotlight:
State of Vermont WIC Program and HIE Integration

The State of Vermont WIC Program offers a detailed example of how HIE-based systems can be implemented and scaled. Vermont initially granted WIC staff access to the front end clinical portal of the Vermont Health Information Exchange (VITLAccess) under existing public health regulations, with approval from the HIE authority, the state health department, and the health commissioner. The COVID-19 pandemic heightened urgency and reinforced the public health rationale for access due to pivoting to remote WIC appointments. Privacy safeguards were established through a dedicated WIC user role and comprehensive staff training.

Once HIE access was established, Vermont pursued integration between the HIE and the WIC MIS using existing development work from a technical collaboration completed in Iowa, a partner state in the Mountain Plains States Consortium (MPSC), and the MIS provider supporting the consortium. Iowa funded the initial HIE–MIS API-based integration using American Rescue Plan Act (ARPA) Modernization Grant funding. The MIS provider reused this integration code as a template for Vermont, enabling the state to avoid duplicative development and accelerate implementation. Vermont funded the technical work that needed to be completed on the HIE side with ARPA Modernization Grant funding.

Program staff played a critical role as subject matter experts during API development, ensuring that data were mapped correctly into WIC screens and accounted for variations in how values (e.g., hemoglobin) are recorded in medical records.

While automation improved efficiency, implementation required substantial coordination among WIC program staff, internal IT teams, the HIE organization, and the MIS provider. Dedicated project management was consistently identified as essential to maintaining momentum and resolving issues.

To support implementation, the State WIC Agency:

- Collaboratively developed a custom "WIC user role" in the front end clinical portal of the HIE to limit access to only approved data and screens.
- Developed policies and procedures governing appropriate system use.
- Provided comprehensive staff training.
- Utilized an existing state-level help desk to provide troubleshooting and support.
- Conducted ongoing evaluation on Vermont WIC's use of the HIE.

The API integration launched in April 2025 and now supports automated retrieval of key medical data into the MIS, with HIE medical portal access retained as a backup. The State Agency monitors match rates and data quality monthly and uses a structured help desk process to identify and resolve issues. During the first five months of the integration, the match rate (the HIE finding a patient match to a participant in the WIC system) averaged 95%, with 88% of those matches returning at least one data point. This phased, collaborative approach demonstrates how states can modernize systems while managing risk and capacity.

For questions about this system, please contact the Vermont WIC State Agency (wic@vermont.gov).

RE-AIM SNAPSHOT: SYSTEM-LEVEL INSIGHTS

This snapshot synthesizes key findings across RE-AIM to illustrate how HIE-based systems function in real-world WIC settings and where agencies may encounter opportunities or constraints.

Figure 12. RE-AIM Assessment of HIE Systems for WIC Agencies

R REACH	E EFFECTIVENESS	A ADOPTION	I IMPLEMENTATION	M MAINTENANCE
HIE improves access to medical data, reducing burden on participants, providers, and WIC staff.	HIE streamlines certification and reduces participant burden when data are available.	Adoption accelerates when states reuse shared models, code, and lessons learned.	Successful implementation requires phased rollout, strong governance, and trusted cross-sector partnerships.	Ongoing performance monitoring and structured support keep the system reliable.
Incomplete data and errors across records can limit usability.	Faster retrieval of medical data to support certification.	Consortium-based adoption reduces duplication and cost.	HIE portal access → MIS integration as a manageable phased approach.	Monthly match rate and data quality monitoring informs iterative fixes.
Regional variation in data availability creates uneven access and equity concerns.	Supports remote certification and reduces reliance on paper, fax, and phone.	Peer-state templates create a scalable pathway for new states.	Customized access controls and policies, training enable privacy compliance.	Tiered help desk and vendor partnership turns local issues into system improvements.

KEYS TO SUCCESS FOR HIE-BASED SYSTEMS

What this system does well:

- Reduces manual data collection and administrative burden.
- Streamlines certification when data are available.
- Improves participant experience by minimizing in-person appointments.

Common challenges to plan for:

- Inconsistent data availability
- Technical complexity and troubleshooting demands.
- Resource constraints within centralized IT environments.

What makes this system work:

- Strong public health justification and leadership support.
- Dedicated funding and project management.
- Trusted partnerships with HIE organizations and MIS providers.
- Consortium-based learning and shared technical assets.

Actionable tips for WIC agencies:

- Leverage internal and external expertise and collaboration to support the technical aspects of HIE implementation.
- Use a structured and phased implementation approach.
- Develop comprehensive policies, procedures, and training materials to ensure staff properly utilize the HIE.

Best fit for programs that:

- Operate within strong state or regional HIE environments inclusive of a range of health systems.
- Have the capacity for cross-agency or consortium collaboration.

