HOW TO ESTABLISH REFERRAL AND DATA SHARING PROCESSES WITH HEALTHCARE PROVIDERS

THE BENEFITS OF ENHANCED COORDINATION BETWEEN WIC AND HEALTHCARE PROVIDERS

As an evidence-based, targeted intervention associated with improved health outcomes for its participants, WIC is critical to strengthening the healthcare system's efforts to improve maternal and child health. While many healthcare providers understand the value of enhanced coordination with WIC, few have established standardized or electronic WIC referral channels, often relying on paper and fax, or encouraging their patient to contact WIC. In addition to referrals, there are opportunities for healthcare providers such as pediatricians, OBGYNs, etc., and WIC to establish data sharing systems, whereby data already collected in the physician's office that is needed for WIC certification is securely shared with WIC to streamline the enrollment process and reduce burden on both WIC participants and staff. Improving coordination with healthcare providers can not only increase referral volume, but also has the potential to get eligible families connected with WIC earlier so they can benefit from all of WIC's services.

HOW TO RECRUIT HEALTHCARE PARTNERS TO ENHANCE REFERRAL AND DATA SHARING SYSTEMS

NWA has been working with WIC local agencies to understand the barriers and enablers to partnering with healthcare providers. In addition to conversations with WIC local agency staff, the below recommendations are informed by pilots funded under the NWA's "Reducing Barriers to WIC Enrollment" grant from the Kaiser Permanente National Community Benefit Fund at the East Bay Community Foundation. Under the grant, NWA subgranted funds to two projects piloting enhanced models of WIC-healthcare collaboration: Lāna'i Community Health Center WIC in Lāna'i City, Hawai'i and the California WIC Association who led pilots at Northeast Valley Health WIC and Watts Healthcare WIC in Los Angeles, California. For more information on these projects, please see the case studies in the Appendix. The projects involved recruiting and engaging healthcare providers in streamlined WIC referral and data sharing systems, which depended on buy-in and coordination with health center medical providers and staff.

Once you are in contact, gauge their interest in developing a more streamlined referral and communication system with WIC.

1. FIND A WIC CHAMPION: Determine who at the health center is involved in referrals and communication with WIC. Keep in mind that in addition to healthcare providers, care coordinators, social workers, community health workers, and medical assistants may also be involved in referring and sharing information with WIC. Find someone who is passionate about WIC and making referral systems more efficient so that they can champion the cause and bolster long-term buy-in and engagement among their colleagues. Involve other partners at the health center depending on project needs, including administrative and IT staff.

2. UNDERSTAND CONTEXT: How do they currently refer patients to WIC? Is this the same referral system they use to refer patients to other healthcare providers and social programs? Do they have interest and capacity to partner to streamline referrals and/or share data with WIC? What data linkage opportunities are available? Does the health center have access to a Health Information Exchange?

3. MEET THEM WHERE THEY ARE: By understanding where the health center is on the spectrum of coordination with WIC, you can offer to use existing referral workflows as they are, or build off of them to minimize burden on providers and staff and ensure the system is achievable and sustainable. For instance, if a health center currently faxes a paper referral form to WIC on an as-needed basis and is most comfortable with a paper-based system, propose standardizing and enhancing this system so that all prenatal, postpartum, infant, and well child visits (up to 5 years) are screened for interest in WIC and referral forms are faxed to WIC in batches. Update the referral form to include space for clinical data (e.g. height, weight, hemoglobin) that can be sent to WIC with patient consent.

ELECTRONIC LINKAGE OPPORTUNITIES

Establishing electronic linkages between WIC and healthcare providers to facilitate referrals and data sharing can streamline processes, reduce duplicative testing, and improve coordination of care for WIC families. There are a variety of methods for establishing electronic linkages between WIC and healthcare providers, including those described below:

An **Electronic Health Record (EHR)** is the digital version of a patient's medical chart, including medical history, medications, immunizations, allergies, laboratory data and more. EHRs update in real time and are accessible by multiple care providers across different healthcare settings. EHR-WIC linkage opportunities include adding a WIC referral within the EHR referral workflow and providing WIC agencies with read-only access to clinical data needed for certification. For an example of linkages using an EHR, please see the Lāna'i Community Health Center WIC case study in the Appendix.

