The Oregon WIC Program at 30: A Closer Look at Who's Delivering WIC Services and What's Needed to Move WIC into its Fourth Decade

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Abstract

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has evolved from a commodity supplemental food program to a primary source of nutrition education, breastfeeding promotion and support, and referrals for pregnant women and families with young children. With an increased emphasis on addressing complex health issue such as obesity, the State of Oregon WIC program sought better understand the personal and professional backgrounds of those delivering WIC services. The goal of this article is to describe 1) who is delivering nutrition education and determining nutritional risk in the Oregon WIC program, 2) what training they have received, and 3) what additional training they would like to receive. Data were gathered through self-administered questionnaires from three hundred and five local agency WIC staff representing the 34 local WIC agencies in Oregon. Only one-third of local agency staff had earned a Bachelor's degree or higher and the amount of additional training received varied considerably. While the majority of staff felt they had received sufficient training to do their jobs, when asked specifically about completion of required training modules a number of gaps were evident. Respondents expressed interest in expanding training methods beyond written modules and requested training materials in languages other than English. In addition, a lack of continuing education opportunities for paraprofessional staff was noted. An expansion of methods for local agency staff to achieve desired competencies for their position is needed. Communication with decision makers about the importance of supporting training opportunities, particularly for paraprofessional is vital.

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Introduction

The Special Supplemental Food Program for Women, Infants, and Children (WIC) was formally authorized in 1972 by an amendment to the Child Nutrition Act of 1966. Evolving from earlier programs that dispensed commodity foods to pregnant, low-income women, WIC began as a two-year demonstration project administered by the U.S. Department of Agriculture and became an official program in 1974 (Oliveira, et al, 2002). That same year, WIC came to Oregon, serving 2,509 clients at five different local agencies. The original group of dedicated clerical staff (clerks), competent professional authorities (CPA's or certifiers), registered dietitians (RD's), nurses and local agency coordinators incubated the seeds that grew to be the program Oregon has today.

As the Oregon WIC program celebrates 30 years of serving women and children, it seems logical to take time to reflect upon and assess the changes WIC has undergone, and to plan for the program it will become in the next decades. The Oregon program now serves more than 103,000 participants each month through 30 local health departments, two Tribal organizations, and two non-profits. Close to half of all women who deliver in Oregon each year are WIC clients. No longer a program of the early 1970's when the primary focus was supplying supplemental foods, the program has evolved to become a key source of targeted nutrition education, breastfeeding promotion and support and referrals for other health and social service programs. At the same time, the program in

Oregon has moved from being delivered primarily by nurses and dietitians to one staffed predominantly by paraprofessionals. Therefore, Oregon WIC is faced with the conundrum of needing to provide increasingly sophisticated services while having fewer degreed, professional staff to deliver them.

Need for Standardized Training

With the shift that occurred in the 1980's from a staff of primarily dietitians and nurses, to one of mainly paraprofessionals, the State program recognized the need to provide some standardized training for the newly hired WIC staff. The current system of printed, notebook bound training modules first appeared in the Oregon WIC program in the late 1980's, with the complete set of 12 modules developed in the mid 1990's. The modules were originally designed to be coordinated by a trained local agency staff member, with new staff completing pre and post tests for each module. However, with fewer program dollars and the implementation of a new data system, the modules are now mainly self-directed learning tools.

In recognition of this shift in personnel and of the increasing demands for WIC to show measurable changes in participant behaviors, the State of Oregon WIC program sought to survey all local agency staff to better understand the personal and professional backgrounds of those delivering WIC services, to determine how well current training methods are working, and to plan for future training efforts. The purpose of this study was to obtain a clearer picture of 1) who is delivering nutrition education and determining nutritional risk in the Oregon WIC program, 2) what training they have received, and 3) what additional training they would like to receive.

Methods

Three hundred and fifty surveys were mailed in August 2004 to all 34 local WIC agencies in Oregon. The survey came in two versions, one intended for the Local Agency Coordinator only and one for all other staff. The Local Agency Coordinator version contained all items in the staff version plus an additional 13 questions. Each survey booklet was numbered sequentially to assist with tracking returns from each agency. The number of surveys sent to each agency was estimated from the number of staff who attended a mandatory, state sponsored computer training the previous year. The project was reviewed by the Oregon Department of Human Services Institutional Review Board and determined to be exempt. SPSS 11.5 (SPSS, Inc. Chicago, Illinois) was used for all data entry and analysis.