THIRD-PARTY AND STATE-DEVELOPED PLATFORMS

SYSTEM SNAPSHOT: THIRD-PARTY AND STATE-DEVELOPED PLATFROMS

Some WIC agencies use third-party referral platforms or state-developed and internally managed systems to support referrals, intake, communication and limited information exchange. These systems are most often used to help individuals or providers identify WIC as an available service, initiate referrals, or support early stages of the application process. Third-party platforms are typically designed as **service navigation and referral** tools that list multiple social services, including WIC. They are commonly used by members of the public, healthcare providers, or community-based organizations to identify available support and submit referrals. While these platforms can facilitate referrals to WIC, they are generally not designed for direct medical or anthropometric data exchange or integration with WIC MIS.

State-developed platforms, by contrast, are created and managed by State WIC Agencies or their partners to support WIC-specific workflows. These tools often include online referral or intake forms, pre-application systems, participant portals, and internally managed communication or document-sharing tools.

Compared with EHR-based approaches, third-party and state-developed systems may offer greater flexibility and faster implementation (U.S. Department of Health and Human Services, 2021), but their functionality and ability to integrate with WIC MIS vary widely. Many platforms primarily support referral intake and tracking rather than direct medical data sharing, and their effectiveness often depends on local champions, training, and ongoing funding. As a result, success is driven less by technology itself and more on staffing capacity, partner participation, and alignment with existing workflows (Alderwick et al., 2018).

ABOUT THIS SECTION

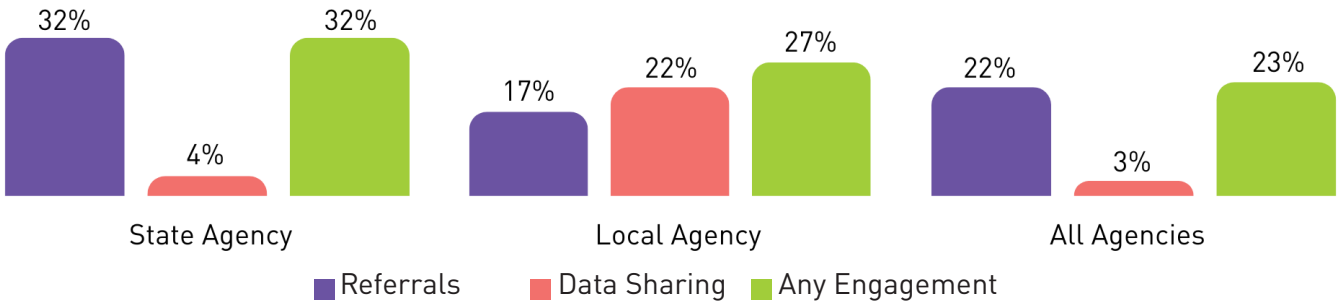
This section describes how WIC agencies leverage third-party platforms and state-developed systems as a **supporting infrastructure** for WIC referral and data-sharing activities, rather than as systems of record for WIC services. These platforms are most commonly used to initiate referrals to WIC agencies, support outreach, facilitate communication, or manage documents prior to enrollment.

Findings in this section draw from both the quantitative and qualitative interviews that uncovered reported system utilization by some WIC agencies. This section highlights how third-party and state-developed systems can be effective in supporting referrals to WIC, particularly when coupled with other referral and data collection processes.

WHO IS USING THIS SYSTEM

Third-party and state-developed platforms were used by a subset of WIC agencies to support referral intake, participant communication, and document submission. Local WIC Agencies reported more use of third-party platforms to facilitate referrals, whereas, State WIC Agencies reported facilitating more state-developed portals, such as online pre-screening and referrals.

Figure 13. Third-Party and State-Developed Platform Reported Utilization among State and Local WIC Agencies



State Agency n=28; Local Agency n=176; All Agencies n=204

Agencies primarily reported use of these systems in addition to other referral and data-sharing methods. Agencies using third-party platforms commonly cited FindHelp, NWA's signupwic.com site, the Integrated Referral and Intake System (IRIS), and Unite Us.

State-developed platforms include electronic referral forms and/or participant pre-application forms hosted on the State Agency website. These resources support referrals to Local WIC Agencies and are sometimes integrated with the state's WIC MIS.

HOW REFERRALS WORK USING THIRD-PARTY AND STATE-DEVELOPED SYSTEMS

Third-party and state-developed platforms primarily support **referral initiation and routing** rather than end-to-end referral management.

- Some third-party platforms, such as FindHelp, are open to the public and are designed to help individuals, healthcare providers, and community organizations identify and refer to a wide range of social services, including WIC.
- Other third-party platforms, such as Unite Us and IRIS, support community-level closed loop referral tracking, notifications, and coordination across registered service providers. These platforms facilitate referrals between registered healthcare providers and community organizations. WIC agencies receiving referrals from these platforms follow up with the referred individual to initiate the enrollment process, if they are not already receiving WIC services.
- NWA's signupwic.com is a public-facing website that has information and resources to help families enroll in WIC. The site serves as a gateway, connecting users to their State and Local WIC Agencies. Users begin the process by selecting their state. Based on their location, they are either directed to their State Agency's website or pre-application form, or they are prompted to provide eligibility and contact information to generate a referral to the appropriate Local Agency. Agency staff then follow up directly with the individual to complete enrollment.
- State-developed participant portals vary in functionality and may allow WIC applicants or participants to assess eligibility, enter household information, request or schedule appointments, and/or submit documentation related to certification or recertification. These systems indirectly support referrals by streamlining intake workflows.