A **Health Information Exchange (HIE)** is an electronic system that securely shares patient health information across different healthcare organizations. It improves interoperability and care coordination by allowing various EHR systems to communicate, providing centralized data access, and reducing redundant testing. HIEs have strict privacy and security measures to protect patient information, ensuring data is shared only with authorized users and in compliance with HIPAA and other state and federal laws and regulations.

A **Community Information Exchange (CIE)** is similar to an HIE, but involves a wider base of community partners in addition to healthcare providers, including social service providers, schools, housing, and other community resources.

STEPS FOR ESTABLISHING WIC-HEALTHCARE LINKAGES USING A HEALTH INFORMATION EXCHANGE

Where there is interest and capacity to develop electronic linkages between the WIC agency and healthcare providers, utilizing an HIE is a promising option. Below are suggested steps for working with an HIE, which were informed by the California WIC Association project piloting data linkages between WIC local agencies and their associated Federally Qualified Health Centers using the regional HIE, LANES.

1. ESTABLISH PROJECT TEAM AND OBJECTIVES

- Identify the HIE, which may be regional or state-designated. WIC Agencies that are part of a larger health center may already have access to an HIE.
- Recruit and form the project team, including HIE operations and IT staff, health center administrators, IT, healthcare providers and staff, and WIC agency administrators, IT and staff.
- Develop objectives for the electronic linkages to be established (i.e. referrals, data sharing, and/or care coordination messaging between WIC and healthcare providers/staff) and outline the general proposed workflow for each.

2. PLANNING & DEVELOPMENT

- Establish regular meetings with partners to share organizational needs and processes and develop implementation plans.
- Sign agreements among partners to allow for data access and sharing, such as Business Associate Agreements (BAAs), Memorandums of Understanding (MOUs), and Data Sharing Agreements (DSAs).
- Review data sharing regulations, data availability, and the data governance structure of the EHR to be able to mine and extract data into the HIE on a regular basis. Patients provide consent for their information to be shared with the HIE, but you may need to establish consent procedures if the WIC agency plans to send information back through the HIE on WIC enrollment status or other data points.

- Identify existing workflows for healthcare providers and staff in the EHR and HIE (if any) as well as WIC staff workflows in the HIE (if any) and the WIC MIS. Develop each partner's new proposed workflow for referrals and data sharing. For example, the team might identify the care encounters at the health center at which patients will be referred and certain characteristics of referred patients (i.e. to match WIC categorical eligibility).
- Define roles, technology needs and parameters of each organization, and create work plans for developing each linkage.
- Design the "WIC view", which is the data that WIC staff will be able to access in the HIE. This includes the minimum data needed for referrals (to allow WIC staff to conduct outreach and identify matches in the WIC MIS) as well as required anthropometric and clinical data necessary for certification. The "WIC view" may also include additional relevant data for enrollment and certification, as described below.

DATA TO CONSIDER INCLUDING IN THE "WIC VIEW" OF THE HIE

Minimum data necessary for referral	Patient Name, Date of Birth, Address, Phone Number
Data required for certification	Height/length, weight, hemoglobin/hematocrit
Additional data collected at certification	Immunization record, blood lead level, demographic information
Health data which can be used to tailor nutrition education and food packages. (Medical conditions can be extracted into the HIE using EHR diagnostic codes)	Diet: Food allergies, therapeutic infant formula, nutritionals for women and children Medical conditions: breastfeeding complications, prematurity, failure to thrive, Neonatal Abstinence Syndrome, diabetes, preeclampsia, hypertension, inborn errors of metabolism, gastrointestinal disorders, etc.
Data to allow for WIC eligibility screening	Medicaid identification number, if available

2. PLANNING & DEVELOPMENT (CONTINUED)

- Design training plans and job aids based on each partner's roles and determined workflow for referrals and/or data sharing.
- Identify staff that will be involved in the referral and/or data sharing systems and conduct training at each organization: WIC, health centers, and HIE.