Response Rate

To estimate the response rate, the number of completed surveys was compared to the number of individual staff time studies returned to the State office in July 2004. Each local agency staff member whose position is even partially funded by WIC dollars is required to complete a time study, providing the most accurate estimate of the current number of potential survey respondents. Using the time studies to determine the denominator, the survey response rate was 91% (305/328).

Profile of Oregon's Local Agency Staff

Of the 305 respondents, the majority were paraprofessionals serving in the role of certifier or clerk (Table 1). Ninety-seven percent of respondents were female. Approximately 60% of staff were over the age of forty, with half of those being fifty or older. Thirty-nine percent of all WIC staff stated they were currently or had previously been a WIC client. While only 5% of those who were Registered Dietitians had been WIC clients, 45.7% of clerks and 44.6% of certifiers indicated being current or previous WIC participants.

The majority (65.8%) of Local Agency WIC staff classified themselves as White with 24.6% identifying themselves as Hispanic or Latino (Table 2). Slightly more than 40% of staff reported speaking a language other than English, with Spanish being most frequently cited, followed by sign language and Russian. When asked what they considered to be their "first language," 226 (74%) said English, 70 (23%) Spanish, and 4 (1.3%) Russian.

Table 1
Description and Percent of Local Agency Employees by WIC Job Position

Position	Duties	Number	Percent
Clerk	Assist clients with appointment scheduling and check-in, update client information, review and enter data on proofs required for WIC services (identification, residency, and income), print and issue food instruments (vouchers)	94	30.8
Certifier (CPA)	Assess client’s ht/wt, iron status, and diet, provide nutrition education appropriate to risk, work with client to set goals related to diet and physical activity, provide appropriate referrals	133	43.6
Registered Dietitian	Perform duties similar to Certifier but also provide high risk follow-up/case management, may develop and review nutrition ed materials	26	8.5
Coordinator	Manage fiscal and compliance components of program, maintain client caseload, develop policy and procedures, liaison to State Office, may supervise WIC staff, may provide direct counseling to clients	29	9.5
Other	Mix of home visit nurses, Health Educators, Business Administrators, or other agency staff	23	7.5
TOTALS		**305**	**100**

Table 2
Self-Reported Racial/Ethnic Identity and Language Skills of Local Agency Staff

	Number	Percent
Racial/Ethnic Identity		
White	200	65.6
Black/African American	2	0.7
Hispanic/Latino	76	24.9
Asian	8	2.6
Native American/Alaskan	4	1.3
Pacific Islander	1	0.3
Other	2	0.7
Prefer not to Answer	12	3.9
Language Skills of Local Agency Staff		
Speak English Only	178	58.4
Speak Spanish	112	36.7
Speak Russian	5	1.6
Speak Vietnamese	1	0.3
Use Sign Language	6	2.0
Speak Farsi	2	0.7
Speak Chinese	1	0.3

Just over one-third of all local agency staff had a Bachelors Degree or higher. Only 14 of 305 respondents had a graduate degree. Among certifiers 50.0% had not earned a degree higher than a high school diploma (Table 3). Of those with degrees beyond high school, the largest number were in nutrition / dietetics, followed by nursing and health education.

Table 3
Highest Level of Education Completed by Position in WIC

Highest Educational Level	Job Positions		
	Clerk	Certifier	R.D.
< High School	2.1% (2)	-	
H.S. Diploma or GED	28.7% (27)	13.4% (15)	-
Some college	46.8% (44)	36.6% (41)	-
Two-year degree	13.8% (13)	17.0% (19)	-
Four-year Degree	8.5% (8)	30.4% (34)	80.8% (21)
Graduate Degree	-	2.7% (3)	19.2% (5)

Table 4.
Degrees (Associates or Higher) and Certifications Held By Local Agency WIC Staff

	Number
Degree Area	
Nutrition/Dietetics	43
Nursing	24
Health Education	10
Business	5
Science	4
Medical	3
Sociology	3
Certification	
Registered Dietitian (RD)	38
Registered Nurses (RN)	33
Certified Lactation Educators (CLE)	19
Internationally Board Certified Lactation Consultants (IBCLC)	5
Certified Health Education Specialist (CHES)	2

Staff Training

Eighty-six percent of local agency WIC staff felt they had received sufficient training to do their jobs in a competent manner. However, 30% percent of staff had not completed the Introduction to WIC module, which is the one module required for all positions at WIC and ideally would be completed before serving clients. Not all local agency staff members need to complete all 12 of the training modules, as they are only required to finish those related to their position. Nonetheless, certifiers should complete all of the modules within their first year of hire. The survey showed, however, that a significant number have not completed training modules on marketing nutrition education, providing individual nutrition education, and providing group nutrition education (Table 5).

