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Carolyn Barnes
Sarah Petry
Duke University

"It Was Actually Pretty Easy": COVID-19 Compliance Cost Reductions in the WIC Program

Research Article

Abstract: *In recent years, scholars have examined the barriers to accessing public assistance benefits. Research identifies learning, compliance, and psychological costs as deterring program use. Compliance costs reflect the burdens of following program rules, which may entail providing documentation, responding to discretionary demands of bureaucrats, or attending appointments to maintain benefits. Studies identify one element of compliance costs—quarterly appointments—as a barrier to continued WIC participation. This article draws on 44 in-depth qualitative interviews with participants in the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC). We examine how WIC participants perceive the reduction of compliance costs following the implementation of remote appointments in response to the COVID-19 pandemic. WIC participants report satisfaction with remote appointments and a reduction in the compliance costs of accessing and maintaining benefits. We conclude by recommending longer term changes to policy and practices to increase access and continuity in WIC receipt.*

Evidence for Practice

- *Most WIC participants reported positive experiences with remote appointments.*
- *WIC participants viewed remote appointments as more convenient and faster than pre-pandemic in-person appointments.*
- *Remote appointments alleviated WIC participants' safety concerns about in-person visits during the COVID-19 pandemic.*
- *We recommend and highlight long-term changes to WIC policy that enable continued remote appointments to increase access to and maintenance of WIC receipt.*

Scholars have demonstrated low take-up rates for public assistance programs and attribute this to challenging application processes, stigma, and stringent eligibility rules (Friedrichsen, König and Schmacker 2018; Hanratty 2006; Homonoff and Somerville 2020; Sommers et al. 2012). Moynihan, Herd, and Harvey (2015) conceptualize these barriers as administrative burden, or onerous experiences with policy implementation (Burden et al. 2012). Administrative burden can include the costs of following program rules, the costs of learning eligibility rules and application processes, and the stress and stigma of accessing public benefits (Herd and Moynihan 2018).

Rising unemployment following the COVID-19 outbreak has increased the demand for public assistance programs and revealed the challenges of accessing safety-net programs (Herd and Moynihan 2020). There is record demand for unemployment insurance, and millions of Americans have encountered barriers to accessing the program (Aaron 2020). Likewise, recent reports show that vulnerable families face difficulties in accessing nutrition assistance programs such as the Pandemic EBT, an additional Supplemental Nutrition Assistance Program targeting school-aged children affected by the pandemic (Gassman-Pines, Ananat, and Fitz-Henley 2020). The COVID-19 outbreak revealed the limitations of the social safety net, but also spurred innovative policy responses designed to ease access to safety net programs and, ultimately, reduce administrative burden.

As a part of The Coronavirus Aid, Relief, and Economic Security (CARES) Act, the federal government has allowed states to conduct remote interviews, shift recertification deadlines, and waive documentation requirements across SNAP, Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC), and Medicaid (Center on Budget and Policy Priorities 2020; United States Department of Agriculture (USDA) 2020; Centers for Medicare and Medicaid Services 2020). These kinds of policy waivers offer a short-term opportunity to examine how policy changes can shape program experiences. We examine two major

Carolyn Barnes is an assistant professor in the Sanford School of Public Policy at Duke University. Her research explores social policy implementation in the areas of childcare policy and supports for young children.
Email: carolyn.barnes@duke.edu

Sarah Petry is a PhD student in public policy, concentrating on sociology. She studies demography of aging to consider how population composition and change impact our healthcare system, Medicare, and Medicaid. Her work also explores policy interventions for palliative care, hospice, and caregiving for seniors.
Email: sarah.petry@duke.edu

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policy changes offered through the USDA waivers for the WIC program: remote appointments and waiving anthropometric data—data that capture participants' iron levels, height, and weight and is used to determine participants' nutrition risk. Research has demonstrated how taxing compliance costs can reduce program uptake and pointed to remote intake processes as a way to boost program enrollment (Herd et al. 2013). However, these studies are large and quantitative and provide less insight into how program applicants and beneficiaries experience policy changes designed to reduce compliance costs. Further, research has not yet examined how program beneficiaries are experiencing policy changes brought about by COVID-19 policy waivers. How do WIC participants experience and evaluate remote appointments and changes in the intake process?

We examine how these waivers have shaped program experiences for 44 WIC participants in North Carolina—a state that has experienced significant declines in program enrollment since 2014 but a sharp increase in uptake since the COVID-19 outbreak in March 2020 (Food Research and Action Center 2020). WIC reflects an ideal case to examine the role of waivers in program experiences because of the program's expansive scope: more than half of all infants born each year receive WIC (Kline et al. 2020). Despite the program's reach, WIC enrollment has declined significantly since 2011 and is covering fewer eligible families (Gray et al. 2019). Declining enrollment could be—in part—attributed to required quarterly WIC appointments, two of which are "in-person" appointments. These regular appointments may reflect compliance costs that discourage long-term program use (Woelfel et al. 2004).