3. TRAINING

- Design training plans and job aids based on each partner's roles and determined workflow for referrals and/or data sharing.
- Identify staff that will be involved in the referral and/or data sharing systems and conduct training at each organization: WIC, health centers, and HIE.

4. IMPLEMENTATION, MONITORING & EVALIUATION

- Determine internal management protocols at the WIC agency: assign staff to access the HIE at specified intervals, decide how the referral status for each patient will be coded and tracked, develop outreach protocols for referred patients, and outline procedures for transferring referral and clinical information for patients to be enrolled in WIC from HIE into WIC MIS.
- Design regular reports that are sent from the HIE to the WIC agency, which provide summaries on the number of referrals received, contacted and enrolled in WIC.
- Solicit ongoing feedback from all partners to inform adjustments. Topics may include ease of access to data in WIC view, cases of missing data, refining the data available in the WIC view and in the status reports, and feedback from WIC participants.

BENEFITS OF USING A HEALTH INFORMATION EXCHANGE

Utilizing an HIE to form electronic linkages between WIC and healthcare has numerous potential benefits:

- The HIE provides access to historical and real-time data, including historical contact information which can make it easier for WIC to contact the family
- Families are connected to WIC earlier and in a more systematic manner, ensuring no one falls through the cracks
  - If prenatal patients are referred at one of the first care encounters, they receive WIC supplemental foods and breastfeeding and nutrition information earlier, which has the potential to improve diet quality during critical early months of gestation and increase breastfeeding rates.
  - Referring children at well child visits helps WIC increase participation among children aged 1-5 and re-engage participants who may have missed an appointment.

- Families are given a warm handoff between their healthcare provider and WIC and do not have the burden of contacting WIC, and locating and providing data that WIC requests at certification.

APPENDIX

Lāna'i Community Health Center WIC

Health Information Exchange Pilots at Two WIC Local Agencies in Los Angeles

CASE STUDY

LĀNA'I COMMUNITY HEALTH CENTER WIC

STREAMLINING WIC REFERRAL AND DATA SHARING SYSTEMS

For 50 years, WIC has improved pregnancy, birth, and child nutrition outcomes for millions of participants and is a critical program in strengthening the healthcare system's efforts to improve maternal and child health. Yet, WIC agencies and healthcare providers are often siloed. Enhancing WIC-healthcare coordination is essential to simplify the WIC enrollment process, reduce duplicative testing, and more holistically coordinate care for WIC families. The National WIC Association funded two projects—in Lāna'i City, Hawai'i and Los Angeles, California—to build on partnerships with healthcare providers and pilot enhanced models of WIC-healthcare collaboration.

CONTEXT & PROJECT OVERVIEW

Lāna'i Community Health Center (LCHC) is a Federally Qualified Health Center on the island of Lāna'i, the smallest of the major Hawaiian Islands with 2,888 residents. While walking around the center of town, the tight knit community on Lāna'i is immediately apparent. As WIC CPA Olivia Pascual described it, **"It's like your own blood when you see [participants] [...] we raise each other's kids."** LCHC provides comprehensive medical, dental, vision, and other services to the island.

LCHC serves 69% of the island's population.

LCHC WIC EST. 2017

110 participants

47% identify as Asian

42% identify as Native Hawaiian / Other Pacific Islander

+ large immigrant population from the Philippines and Micronesia.

Prior to the project, LCHC did not have a standardized way of referring patients to WIC. By launching this project, they aimed to create a streamlined system to ensure that WIC referrals were fully incorporated into primary care services and to remove barriers to enrollment, because **"[WIC] is not just another service, it is really a complement,"** said Interim Executive Director Cindy Figuerres. The project team was multidisciplinary, composed of the Interim Executive Director, Associate Medical Director, Advanced Practice Registered Nurse, and the WIC coordinator, who also served as a Community Health Worker and Referral Specialist. The latter three team members were also WIC CPAs.