Barriers to Module Completion

All three of these modules provide guidance in areas that are vital for becoming a competent WIC certifier. Therefore, the key question is what keeps local agency WIC staff from completing State designed training modules? Although there is no one answer it is possible that the need to get new staff “up and running” to keep client caseload at required levels (to sustain funding) limits many to just completing the most essential modules. Plans to go back and complete missed modules often get lost in the day to day reality of the WIC clinic.

Table 5
Percent of Certifiers Not Completing State Provided Training Modules (N=112)

Module	% Not Completed
Introduction to WIC	4.5
Anthropometric	5.4
Biochemical	7.1
Diet Assessment	8.0
Infant Feeding	12.5
Breastfeeding	11.6
Prenatal	14.3
Basic Nutrition	8.0
Marketing Nutrition Education	32.1
Providing Individual Nutrition Education	22.9
Providing Group Nutrition Education	28.6

Another barrier to training completion is the format of the modules themselves. With recognition of the many different learning styles that exist, having a training system that requires a lot of reading leaves many in a less than optimal learning situation. Since the modules are only in English, the task becomes even more arduous for those for whom English is not their first language. With the many different literacy levels, professional backgrounds, and personal experiences that new WIC staff bring to the job, it is likely impossible that any single training system alone could meet everyone's needs. Indeed, this is evident from the comments received from Local Agency staff, which range from the modules being too detailed to not detailed enough, from being a great method to the worst method for learning (Figure 1). In addition, the comments reveal the universal weakness of relying on written materials to convey continually changing information. As soon as a training module is printed and distributed, something needs to be updated. Yet time and cost prohibit small, frequent changes, leaving staff to wait years for new material to become available. In recognition of the delay in receiving updated State produced materials, several local agencies provide supplemental materials when training new staff members.

Updates every year or when they change, for answers too.
When I did them they were all out of date.
Less writing and reading and more hands on materials.
Update them and make them more realistic for clinic setting and time constraints.
Maybe video or computer training modules would be more interesting to staff.
Sections that are beyond the basics: modules come off as we're in the 8th grade!
Some are way too long.
The self-testing structure seems more like busy work than instructional.

Figure 1
Responses from Local Agency WIC Staff to the Question
"If you could make one major change to the current training modules, what would it be?"

Barriers to Alternative Training Methods

Some other State WIC programs provide in-person regional trainings for new and existing local agency staff. However, in a state like Oregon, where the number of new local agency employees at any given time is relatively small, and driving distances are long, providing this type of training is not always cost-effective. While advances in technology will eventually allow Oregon to meet some of this need through internet training and distance learning, a significant number of our local agency staff have no access to the internet at work and still are a significant distance away from centers in the state that host televised, interactive broadcasts.

In addition to the technical challenges, more traditional ones remain as well. Local Agencies Coordinators were asked, in the survey, to identify factors that serve as barriers to sending their staff to additional training. The two most commonly cited barriers were clinic coverage (80%) and funding (79%) followed by travel distance (60%), staff members working for multiple health department programs (32%) and approval from higher administrators (20%). Few indicated that a lack of appropriate training opportunities was a barrier.

Since travel to regional trainings may be limited by time and distance, enhancing training at the local agency level is an alternative. However, when asked how often they receive a training or in service at their local agency, almost one-third stated they received something only once a year or practically never.

Ideally, each local agency would have a designated training coordinator, who would work not only with new staff but plan for the continuing education needs of existing staff as well. Yet when Local Agency Coordinators were asked what the specific duties of the training coordinator are, most saw the role as only overseeing the completion of appropriate training modules by new staff. Very few mentioned the training coordinator as having a role in planning ongoing trainings and updates (Figure 2).

This limited focus of the role of the training coordinator may be partially attributed to the selection process and time allotment for filling the position. Of those who are currently acting in the position, most indicated being selected because they had been employed at their agency for the longest period of time, or they were the only person with an appropriate degree. Very few indicated having time to develop their role as training coordinator, and fewer yet had any formal training in how to train or coach adult learners.

To make sure and help WIC staff complete modules
Organize modules, help with orientation, and send in information (to state) regarding completion.
Teach modules, answer questions.
Training all new staff and updating.
Ensure all new staff trained.
Coordinate training of new staff, may do training herself, may designate another.
Have contact with State to update training and staff.
Monitor completion of modules and assist with in-service presentations

Figure 2
Responses from Local Agency Coordinators to the Question
"What are the specific duties of the training coordinator?"

