



Policy 325 Caseload Management June 28, 2019

POLICY

Local WIC programs shall maintain caseload levels that meet their assigned caseload set by the State WIC program.

PURPOSE

To provide WIC services to as many eligible participants as possible by fully utilizing available resources in accordance with the federal priority system.

RELEVANT REGULATIONS

- ◆ 7 CFR §246.16 ¶(e) 2 Performance Standards
- ◆ 7 CFR §246.7 ¶(e) 4 Nutritional Risk Priority System

OREGON WIC PPM REFERENCES

- ◆ [470—Local Program Outreach](#)
- ◆ [475—Waiting List](#)
- ◆ [605—Processing Standards](#)
- ◆ [670—Overview of Risk Criteria and Priorities](#)

DEFINITIONS

Assigned Caseload: The number of individuals the state gives a local program money to serve. This caseload goal is based on prior performance and available monies.

Certified Caseload: The number of individuals who completed a WIC certification and are eligible for WIC benefits.

Priority: The ranking assigned to a participant based on the individual's WIC category and identified risk factors in accordance with the federal nutrition risk priority system.

Participating Caseload: The total number of participants included in the following groups:

- certified individuals who have been issued benefits;
- certified infants who do not receive benefits, but their breastfeeding mothers receive benefits;
- certified breastfeeding women who do not receive benefits, but their infants receive food benefits.

Participant: An individual receiving WIC benefits and services appropriate for their category.

PROCEDURE

Managing caseload

- 1.0 Local WIC programs will develop and enact caseload management policies and procedures to achieve and maintain 97% to 103% of their assigned caseload level set by the State. All caseload management decisions need to account for service to the highest priorities possible based on the federal nutrition risk priority system. See [◆670—Overview of Risk Criteria and Priorities](#).
 - 1.1. Review caseload reports in the management information system (MIS) every month to achieve and maintain a participating caseload as close to 100% of assigned as possible.
 - 1.2. Utilize caseload management tools posted on the Oregon WIC website to assist with routine caseload management and monitoring:
<https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WIC/Pages/caseload-management-resources.aspx>
 - 1.3. Use state staff as a resource for technical assistance in interpreting reports and developing strategies.
 - 1.4. Talk with experienced coordinators to learn how they have handled caseload changes and to learn more about the art of managing caseload.
 - 1.5. Compare caseload levels with trends and patterns from past reports. Maintain and evaluate records that identify caseload fluctuations that occur in response to changes made by the local program, such as closing or opening a new clinic site or changes in staffing patterns.
 - 1.6. Determine immediate and long-term monthly caseload levels needed to meet assigned caseload goals.
 - 1.7. Develop strategies to achieve immediate and long-term goals.
 - 1.8. Take action. Implement selected strategies.
 - 1.9. Maintain ongoing evaluations. Reassess plans as information changes. Adjust goals and alter strategies as needed.
 - 1.10. Keep staff and agency managers informed about caseload performance, the implications of current trends and possible impact of changes in caseload management policies. Involve them in decision making.

Increasing caseload

- 2.0 Increase caseload levels when caseload is below assigned levels. Options for increasing caseload include, but are not limited to the following:
 - 2.1. Serve all priorities unless instructed differently by the State. If not serving all priorities, adjust priorities served to increase caseload to assigned levels.
 - 2.2. Increase outreach activities. See [◆470—Local Program Outreach](#).
 - 2.2.1. Utilize census data to identify growing populations in the local area and develop plans to reach those groups.

- 2.2.2. Encourage word-of-mouth referrals. Develop “tell a friend” campaigns.
 - 2.2.3. Distribute WIC information to local stores, clinics, agencies. Utilize posters, pamphlets, and fliers printed in languages spoken in the community. Contact the state program for available outreach materials.
 - 2.2.4. Consider promotions via billboards, local newspapers and radio stations. Contact television stations regarding public service announcements.
 - 2.2.5. See the Outreach section of the Oregon WIC website for additional ideas.
 - 2.2.6. Contact the state WIC Outreach Coordinator for technical assistance to develop a local agency outreach plan.
- 2.3. Increase the number of available appointments.
- 2.3.1. Add staff time by increasing existing staff hours or by hiring additional or temporary staff. Review staffing patterns and activities. Use volunteers or non-professional staff for support services, routine clerical tasks, and participant weighing and measuring, to increase availability of trained professional staff for certification appointments. Assure that all volunteers receive appropriate training for assigned tasks.
 - 2.3.2. Streamline service to reduce length of time spent per participant so additional appointments can be scheduled. Analyze participant movement through the clinic. Evaluate for logical traffic patterns with efficient flow of participants and staff. Look for duplication of service and grouping of task assignments. Identify problem areas and plan for effective change. Contact the state program for information regarding analysis of clinic flow.
 - 2.3.3. Consider group certifications.
 - 2.3.4. Share staff from other health department programs, local WIC programs, doctors’ offices, or other agencies, to assist with certification. Pursue integrated services when possible. Consider training Community Health Nurses as CPAs to complete certifications and follow up visits in the home during home visits.
- 2.4. Increase accessibility to program services. Conduct participant surveys to identify barriers to service and to obtain responses to proposed changes.
- 2.4.1. Increase ease of phone contact with local program. Examine need for additional phone lines or operators. Consider answering machines to relay information and/or take messages when staff are unavailable or the clinic is closed. Provide adequate staff or volunteers to answer phones and return text, email and voice mail messages.
 - 2.4.2. Extend clinic hours to include weekend, evening, early mornings, or lunch times.
 - 2.4.3. Check availability of public transportation and free parking near clinic sites.