While these systems expand entry points into WIC, referrals typically still require manual review and follow-up by WIC staff.

HOW MEDICAL AND ANTHROPOMETRIC DATA ARE RECEIVED

Third-party and state-developed systems play a limited role, if any, in direct medical and anthropometric data sharing. Most platforms, particularly third-party platforms, do not transmit medical or anthropometric data such as height/length, weight, or hemoglobin.

Some state-developed websites or portals may allow participants to upload medical documentation forms or screenshots from other patient portals (e.g., MyChart), which staff then manually review and enter into WIC MIS.

As a result, medical and anthropometric data sharing through third-party and some state-developed systems remains indirect and staff-mediated, reinforcing reliance on manual processes even in otherwise electronic workflows.

WORKFLOW, STAFFING, AND SYSTEM INTEGRATION

Third-party and state-developed systems influence workflow primarily by r**edistributing, not eliminating, staff effort**. WIC staff incorporate referrals received through these methods into their current referral follow-up processes. However, because these systems, particularly third-party platforms, are not usually integrated with the MIS, staff must still manually review referrals, contact participants, verify eligibility, and reconcile documentation. State-developed systems may offer additional support, with integration into the WIC MIS, such as automated referral routing to Local WIC Agencies that can reduce intake bottlenecks and speed initial outreach.

Staffing models rely heavily on designated intake or follow-up staff, supported by informal cross-coverage during peak periods. Agencies emphasized that these systems are most effective when staff roles are clearly defined and supported by strong internal coordination.

When considering system integration with WIC MIS, third-party platforms are not generally supported. State-developed platform integration with MIS is more common, but its usefulness depends on the amount of data collected.

BARRIERS, FACILITATORS, AND LESSONS LEARNED

Key Barriers

Agencies reported several challenges when using third-party and state-developed platforms. These challenges generally fall into three main areas:

- **Limited data sharing and continued manual work**: Most platforms do not send referral data directly into WIC MIS. Consequently, staff frequently need to manually input information, which consumes time and raises the risk of errors.
- **Too many systems to manage**: Staff may need to use several platforms at once, which can create extra steps and make workflows harder to manage. Using parallel tracking systems also adds to staff workload.
- **Uneven use and access**: Not all agencies or partners use these platforms in the same way. Some participants also have trouble navigating secure platforms, which can slow referrals and cause follow-up gaps.

Key Facilitators

Agencies also identified strengths that help third-party and state-developed platforms work more effectively:

- **Easier referral intake through electronic tools**: Automated referral routing and multiple ways to submit referrals make it easier for providers and participants to connect with WIC.
- **Flexible staff and shared systems**: Staff problem-solving and state-level standardization of referral platforms help agencies adapt workflows and create more consistent processes across locations.

WIC Agency Spotlight:

Wisconsin WIC's State-Developed Platform

Wisconsin State WIC operates a state-developed online pre-application system that routes directly into the state's WIC MIS. Individuals interested in WIC submit a basic contact information form through a public-facing website. That information flows automatically into the MIS and is assigned to one of the state's 60 Local WIC Agencies based on county, and in some cases, zip code. Local WIC Agencies receive alerts within the MIS when new forms are submitted. Staff then review the form, follow up with the family, gather additional information, and determine whether to schedule an appointment.

The pre-application form begins with screening questions to reduce submissions from individuals who do not meet basic eligibility requirements. The form then collects basic information, including name, date of birth, phone number, email address, zip code, preferred language, best time to contact, and preferred contact method. The system reduces submissions from ineligible individuals, helping manage staff workload and focus outreach efforts on potentially eligible families. The contact information collected enables routing to the correct Local Agency and allows staff to initiate outreach while keeping the intake process simple for families.

Wisconsin tracks the status of the forms within the MIS (e.g., in process or completed), though full enrollment conversion analysis has not yet been conducted. Staff have expressed interest in eventually converting the form information directly into participant records, but doing so would require collecting additional required data fields or modifying the MIS to support automatic record creation.

State staff describe the integration of the pre-application form with the MIS as a significant improvement over prior workflows, which required logging into a separate system to view leads. Because the system operates within the MIS, data flow remains confidential and centralized, reducing the need for parallel platforms.

Overall, Wisconsin's experience demonstrates how a state-developed pre-application tool embedded within the MIS can streamline referral routing, improve pre-application form visibility for Local WIC Agencies, and reduce reliance on separate tracking systems while still operating within the limits of basic individual-level data collection.

For questions about this system, please contact Carol Birkeland, Wisconsin WIC Program Operations Coordinator (carol.birkeland@dhs.wisconsin.gov) or Kaila Baer, Wisconsin WIC Nutrition Services Coordinator (kaila.baer@dhs.wisconsin.gov).