PLANNING & IMPLEMENTATION

Understanding the importance of using healthcare providers' existing workflow, the team decided to add WIC referral capabilities within the Electronic Medical Record's (EMR) established referral system. Provider notes in patient records within the EMR system included a field for referrals; the LCHC team added "Lāna'i WIC" as a referral option, which when selected, is automatically assigned to WIC staff. The referral process is described in the graphic below. Once the new referral system was in place, the Associate Medical Director conducted a training with providers to introduce the new WIC referral system, reinforce that the process followed their existing workflow, and remind providers of the benefits of WIC for their patients.

HEALTHCARE PROVIDER

When seeing an obstetric, postpartum, or pediatric patient, the healthcare provider discusses the benefits of WIC and asks the family if they would be interested in participating, if not already enrolled. After the visit, the healthcare provider writes a note in the patient's record in the EMR. If the family expressed interest, the provider selects "Lāna'i WIC" in the referral field of the note.

WIC

The WIC team accesses the EMR, is alerted to a new patient in the referral work queue, reaches out to the family and schedules the WIC appointment. The WIC team adds a note to the referral documenting the status (contact made, appointment scheduled, enrolled).

The provider can then look back at the note to see the status of the referral.

The WIC team also has read-only access to the patient's chart to find the patient's height, weight, hemoglobin, and immunization record, which they use for certification.

IMPACT ON WIC PARTICIPANTS, WIC STAFF, AND HEALTHCARE PROVIDERS

FIRST 8 MONTHS OF NEW REFERRAL SYSTEM

- **20** WIC referrals made
- **14** eligible for WIC
- **14** enrolled

The team noticed that engaging healthcare providers in the WIC referral process and encouraging them to discuss WIC with their patients improved coordination of care and provided a "warm handoff" between providers and WIC.

With the new EMR-integrated referral, WIC Coordinator Tanisha Magaoay noticed she was getting a larger number of WIC referrals and receiving them in a more organized manner. She shared that it made it "easier to keep track" of referred families and to update the provider via the referral note when appointments were scheduled and then completed.

Associate Medical Director Jared Medeiros reported that the referral system has **improved his ability to create "measurable and achievable treatment plans"** and follow through to "hold ourselves accountable". As a provider being pulled in multiple directions, he noted that having the referral within the EMR and assigning it to the WIC team to follow up on simplified his workflow.

> "As a provider, that's really helpful for us to make sure that our patients are actually following through with things that we're referring them to. And by having [the WIC referral] a part of [the EMR], where we can actually document and see, okay, yeah, they got an appointment, and they came to the appointment, [...] is really helpful and useful."
>
> **- Jared Medeiros, FNP, Associate Medical Director, WIC CPA**

Questions about this project?

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NWA's Center for Innovative Practices in WIC: cipwic@nwica.org.

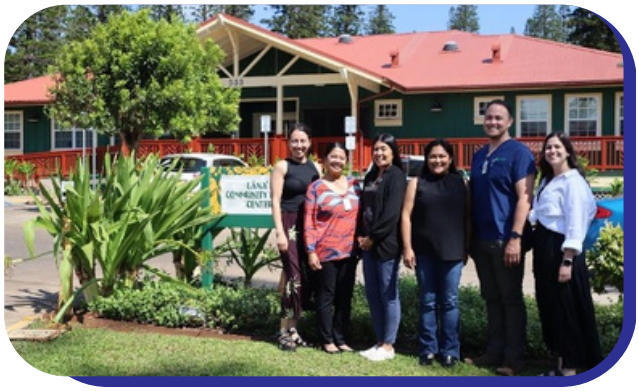
NWA is grateful for the support of Kaiser Permanente National Community Benefit Fund of The East Bay Community Foundation, who funded this project.