Desired Training

In addition to providing information about their personal and professional backgrounds, and prior training, local agency staff were asked to identify their top three choices of training topics from lists of broader topic areas. A full listing of

training topics and their rankings is included in Appendix A. While topics that related directly to common WIC scenarios such as prenatal nutrition and toddler feeding were popular, other topics such as current controversies in nutrition ranked higher. This may reflect the fact that while staff acknowledge the need to brush up on their basic skills, issues such as low-carbohydrate diets and other trends are common discussion points in the world of WIC.

Another highly rated topic was "talking to parents about weight," suggesting staff recognize the need to improve their skills for dealing with an increasingly common yet extremely complex and emotional charged topic. Breastfeeding promotion and support was also highly ranked, with the greatest interest in "getting the need to know breastfeeding information into one minute." The popularity of this topic likely reflects the limited time available in a 20-minute appointment to deliver important health and nutrition messages.

Interest was also expressed in scholarship funding that would allow paraprofessional certifiers to pursue more college education. Many staff suggested moving to a computer or web based training system, which would allow them to stay up-to-date on the latest in nutrition and health without having to travel. When asked what areas are currently overlooked in the training process, counseling skills, dealing with angry clients, management skills, obesity counseling, encouraging physical activity, feeding relationships, and communicating across cultures all received multiple mentions.

When choices of training topics were analyzed by the respondent's job position at WIC an interesting pattern emerged. While it had been proposed that we offer a number of topics that would appeal specifically to clerks, selection patterns reveal that clerical staff are just as interested in "certifier" topics as they are in office topics (Table 6). While this may reflect the fact that almost half of all WIC clerks are current or former WIC clients, and therefore many of these topics may be of personal interest, it may also be an indicator of the type of contact clerical staff have with clients. While they do not provide direct counseling, clerical staff are often the first to hear about a client's problems and therefore need the skills and knowledge to properly respond. Therefore it seems as though well informed clerks are key to the delivery of consistent messages on infant feeding, breastfeeding, and other areas common to WIC.

Table 6
Percent of Staff Members, By Position, Indicating Interest in a Specific Training Topic

Training Topic	**% Of all Clerks**	**% Of all Certifiers**	**% Of all RD's**
Prenatal Nutrition	36.2	51.7	13.2
Current Controversies in Nutrition	44.7	58.9	52.6
Children with Special Health Care Needs	35.1	40.2	67.2
Talking to Parents about Weight	48.9	60.7	57.1
Encouraging Clients to be Physically Active	37.2	37.5	35.7
Teaching Health Messages to Low Literacy Clients	31.9	30.4	39.2
Delivering the Need to Know Breastfeeding Information in one minute	30.9%	53.6	50.0
Dispelling Breastfeeding Myths	41.5	42.9	10.7
The Power of Clerks: How to Support BF	43.6	22.1	14.3

Discussion

According to the Code of Federal Regulations governing WIC, a competent professional authority means an individual on the staff of the local agency authorized to determine nutritional risk and prescribe supplemental foods. The following persons are the only persons the State agency may authorize to serve (in this role): physicians, nutritionists (Bachelors or Master's degree in Nutritional Sciences, Public Health Nutrition, Dietetics, or Home Economics with emphasis in nutrition), dietitians, registered nurses, physician's assistants, or State or local medically trained health officials.

This allowance for locally trained staff has permitted the WIC program to have paraprofessionals serving in the role of Competent Professional Authorities (CPA). This leaves the question of how we should best fulfill the requirement of locally medically trained?

While it is not the role of WIC to diagnose or treat medical conditions, staff are expected to properly assess nutritional risk and deliver appropriate counseling. A return to a program delivered by nurses, dietitians and health educators would help address this issue, but without a substantial increase in funding, this is unlikely. Although the Oregon WIC program may have been among the first in our region to shift to a primarily paraprofessional workforce, other states are now moving in a similar direction.

The Oregon WIC program acknowledges that paraprofessionals will likely remain the majority of our local agency staff, and therefore open and thorough assessment of our current training methods and content is the critical first step in assuring competency. From our initial effort we have discovered that our current method of printed, notebook bound training modules cannot serve as the sole means of fulfilling our future training needs. Computer and web-based learning are being explored as alternative methods of delivering training. There is also an interest in examining how other professions train and certify their paraprofessional staff. The emergence in education of a portfolio system for paraprofessionals, in which there are a set of predetermined competencies and several methods of meeting each one, may be adaptable for training WIC staff. Use of this type of system would certainly help address the challenges of differing language needs, literacy levels and learning styles.

In addition, we have confirmed that most paraprofessionals, both certifiers and clerks receive little continuing education. As the State currently does not provide many training opportunities for existing staff, beyond a yearly or biennial statewide meeting, planning for continuing education opportunities must occur. In addition the need for continued training must be communicated to local agency administrators, so they will not view a brief closure of a clinic for training as a burden, but rather as an investment in their staff.