RE-AIM SNAPSHOT: SYSTEM-LEVEL INSIGHTS

This snapshot synthesizes key findings across the RE-AIM framework to illustrate how third-party and state-developed platforms function in real-world WIC settings and where agencies may encounter opportunities or constraints.

Figure 14. RE-AIM Assessment of Third-Party and State-Based Platforms for WIC Agencies

R REACH

Expand access through multiple entry points, including self-referrals and online applications, but usability challenges can limit reach for some populations.

E EFFECTIVENESS

Improve intake speed and communication efficiency, though client navigation issues and partial integration reduce overall impact.

A ADOPTION

Driven primarily by state-level decisions, with uneven awareness and uptake across local agencies.

I IMPLEMENTATION

Most effective when integrated with the MIS; otherwise, reliant on manual workarounds and parallel systems.

M MAINTENANCE

Sustained through staff expertise and adaptability rather than automated or fully interoperable system design.

KEYS TO SUCCESS: THIRD-PARTY SYSTEMS AND STATE-DEVELOPED PLATFORMS

What These Systems Do Well:

- Expand entry points into WIC through online applications, self-referrals, and community-based referrals.
- Reduce intake delays and staff burden when referrals feed directly into the MIS.

Common Challenges to Plan For:

- Limited ability to receive medical and anthropometric data.
- Fragmented workflows when systems are not fully integrated with the MIS.
- Increased staff burden from manual data entry and parallel tracking.
- Participant and partner lack of awareness or difficulty using platforms.

What Makes the System Work:

- Direct MIS integration for referral intake and document routing.
- Clearly defined staff roles.
- Strong internal coordination and adaptability.
- Simple, participant-friendly tools.

Actionable Tips for WIC Agencies:

- Prioritize promotion of state-developed platforms that feed directly into the MIS.
- Assign a designated staff role to monitor referrals and uploads
- Provide participants with clear instructions and alternatives to access WIC services.
- Standardize workflows for referral processing and management.
- Regularly assess which tools add value and retire redundant systems.

Best Fit for Programs That:

- Have strong local and/or state networks of community partners.
- Need additional referral entry points beyond healthcare providers.
- Serve participants who benefit from online or self-directed application.
- Lack access to EHRs or HIEs.
- Have staff capacity to manage manual follow-up and reconciliation.
- Are early in system modernization efforts.

TRADITIONAL AND PAPER-BASED SYSTEMS

SYSTEM SNAPSHOT: TRADITIONAL AND PAPER-BASED SYSTEMS

Traditional and paper-based methods include referrals and medical data shared through paper forms, fax, email, scanned documents, or information delivered by participants themselves. Despite continued advances in health information technology, these methods remain widely used across WIC agencies, particularly in rural areas, smaller jurisdictions, and settings with limited access to electronic systems. Traditional approaches are often familiar, low-cost, and flexible, allowing agencies to operate without complex technical infrastructure (United States Government Accountability Office, 2019).

At the same time, paper-based and manual processes are typically labor-intensive and rely heavily on staff time for data entry, follow-up, and verification. These systems can introduce delays, increase the risk of errors or incomplete information, and place additional burden on both WIC staff and participating families. As caseloads grow and expectations for coordination increase, many agencies view traditional methods as functional but increasingly difficult to sustain without additional staffing or process improvements.

ABOUT THIS SECTION

This section describes how WIC agencies use **traditional, paper-based, and low-technology systems**—including faxed medical referral forms, email referrals, participant-delivered documentation, and manual tracking—to manage referrals and receive medical and anthropometric data. While these systems may lack direct connection with electronic records, they remain widely used and, in some settings, highly functional due to strong staff coordination and deeply embedded workflows.

