CCI links WIC participants to primary & preventative services in Montgomery County, MD
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Summary
Although Montgomery County, MD is a thriving region, acute poverty is found in neighborhoods where CCI Health & Wellness (CCI) centers are located. These areas are concentrated with individuals who face a host of challenges. Poorer health outcomes run rampant especially when primary and preventative services are not sought as a necessity, but as a luxury. In addition to providing WIC services to over 33,000 participants, CCI Health & Wellness Services delivers high quality, affordable, primary care to over 26,000 individuals across all stages of life. Over the past year, CCI discovered there is often not a cross utilization of services. A large percentage of WIC participants are unaware that CCI can be their primary medical home that can address not only their need for WIC services, but also for primary care, behavioral health care, prenatal care, and dental services. The Healthy Jumpstart Coalition (HJC) developed and implemented a workflow designed to address this barrier, with the potential of connecting thousands of WIC participants to primary care and preventative services with ease.

Challenge
Montgomery County, MD is saturated with primary care physicians, preventative services and social programs. However pockets of poverty in the county ranks the county at 39.22 on the disparity index according to the county’s community health needs assessment. An index between 1-40 indicates the county is at some disparity. To narrow our scope, access to primary and preventative services is one of social determinants in which impact individuals in these pockets of poverty. The access to adequate and consistent care is vital to sustain life. The HJC developed the resource navigator program which links families to service. Since the launch of this program we have extended our efforts in developing a strong bond between WIC staff and CCI providers to increase knowledge and share with families that having consistent primary care will establish the importance of prevention. We emphasize primary prevention (detecting early warning signs before disease) or secondary prevention (detecting of disease at an early stage) will increase the likelihood for individuals to reduce chronic illness.

Solution
As a Joint Commission Accredited, patient centered medical home (PCMH), we know that quality of care, patient experience, and care coordination and access significantly improve quality of life. So as a result of this program, we have fostered a strong bond between the CCI-WIC program staff and CCI primary care providers in an effort to increase knowledge of available primary care services at CCI and the importance of preventative health care. As a result, all CCI staff can now emphasize the importance of primary prevention (detecting early warning signs before disease) or secondary prevention (detecting of disease at an early stage) in decreasing the likelihood of chronic illness. To this end, the HJC developed a workflow that CCI-WIC staff and CCI primary care providers implemented to ensure that WIC families identified as needing primary care services are referred to, and have an appointment made for CCI primary care services. The workflow developed, creates a universal referral process so that WIC families at all 5 CCI-WIC locations, are made aware of, and have help to gain access to any of the eight CCI primary care locations.

Results
After testing the referral model in a few locations, needed changes were identified. The WIC-primary care provider referral initiative was revamped in February of 2016 to include the following: a monthly meeting between WIC center managers and medical center managers allowing cohesiveness, establishing day to day communication between managers and education of services. The systematic workflow introduced an organized way for WIC staff to communicate about primary and preventative services, how to best refer families, and how medical staff at CCI primary care locations can follow up with the referral. In addition, the WIC prescription form now comes with a newly developed cover letter form explaining concerns of participant nutrition status and what is recommended by the WIC nutritionist. Since the implementation of monthly meetings, educational sessions of WIC services, and new prescription cover letter, 441 participants were referred from CCI-WIC to CCI medical. Of those 441 participants, 331 had never previously accessed a CCI primary care site.
“The CPHMC initiative has been effective for our WIC participants to access necessary health care services. Our participants are now receiving care in a timely manner” –Laura Sullivan, WIC Communications and Outreach Manager

**Sustaining Success**
The WIC program is an essential component of whole health. As a WIC participant, individuals receive nutrition education and access to healthy food; and now through this initiative, WIC families are encouraged to access preventative primary care as well. The ability for WIC staff and CCI primary care providers to work collectively in an integrated environment, promotes positive health outcomes for families. The established monthly meetings, assigned point of contact at each primary care location, and same day doctor appointments available for children emphasize how important integrated health is to CCI. As a result, this initiative has become standard practice across all sites. Implementing a clear channel of communication for WIC staff and primary care providers where they can discuss challenges and identify solutions will attribute to the success of this initiative. Furthermore, continuous education about WIC services to providers and medical staff will foster success ultimately stimulating WIC families in having the greatest impact of health and well-being.

**Your Involvement is KEY**
Through the National WIC Association’s support for Community Partnerships for Mothers and Children (CPHMC) they have made it possible to implement policy, systems and environmental improvements. Your ability to increase support by spreading awareness for initiatives such as CPHMC will increase opportunities for nutrition education and chronic disease prevention through community clinical linkages in the most vulnerable populations.