Administrative Burden

Administrative burden refers to "an individual's experience of policy implementation as onerous" (Burden et al. 2012, 742). Administrative burden can emerge in service-seeking bureaucratic encounters, within organizations, and in transactions that occur outside of traditional bureaucracies (Barnes 2021; Burden et al. 2012; Heinrich 2016; Kahn, Katz, and Gutek 1976). Burdens emerge across a range of policy contexts (Herd and Moynihan 2018) and are experienced by bureaucrats and citizens alike (Burden et al. 2012). But scholars have focused on the burdens of accessing social programs (Barnes and Henly 2018; Brodkin and Majmundar 2010; Heinrich 2016; Soss 1999). Accordingly, scholars conceptualize administrative burden as encompassing three kinds of costs: learning costs, psychological costs, and compliance costs (Moynihan, Herd, and Harvey 2015).

Individuals experience learning costs when they must learn what benefits are available, whether they are eligible for these benefits, how to access these benefits, and how to use them (Barnes 2021; Moynihan, Herd, and Harvey 2015). Psychological costs consist of the stress and stigma associated with applying for and using benefits and the loss of autonomy individuals experience in their interactions with the state (Moynihan, Herd, and Harvey 2015). Finally, compliance costs reflect the burdens of following program rules and requirements and can include the costs of applying for benefits, recertifying eligibility, and responding to the discretionary demands of bureaucrats and agencies (Moynihan, Herd, and Harvey 2015).

Studies have found that these costs are formidable barriers to accessing programs (Heinrich 2016; Herd and Moynihan 2018), are both intentional and unintentional (Moynihan, Herd, and Harvey 2015; Peeters 2020), and can disproportionately burden the most vulnerable and marginalized groups (Barnes and Henly 2018; Chudnovsky and Peeters 2020; Nisar 2018), especially those who lack the cognitive and human capital to successfully navigate these costs (Christensen et al. 2020; Herd 2015).

Compliance Costs

Moynihan et al. (2015, 46) define compliance costs as, "the burdens of following administrative rules and requirements." These burdens include, "the costs of completing application forms," "the costs of reenrollments," "providing documentation of status," and "responding to the discretionary demands" of workers and the agency (Moynihan, Herd, and Harvey 2015, 46). Social policy research demonstrates how these compliance costs can negatively shape program experiences and deter program uptake (Barnes and Henly 2018; Watkins-Hayes 2011). For example, Soss' (1999) early work on "Aid to Families with Dependent Children" (AFDC) demonstrates how taxing the information-gathering process is for applicants. More recent collaborative work similarly shows how stringent eligibility rules, work requirements, and discretionary demands of caseworkers can discourage continued participation in AFDC's successor, Temporary Assistance for Needy Families (TANF) (Soss, Fording, and Schram 2011).

To be sure, scholars attribute the low program take-up of many public assistance programs to the burdens of completing applications and following program rules (Heinrich 2016). Brodkin and Majmundar (2010) have demonstrated how the procedural burdens of TANF applications decreased caseloads. Kaye, Lee, and Chen's (2013) New York study of SNAP participation found that face-to-face interview requirements, excessive documentation, and limited assistance with the application deterred program enrollment. Herd (2015) highlighted similar compliance costs for older adults as deterrents to SNAP participation. Asset tests and medical expense deductions increase the amount of documentation needed to determine eligibility, which makes the application process more onerous. In a developing-country context, Heinrich's (2016) study of the South African Child Support Grant has demonstrated how the challenges of providing documentation and reapplying to the program due to minor changes in eligibility could disrupt benefit receipt.

Research also shows how reducing these costs can boost program uptake (Bansak and Raphael 2007; Hanratty 2006; Herd et al. 2013; Herd and Moynihan 2018). For example, Bansak and Raphael's (2007) study of States Children Health Insurance Program (SCHIP) policy design found that eliminating asset tests and simplifying the application and renewal process increased take-up rates. Herd and colleagues' (2013) study of the Wisconsin's Medicaid program, Badger Care, found that auto-enrollment, simplifying application forms, and presumptive eligibility increased program uptake. Measures such as lengthening eligibility periods, providing online applications, and offering application assistance have also increased SNAP uptake overtime (Herd and Moynihan 2018).

One important source of compliance costs is in-person appointments or interviews that are designed to gather information to determine program eligibility. While a number of studies suggest that appointments and interactions with bureaucracies impose

psychological costs to claimants (Soss 1999; Watkins-Hayes 2011), research suggests that these bureaucratic encounters are also a form of compliance cost (Herd and Moynihan 2018; Soss 1999). Appointments or interviews require claimants to fill out application forms and submit information that helps determine eligibility status initially and over time. Reducing or eliminating these kinds of appointments can increase program uptake. For example, Wolfe and Scrivner's (2005) study of SCHIP uptake suggested that eliminating face-to-face interviews was positively associated with SCHIP uptake. Eliminating in-person interviews for SNAP similarly boosts program enrollment (Herd and Moynihan 2018).