Armed with a better understanding of our local agency workforce, gaps in our current training, and future training needs, the Oregon WIC program stands in a unique position to develop and deliver a new level of training that can better prepare all our staff to meet the increasingly complex needs of our clients as we move into our fourth decade of service.

Implications for Health Educators

Honest Assessment. Honest assessment of what you're doing now and whether or not it is working is essential for a program to grow and change in a way that can produce better outcomes for clients, staff and the community.

Communication. The importance of communicating assessment results and on-going needs to higher-level program administrators should not be overlooked. These decision makers can serve in a vital role as advocates for the approval and funding of training opportunities and making continuing education for para-professionals a priority for the agency.

Staff Training. Staff training does not end with orientation. Each staff position should have a specific training plan that includes continuing education. This is especially important for

clerical staff and paraprofessionals who do not usually have continuing education requirements to maintain a certification.

The Health Message. Don't limit your concept of who delivers health education. Clerical staff also play a vital role in delivering consistent health messages to clients.

Tailored Training. A one-size-fits-all approach to training is a risky proposition. With the variety of learning styles, literacy levels, and backgrounds that new and existing staff bring to a program, giving staff several different methods to demonstrate a competency rather than just one is more likely to produce success.

Other Languages. Staff training materials may need to be in languages other than English. With the increasing language diversity of our clients, new staff will need to be hired to meet these needs.

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Appendix A

Number and Percent Local Agency WIC Staff Indicating Interest in a Training Area, By Topic Track

Track 1
Nutrition Updates

Topic	Number	Percent
Current Controversies in Nutrition	168	56
Prenatal Nutrition	125	42
Children with Special Health Care Needs	122	41
Toddler Feeding	109	36
Infant Feeding	100	33
Diabetes	88	29
Drug-Nutrient Interaction	78	26

Track 1a
Topics of Interest For Children with Special Health Needs

Topic	Number	Percent
Feeding Practices for Very Low and Low Birth Weight Infants	128	43
Alcohol and Drug Affected Children	117	39
Cleft Palate	55	18
Down’s Syndrome	45	15
Tube Feeding Evaluation and Assessment	43	14
Seizure Disorders in Infants and Children	41	14
Cerebral Palsy	37	12
Cystic Fibrosis	26	9
PKU and other metabolic disorders	20	7
Cardiac disease	15	5
Renal Disease	7	2

Track 2
Nutrition Education (NE)

Topic	Number	Percent
Talking to Parents About Weight	169	56
Encouraging Clients to be Physically Active	105	35
Teaching messages to low literacy skills clients	91	30
Creative Teaching Strategies	87	29
Promoting Vegetables and Fruit	75	25
Developing culturally appropriate classes & materials	71	24
Marketing NE to clients	56	19
Client Centered 3-step counseling	53	18
Client Centered Counseling for High Risk Clients	49	16
Coordinated NE through Community Partners	35	12
Facilitated Group Discussion	30	12

Track 3
Breastfeeding (BF)

Topic	Number	Percent
Getting the need to know BF information into 1 minute	127	42
Dispelling BF myths	102	34
Increasing BF duration rates	99	33
BF complications: knowing when to refer	92	31
The power of clerks-how to support BF	86	29
Making the Case for Exclusive BF	78	26
Providing Culturally Competent BF Support	73	24
Watching our Language: Risk vs. Benefit	56	19
Building BF Friendly Communities	55	18
BF Data: Where to get it, how to use it	35	12
BF Coordinator Get-Together	20	7

Track 4
Clinic Operations and Outreach

Topic	Number	Percent
Building a Strong WIC Team	105	35
Running a Great WIC Program When Money's Tight	104	35
Using TWIST Reports	79	26
Techniques for Outreach to Hard to Reach Populations	76	25
Improving your Clinic Flow	63	21
Effective Outreach Strategies	45	19
Developing Sustainable Partnerships	55	18
Time Management	53	17
Improving the Integrity of the WIC Program	53	17
Using the Media for Advocacy and Marketing	50	17
Improving Client Ed on Shopping with FI's (WIC Vouchers)	42	14

Track 5
Interpersonal Skills

Topic	Number	Percent
Understanding WIC from the Client's Perspective	172	57
Communicating Across Cultures and Languages	170	57
Diffusing Difficult Situations	167	56
Building a Strong Local WIC Team	141	47
Models for Integrating WIC with Maternal/Child Health	77	26
Time Management	75	25