LESSONS LEARNED & NEXT STEPS

This project exemplifies the many benefits of integrating WIC referrals into primary care in a small community setting and the importance of adapting the system to best suit the needs of the health center and WIC participants. The team originally planned to transition to a different EMR used across most health systems in Hawai'i but had to pivot due to unanticipated lengthy timelines and cost; they wished they had allotted more time in the initial stages of the project to research feasibility. However, continuing with the same EMR and utilizing the existing referral workflow had its benefits; the new system did not require providers to learn and adopt a new workflow or go outside of the EMR to send a referral. The Associate Medical Director said, **"I think when approaching medical providers, make it really straightforward and easy and try to make it integrate into what they already do is key..."** The team also reported that being willing to change and recognizing that the standard of care may no longer be the best system enabled LCHC to implement improvements to better serve their patients.

Following the success of the new referral system, the LCHC team will explore partnering with the other healthcare system on the island to integrate an electronic WIC referral into their EMR. While the EMR-embedded referral system has improved efficiency, LCHC says their future goal is improved interoperability between the EMR and WIC MIS to reduce WIC staff burden and minimize data entry errors in manually transferring referral and clinical data from the EMR into the MIS.

> "Having this technology to be able to integrate with other organizations will help us have a better workflow overall, get more WIC participation, and more community exposure."
>
> **– Olivia Pascual, APRN, WIC CPA**



Site Visit at Lāna'i Community Health Center, June 2024. Pictured from left to right: Chloe Dillaway (NWA), Olivia Pascual (LCHC), Tanisha Magaoay (LCHC), Cindy Figuerres (LCHC), Jared Medeiros (LCHC), and Marie Gualtieri (NWA).

CASE STUDY

HEALTH INFORMATION EXCHANGE PILOTS AT TWO WIC LOCAL AGENCIES IN LOS ANGELES

STREAMLINING WIC REFERRAL AND DATA SHARING SYSTEMS

For 50 years, WIC has improved pregnancy, birth, and child nutrition outcomes for millions of participants and is a critical program in strengthening the healthcare system's efforts to improve maternal and child health. Yet, WIC agencies and healthcare providers are often siloed. Enhancing WIC-healthcare coordination is essential to simplify the WIC referral and enrollment process and more holistically coordinate care for WIC families. The National WIC Association (NWA) funded two projects—in Lāna'i City, Hawai'i and Los Angeles, California—to build on partnerships with healthcare providers and pilot enhanced models of WIC-healthcare collaboration.

CONTEXT & PROJECT OVERVIEW

The California WIC Association (CWA) led pilots at two Federally Qualified Health Centers (FQHCs) in Los Angeles: Northeast Valley Health Corporation (NEVHC) and Watts Healthcare, each having an associated WIC local agency. Both health centers worked with the Los Angeles Network for Enhanced Services (LANES), a regional health information exchange (HIE), to establish a referral and data sharing process with their respective WIC agencies. LANES serves as a central hub aggregating data across multiple Electronic Health Record (EHR) systems and providers in the Los Angeles area.

Both WIC local agencies serve mainly urban areas with participants who identify predominantly as Latina/Hispanic, Black, and Asian American.

NEVHC WIC	WATTS WIC
9 centers	5 centers
40,210 participants	11,270 participants
San Fernando & Santa Clarita Valleys	South LA, Compton, Huntington Park

PLANNING & IMPLEMENTATION

Multidisciplinary Project Team

CWA	LANES	Health Centers	WIC
Project lead	Operations & IT staff	Administrative, clinical & IT staff	Administrative staff from each agency

Prior to this project, healthcare providers referred patients to their associated WIC agency through paper referral forms or by encouraging them to contact or visit WIC to apply. The team began by considering the different options for the referral system that would build on existing workflows across pediatric and women's health departments and require minimal provider time. Providers were already familiar with LANES, using it to send some specialty referrals and access their patients' records if seen at other health centers.