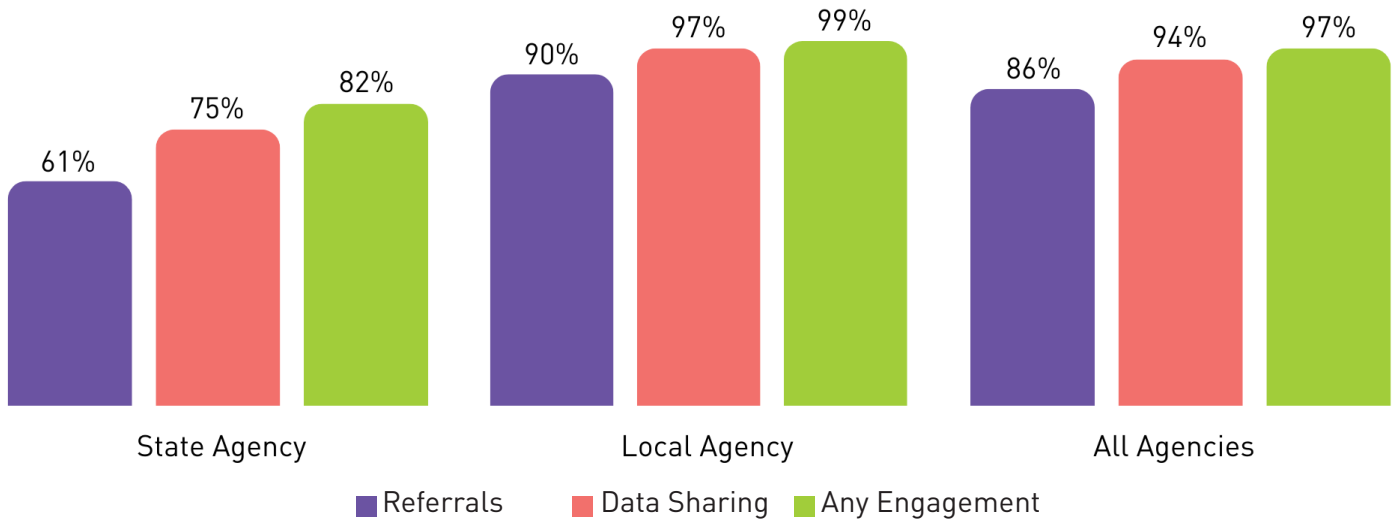
The findings in this section are based on survey data and interviews with Local WIC Agencies that use paper-based processes alone or in combination with other electronic systems. These findings highlight how traditional systems can support timely enrollment and high participation when sustained by experienced staff, while also revealing vulnerabilities related to staffing capacity, data timeliness, and scalability.

WHO IS USING THIS SYSTEM

Traditional and paper-based systems were used by most WIC agencies responding to the survey. These approaches were common across both State and Local WIC Agencies and were frequently used even among agencies that also reported using EHRs, HIEs, third-party, or state-developed platforms.

Paper-based processes played a particularly prominent role in the exchange of medical and anthropometric data required for certification, underscoring their continued importance in WIC operations despite ongoing modernization efforts. For many agencies, traditional and paper-based methods are the only process used to receive referrals (90%) or collect medical data (69%).

Figure 15. Traditional and Paper-Based Systems Reported Utilization among State and Local WIC Agencies



State Agency n=28; Local Agency n=176; All Agencies n=204

HOW REFERRALS WORK USING THIS SYSTEM

Referrals are received through multiple channels, including fax, email, phone calls, and direct outreach from participants and community organizations. Upon receipt, staff determine whether the referral is for an existing participant or a new applicant and then initiate follow-up—most often by phone—to explain WIC services, confirm eligibility, and schedule appointments.

A defining feature of this system is its high-touch, staff-driven nature. Referrals are organized based on the agency's internal referral management process, which can include various systems for organizing paperwork and assigning to specific staff for follow-up. Contact attempts, outcome, and appointments may be documented directly on the referral form or within internally developed spreadsheets, display boards, or folders, supporting continuity even in the absence of a centralized electronic tracking system.

HOW MEDICAL AND ANTHROPOMETRIC DATA ARE SHARED

Medical and anthropometric data sharing under this system is predominantly paper-based. Healthcare providers complete WIC referral forms or WIC medical documentation forms, providing information such as height/length, weight, hemoglobin, blood lead level, immunizations, pregnancy information, and consent, and fax or email the forms to the WIC office. Staff then manually enter the data into the MIS.

In some cases, participants supplement provider documentation by sharing screenshots from patient electronic health portals via text, email, or document uploaders. Where available, agencies may identify other opportunities to access information electronically through state-based systems (e.g., immunization records, etc.), reducing reliance on providers for some data elements.

While staff note that electronic records are generally clearer than handwritten faxes, the overall process remains labor-intensive and dependent on timely provider documentation and participant follow-through. Medical documentation forms required to request medically indicated specialty foods or non-contract infant formulas, often require additional clarification and follow-up due to complexity or incomplete provider responses.

WORKFLOW, STAFFING, AND SYSTEM INTEGRATION

Traditional and paper-based system workflows rely on adaptive, staff-driven processes rather than highly formalized protocols. Referrals are managed using a mix of manual and informal tools. Although these tools may not be centralized or automated, they are often deeply embedded in daily operations and consistently understood by all staff.

Staffing capacity is central to sustaining this system. Long-tenured employees with cross-training across all office functions provide flexibility during staffing shortages and periods of high demand. Leadership oversight reinforces accountability, with supervisors stepping in as needed to ensure continuity.

Integration with external systems remains limited. Agencies expressed strong interest in more seamless electronic data sharing, such as direct access to referrals from Medicaid or SNAP applications, but options are often constrained by consent and legal requirements, navigation challenges, and limited interoperability. As a result, many systems remain largely manual, supplemented by selective electronic tools rather than connected solutions.

BARRIERS, FACILITATORS, AND LESSONS LEARNED

Key Barriers

Agencies shared several challenges with using traditional and paper-based referral methods. These challenges generally fall into three main areas:

- **Hard to track and follow up on referrals**: Paper referrals are not always logged in one place. This can lead to missed follow-up, delays in outreach, and extra work to find or re-enter information.
- **Staff capacity and workload limits**: Staff shortages, high caseloads, and time-consuming paperwork make it harder to follow up quickly and keep records up to date. Manual data entry and fax-based processes increase staff burden.
- **Problems with information quality and access**: Handwritten or outdated medical forms can be hard to read or incomplete. Changing phone numbers, language barriers, and complex medical documentation requirements also make it harder to connect with families and complete certification on time.