- 2.4.4. Assure barrier-free access for individuals with disabilities.
- 2.4.5. Consider additional clinic sites in under-served or isolated areas.
- 2.4.6. Have interpreters available for non-English-speaking or hearing-impaired participants.
- 2.4.7. Make program information available in alternate formats such as large prints, audiotapes, Braille, etc.
- 2.4.8. Provide adequate waiting room and clinic space to serve the number of participants being seen at each clinic site.
- 2.5. Improve show rates. Evaluate data to identify specific problem areas and strategies for increasing efficiency. Show rates may vary depending on time of month, time of day, or type of appointment.
 - 2.5.1. Identify text or voice mail options for participants in order to utilize the automated ANSWR system for appointment reminder calls prior to their scheduled appointments. Send reminder postcards.
 - 2.5.2. Allow participants to select appointment dates and times that best serve their needs.
 - 2.5.3. Contact participants to reschedule missed appointments.
 - 2.5.4. Adjust appointment schedules to compensate for show rates by over-booking appointments.
 - 2.5.5. Create an on-call list of participants who are willing and able to come in on short notice to fill appointment slots that became available when participants cancel.
- 2.6. Adjust for caseload fluctuations of seasonal or migrant workers.
 - 2.6.1. Examine past caseload data and make allowances for increased staff and temporary clinic sites needed to provide adequate services in an efficient manner.

Temporary limitation of services to specific priorities

- 3.0 Check with the State WIC program if there is a need to discontinue services to specific priority levels when participating caseload levels are above assigned levels. Options for restricting priorities to reduce caseload include, but are not limited to, the following:
 - 3.1. Focus service on the highest priorities. Service to lowest priorities must always be restricted prior to altering the availability of services to higher priorities. For example, service to priority VI women must be discontinued before services to priority V children can be restricted. State must approve any restrictions of priorities served. See [◆670—Overview of Risk Criteria and Priorities](#).
 - 3.1.1. Consider setting priorities within a priority. This approach can be useful when gradual caseload changes are required.
 - EXAMPLE 1:** Discontinue service to priority VI women who only have presumed eligibility as a risk factor.
 - EXAMPLE 2:** When service to all priority VI women has been discontinued, consider serving priority V children only under four

years of age. Remember that if any priority V children are served, all participants who are priority I, II, III, or IV must be served.

- 3.1.2. Restrictions of priorities served will be documented in the MIS.
- 3.1.3. Develop a plan for informing participants, agency personnel, and the community regarding changes in service priorities. A consistent and clear message is important to avoid misinformation and allow for caseload maintenance. All WIC staff need to repeatedly emphasize that as many participants as possible will continue to be served.

EXAMPLE: If a local program is not serving priority VI participants, communicate that services will continue to all pregnant women, all breastfeeding women, all infants, most children, and some post-partum, non-breastfeeding women. Explain that the highest risk participants are served first when funding and caseloads are limited. This is a key message to repeatedly communicate to participants, other health department or agency staff and community partners.

Maintaining Caseload

- 4.0 Maintain current caseload levels by gradually adjusting present caseload management policies when assigned caseload levels are being met.
 - 4.1. When policies for increasing or decreasing caseload have been implemented successfully and caseload levels approach assigned target, gradually adjust policies to allow for caseload to stabilize at assigned levels. Continue to evaluate caseload levels monthly to identify adjustments needed for on-going maintenance of the assigned caseload.

**If you need this in large print or an
alternate format, please call 971-673-0040.**

This institution is an equal opportunity provider.

POLICY HISTORY

Date	* Major revision, Minor revision
3/19/1999	Revised
8/1/2009	Revised
10/1/2011	Revised
5/22/2015	Revised
6/28/2019	Minor revision

The date located at the top of the policy is the implementation date unless an “effective date” is noted on the policy. Policies will become compliance findings 6 months from the implementation date.

Release notes can be found in the corresponding document on the [Policy and Procedure Manual page](#).

***Major Revisions:** Significant content changes made to policy.

Minor Revisions: Minor edits, grammatical updates, clarifications, and/or formatting changes have occurred.

Date of Origin: Date policy was initially released