The team initially designed a one-click button in the EHR for providers to refer individual patients via LANES, but realized that in addition to providers, staff were often the ones making the WIC referrals. To reduce provider and staff inputs, maximize referrals, and maintain consistency across departments, the team devised a roster system, as described below. The team also designed a "WIC view" in LANES, with only the data necessary for enrollment and certification. They ensured data collection complied with regulations and that they understood the data governance structure of the EHR to be able to mine and extract all available data on a regular basis into LANES.

FQHC

IT staff generate a roster of patients seen at prenatal & well child visits each week and send it to LANES. This requires no input from the clinical side, minimizing provider burden. LANES is able to remove matches from previous reports to minimize duplicate referrals.

LANES HIE

Automatically publishes the roster and provides clinical data necessary for enrollment in a "WIC view", including contact info, demographics, height, weight, hemoglobin, and relevant diagnoses.

Sends status reports based on coding back to WIC for evaluation.

WIC LOCAL AGENCY

Staff access LANES weekly for rosters, look up patient names in the WIC MIS, and contact the family.

Code participant status in LANES as: new, already enrolled, declined, number of contact attempts, etc.

For new and re-enrolling participants, staff retrieve data needed for certification in the LANES "WIC view"

IMPACT ON WIC PARTICIPANTS, WIC STAFF, AND HEALTHCARE PROVIDERS

To date, NEVHC has received 6,471 referrals through LANES, 70% of whom were already enrolled in WIC, while Watts has received 3,100 referrals, of which 90% were already enrolled. Nearly all referred patients were income eligible for WIC. While most referred families were already enrolled, having access to the clinical data through LANES reduces the burden on the participant of having to locate and provide it, and on staff to obtain the data, in the case of a remote WIC appointment. Project lead Karen Farley said, "having an HIE, with so much more access to historical and real time data across care encounters, is such a benefit that you can't get anywhere else."

> *"As we continue to ramp up [...] I certainly foresee the lag time between seeing your provider and then getting connected to WIC getting a lot shorter [...] If we are able to get new patients identified faster, we can do that outreach and remove that barrier, the cognitive load of having to juggle all those different appointments."*
>
> - Christine Cho, Watts Healthcare WIC Associate Director

Additionally, with the new system, WIC is able to re-engage children aged 1-5 who may have fallen off the program due to a missed appointment, as well as capture prenatal patients earlier in their pregnancy. NEVHC WIC Associate Director Christine Goulet adds that earlier contact has the potential to improve breastfeeding rates "because we're going to start to educate mom earlier on in her pregnancy." The response from participants has been overwhelmingly positive; **"they are really appreciative because we're saying your doctor recommended we contact you."** WIC staff also reported that because LANES provides historical contact information, there may be multiple phone numbers for a participant, making it easier to contact them.

From the FQHCs' perspectives, they see immense value in using LANES since their providers are already familiar with the platform. Generating the weekly roster is an easy lift for IT staff and ensures no patient falls between the cracks.

LESSONS LEARNED & NEXT STEPS

These pilots provide compelling examples for how an HIE can provide a critical linkage between healthcare providers and WIC agencies, reducing burden on WIC participants, WIC staff, and healthcare providers. The team embraced the fact that their first idea was not what they ended up with, as they designed workflows with consideration of each stakeholder's time, and adapted systems based on emerging needs discovered in open discussion with all partners.

> *"WIC is a program that's adjunct to health care, so the closer we can get WIC working with health care providers, the better. [...] the goal is to use this huge nutrition and lactation force more effectively with healthcare."*
>
> - Karen Farley, California WIC Association Executive Director

The team will continue to evaluate and refine the referral system, status reports received from LANES, and data available in the WIC view. With lessons learned from the pilots, CWA will next look to the other five local agencies in Los Angeles to set up similar data linkage systems using LANES. The team has future goals of exploring ways to include therapeutic formula prescriptions from providers into LANES and enhancing WIC-provider messaging for care coordination.

Questions about this project?

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NWA is grateful for the support of Kaiser Permanente National Community Benefit Fund of The East Bay Community Foundation, who funded this project.

WATTS HEALTHCARE PROJECT TEAM

NORTHEAST VALLEY HEALTH CORP PROJECT TEAM