Key Facilitators

Despite these challenges, agencies identified three main strengths that help paper-based systems continue to work:

- **Strong relationships and direct communication**: Regular communication with healthcare providers and direct outreach to participants help clarify referrals, correct errors, and support enrollment.
- **Flexible referral options**: Using multiple referral methods—such as fax, email, chatbot referrals, and community outreach—creates more ways for families to connect to WIC.
- **Experienced and adaptable staff**: Cross-trained staff, long-tenured employees, and the use of standardized fax forms help agencies manage high workloads and maintain consistency, even with limited resources.

WIC Agency Spotlight:
Broome County WIC Program

In New York, the Broome County WIC Program operates primarily using traditional, paper-based referral and medical data collection systems. Despite limited digital modernization activities and ongoing staffing constraints, the Agency has developed a resilient and effective workflow grounded in strong internal coordination and long-tenured staff.

Medical and anthropometric data are received primarily through faxed WIC medical referral forms and participant-shared screenshots from patient electronic health portals. Immunization and blood lead data are accessed electronically through New York State Immunization Information System (NYSIIS), reducing reliance on healthcare providers for those records and supporting timely certification.

To support easier processing of WIC medical referral forms, WIC nutritionists developed customized fax coversheets for each of the referring providers' offices that are faxed to the provider along with the medical referral form. Coversheets specify the provider's and WIC office's contact information and what information is needed, increasing provider completion rates and cutting down on the need to re-fax forms.

Most referrals arrive via fax and emails, including referrals generated through the New York State WIC chatbot, "Wanda," which supports inquiries about WIC services. A designated staff leader manages referral follow-up, supported by program leadership and nutrition staff. Tasks are coordinated using labeled folders, staff mailboxes, whiteboards, and MIS note alerts. Although formal written procedures are limited, cross-training and shared familiarity ensure continuity and accountability.

Broome County's experience demonstrates that traditional systems can function effectively when supported by experienced staff, clear coordination, and strong leadership oversight. At the same time, the Agency noted that modernization could reduce administrative burden, improve equity in access, and strengthen long-term sustainability. Despite operating near maximum enrollment capacity and experiencing staffing constraints, the Agency maintains performance through shared responsibility, flexibility, and institutional knowledge.

For questions about this system, please contact Michelle Figuerado, WIC Nutrition Services Director at Broome County Health Department (Michelle.Figuerado@broomecountyny.gov).

RE-AIM SNAPSHOT: SYSTEM-LEVEL INSIGHTS

This snapshot synthesizes key findings across the RE-AIM framework to illustrate how traditional and paper-based systems function in real-world WIC settings and where agencies may encounter opportunities or constraints.

Figure 16. RE-AIM Assessment of Traditional & Paper-Based Systems for WIC Agencies

R REACH	E EFFECTIVENESS	A ADOPTION	I IMPLEMENTATION	M MAINTENANCE
Multiple low-tech referral pathways expand access, but language barriers and awareness gaps limit reach for some populations.	High-touch workflows enable timely enrollment, but outdated or unclear data can delay certification.	Adoption is sustained through staff longevity and cross-training rather than formal system diffusion.	Staff-driven adaptability enables effective implementation in the absence of formal integration.	Ongoing performance monitoring and structured support keep the system reliable.
Fax, chatbot, and community referrals support broad intake.	Rapid follow-up supports new mothers and families.	Consistent use is driven by local practice, not shared models or external learning.	Flexible routines and local knowledge compensate for lack of automation.	Embedded expertise and cross-coverage sustain operations.
Language barriers or insufficient interpretation services can hinder understanding of WIC services.	Misaligned visit timelines and incomplete forms reduce efficiency.		Manual processes require constant staff attention.	Staffing changes pose significant risk without system modernization.

KEYS TO SUCCESS FOR TRADITIONAL & PAPER-BASED SYSTEMS

What this system does well:

- Enables rapid follow-up when staff prioritize responsiveness
- Functions reliably in low-tech or resource-constrained environments

What makes this system work:

- Long-tenured, cross-trained staff with strong institutional knowledge
- Clear role assignments, even without formal written procedures
- Multiple referral pathways (paper referral forms, fax, email, chatbot, community partners)
- Strong, ongoing relationships with healthcare providers
- Simple but effective internal organization (folders, mailboxes, whiteboards)

Common challenges to plan for:

- Heavy reliance on staff time and expertise
- Manual data entry and lack of centralized tracking
- Vulnerability to staff turnover and capacity limits
- Delays due to outdated, illegible, or incomplete medical documentation

Actionable tips for agencies using this system:

- Formalize informal practices (e.g., basic tracking logs, written workflows)
- Cross-train all staff on referral intake and follow-up
- Maintain pre-filled or standardized fax templates for providers
- Provide referring agencies with multilingual WIC information to better prepare participants
- Identify opportunities to layer in simple digital tools without disrupting workflows

Best fit for programs that:

- Serve communities where electronic integration is not available
- Have strong staff continuity and local provider relationships
- Need flexible, people-centered approaches to outreach and enrollment

INTEGRATING AND SCALING ACROSS SYSTEMS

Most WIC agencies do not operate within a single, uniform information exchange environment. Instead, State and Local WIC Agencies often manage multiple systems, reflecting variation in healthcare partners, geography, staffing capacity, and historical system development. As a result, strengthening WIC–healthcare coordination frequently requires not only improving individual systems, but also integrating and scaling across diverse approaches.

OPERATING IN MIXED-SYSTEM ENVIRONMENTS

State WIC Agencies commonly support Local Agencies that rely on different combinations of EHRs, HIEs, third-party platforms, state-developed systems, and traditional and paper-based methods. In these mixed-system environments, flexibility is essential. However, without coordination, variation can increase administrative burden, complicate training, and limit opportunities to standardize workflows and measure performance.

Agencies described the ongoing challenge of balancing local adaptability with the benefits of shared guidance, tools, and expectations. Where coordination was strongest, State Agencies provided clear parameters—such as standardized referral forms, shared intake platforms, or common data elements—while allowing Local Agencies to select tools that fit their context.

TRANSITIONING BETWEEN SYSTEMS

Agencies may seek to transition from paper-based methods to electronic systems, enhance existing platforms, or layer in new tools to meet evolving needs. Across interviews, agencies emphasized that successful transitions are typically incremental rather than immediate.

Effective transitions often included:

- Assessing readiness, including staffing capacity and partner engagement
- Piloting new approaches with a small number of sites or providers
- Allowing time for workflow adjustment and staff training
- Using early implementation feedback to refine processes before scaling

Agencies cautioned against assuming that new technology alone would reduce burden, noting that transitions require sustained attention to staffing, governance, and long-term maintenance.

A CONCEPTUAL PATHWAY FOR INTEGRATION AND GROWTH

Findings from this landscape suggest a general progression that agencies may follow over time, recognizing that progress is not linear and that agencies may operate at multiple stages simultaneously:

Foundational → **Emerging** → **Coordinated** → **Integrated**

Foundational
Referrals and data sharing rely mostly on paper, fax, email, or phone. Tracking may be informal, and processes depend heavily on staff effort and follow-up.

Emerging
Electronic tools are being introduced, but workflows are still developing. Systems may run alongside paper processes, and integration with the WIC MIS is limited.

Coordinated
Electronic systems are used consistently with defined workflows and clear staff roles. Referrals and medical data are accessed in a structured way, and processes are more reliable, though full system integration may not yet be in place.

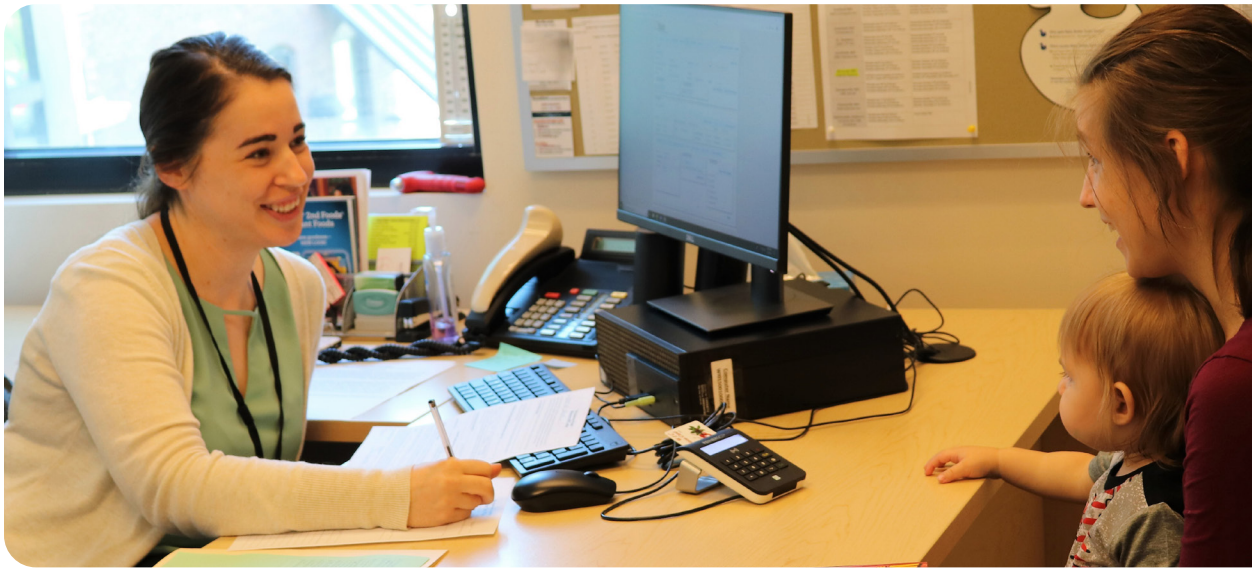
Integrated
Systems are interoperable and embedded into daily operations. Referral and medical data flow directly into the WIC MIS with minimal additional manual burden, and processes are streamlined and sustainable.

Not all agencies aim to reach the same endpoint, and advancement may pause or reverse due to staffing changes, funding cycles, or partner readiness. This pathway is intended to help agencies reflect on their current state and identify realistic next steps aligned with their goals and resources, rather than prescribe a single destination.

IMPLICATIONS FOR STATE AND NATIONAL SUPPORT

Supporting modernization, integration, and scaling requires coordinated effort across levels of the WIC enterprise. State Agencies play a key role in establishing policy guidance, developing templates and standards, and providing technical assistance to Local Agencies. In addition, State Agencies have a role in helping Local Agencies identify resources to support their modernization efforts. National organizations, such as NWA, can support knowledge sharing, tool development, and peer learning across states.

Together, these efforts can reduce duplication, promote equity, and strengthen coordination by ensuring that system design and implementation are responsive to on-the-ground realities.



CROSS-SYSTEM INSIGHTS: WHAT MATTERS REGARDLESS OF PLATFORM

Across all system types—EHRs, HIEs, third-party and state-developed platforms, and traditional paper-based processes—several consistent themes emerged.

Integration matters more than the platform itself.

Systems that integrate directly with the WIC MIS consistently reduce staff burden, support timely follow-up, and minimize data loss. When referrals or documents flow automatically into the MIS, agencies are better positioned to act quickly and consistently. In contrast, systems that operate separate from the MIS, regardless of how sophisticated they are, often require parallel tracking, manual reconciliation, and additional staff time.

Staff capacity is a defining constraint.

Across systems, agencies emphasized that staffing levels and role clarity shape what is feasible. Most agencies rely on a small number of designated staff to manage referrals and retrieve medical data, making processes vulnerable to turnover, absences, and competing demands. Even highly automated systems require staff time for monitoring, follow-up, troubleshooting, and participant communication.

Medical and anthropometric data sharing remains the weakest link.

While referral intake has expanded through electronic and third-party tools, medical and anthropometric data are still most often received via participants or paper-based methods. Direct access to medical data—through EHRs or HIEs—offers clear benefits but remains limited to a small number of agencies due to legal, technical, and workflow barriers. As a result, many agencies operate hybrid processes that combine digital intake with manual data collection.

Relationships and trust drive system success.

Strong partnerships with healthcare providers, HIE vendors, MIS providers, and State WIC Agencies consistently enable progress. Agencies that invested in early communication, shared problem solving, and trust building were better able to navigate legal approvals, refine workflows, and sustain systems over time. Technology alone did not overcome weak relationships.

Usability and flexibility shape participant experience.

Participants benefit most when systems reduce documentation burdens and align with how families already interact with healthcare and social services. Complex portals or rigid workflows often push families and staff back toward simpler tools like phone calls, texting, or screenshots. Systems that allow flexibility while maintaining clear internal processes better support equitable access.

Taken together, these insights underscore that successful referral and data-sharing systems are less about adopting a "best" platform and more about aligning technology with staffing capacity, workflows, partnerships, and participant needs.

CONCLUSION

This landscape analysis demonstrates that WIC agencies across the country are actively working to strengthen coordination with healthcare providers and improve referral and data-sharing processes, often within significant operational constraints. Agencies are navigating a complex mix of systems, ranging from traditional paper-based workflows to advanced EHR and HIE integration, each offering distinct benefits and challenges.

No single system meets all needs. Instead, agencies rely on hybrid approaches that reflect local capacity, state infrastructure, provider relationships, participant context, and available resources or funding to implement modernization activities. Systems that integrate with the WIC MIS, reduce manual steps, and support timely follow-up consistently perform better; however, even these approaches require sustained staff effort, clear governance, and cross-sector collaboration.

Importantly, the findings show that meaningful progress is possible from multiple starting points. Agencies using traditional or state-developed systems are implementing effective practices within existing constraints, while agencies with EHR or HIE access are demonstrating the potential of deeper integration with the healthcare system when supported by funding, leadership, and strong partnerships.

Looking ahead, opportunities for improvement extend beyond technology adoption alone. Agencies may also consider identifying and aligning funding opportunities, such as federal modernization grants, state innovation funds, or cross-sector public health investments, to support sustainable system upgrades. At the same time, modernization efforts require careful attention to legal and compliance considerations, including data-sharing agreements, confidentiality requirements, and clearly defined roles across partners. Intentional system design, clear role definition, sustained investment in staff capacity, and continued collaboration across WIC, healthcare, and public health systems are equally critical. By focusing on these foundational elements, WIC programs can strengthen referral pathways, improve data quality, and better support families, regardless of the systems they use.

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