Current Study

Given the mounting evidence highlighting the dampening effects of compliance costs on program uptake, we examine how WIC participants experience two recent WIC policy changes amidst the COVID-19 pandemic—remote appointments and loosened guidelines on collecting anthropometric data—that may reduce the compliance costs of the program. We use evidence from 44 qualitative interviews to examine how participants experience and evaluate remote appointments and the extent to which participants perceive reductions in compliance costs.

Policy Context: WIC

WIC is the third largest food assistance program in the United States, serving 7.8 million families in 2018. The program serves more than half (53 percent) of all infants born in the United States and offers nutrition assistance to support low-income women with children under the age of 5 years who are at risk for malnutrition (Gray et al. 2019). Eligible populations include children from infancy to their fifth birthday, women who are pregnant, women who are non-breastfeeding up to 6 months postpartum, and women who are breastfeeding up to a year postpartum. Individuals with family incomes below 185 percent of the federal poverty line are eligible to receive WIC (Kline et al. 2020) as well as recipients of TANF, Medicaid, or SNAP. WIC is funded at the federal level but is administered by 90 state WIC agencies. Eligibility requirements are uniform across the country (Kline et al. 2020). While states require quarterly nutritional assessment and education appointments (Kline et al. 2020), they differ in how they deliver nutritional education appointments. For example, Texas, Washington, DC, Nevada, Georgia, Mississippi, West Virginia, Virginia, Oregon, and Massachusetts all use telehealth for nutritional education and breastfeeding support in areas with limited staff.[1] Nevertheless, most states still rely on in-person appointments, and telehealth models have not replaced in-person methods to capture anthropometric information on WIC participants.

As a public health program, WIC aims to promote positive maternal and child health outcomes by reducing nutrition risks, which the program defines as conditions such as anemia, low maternal weight gain, obesity, or inadequate growth in children.[2] To this end, WIC works to promote positive eating behaviors and reduce nutrition risks through food vouchers, nutrition education, and breastfeeding support. Food packages are designed to alleviate participants' nutrition risks as assessed by WIC staff. Packages usually include iron-enriched formula, cereals, vitamin C-rich foods, eggs, milk, cheese, peanut butter, and beans or peas. Nutrition education consists of 15-min sessions in which nutritionists advise participants on how to use WIC approved foods. Nutritionists also teach participants about the relationships between nutrition, physical activity, and good health. Ideally, WIC staff tailor nutrition education to participants' needs, backgrounds, households, language, and cultural preferences. Finally, the WIC program promotes breastfeeding through breastfeeding counselors and support groups.

Substantial evidence across disciplines demonstrates the positive effects of WIC participants on child and maternal health outcomes. For example, research shows how WIC participation increases the use of healthcare services and birth weights, lowers infant mortality, and improves diets for young children (Bersak and Sonchak 2018; Bitler and Currie 2005; Buescher et al. 2003; Siega-Riz et al. 2004). In addition, Jackson (2015) found that prenatal and early childhood exposure (0–3) to WIC is associated with increased cognitive skill development before school entry and academic achievement during school years.

WIC Program Compliance Costs

Unlike other means-tested programs, WIC does not do intake via written applications. Instead, eligibility is determined through an in-person appointment. In the initial certification appointments, applicants are interviewed to assess income eligibility and dietary preferences (Gray et al. 2019). Applicants must present proof of address and proof of income, or (in some cases) proof of participation in Medicaid, SNAP, or TANF.[3] Along with assessing income eligibility, WIC staff members must also collect anthropometric data from applicants to determine nutrition risks. This data collection effort includes drawing blood from applicants, weighing them, and taking their heights. Once deemed eligible, participants remain eligible for a year after their initial certification. However, they must attend quarterly appointments, which includes a 6-month recertification to reassess nutrition risk and two appointments dedicated to nutrition education and benefits distribution (Kline et al. 2020).

WIC participants are not subject to extensive documentation requirements found in other means-tested programs. However, research suggests that quarterly appointments can be burdensome for WIC participants (Panzera et al. 2017; Rosenberg, Alperen, and Chiasson 2003; Woelfel et al. 2004). Earlier research on WIC participation and retention attributes declines in program uptake to the participants' challenges in scheduling and attending appointments (Woelfel et al. 2004). Participants must take time from work or arrange transportation to attend appointments (Hammad et al. 1997; Liu and Liu 2016; Panzera et al. 2017). Further, bringing children to appointments and providing documentation to verify eligibility can be burdensome (Liu and Liu 2016; Panzera et al. 2017; Pelto et al. 2019). Finally, several studies show that lengthy wait times at WIC clinics can diminish the quality of program experiences and deter WIC enrollment (Boe, Riley, and Parsons 2009; Rosenberg, Alperen, and Chiasson 2003; Woelfel et al. 2004).

COVID-19 Policy Waivers and Remote Appointments

In light of social distancing practices due to COVID-19, the Families First Coronavirus Response Act allowed all states to apply for waivers that would waive physical presence requirements for

WIC appointments.[4] These waivers also enabled WIC agencies to defer fulfilling anthropometric data collection requirements. States could request these waivers, as well as extensions to them, to reduce barriers to accessing nutrition benefits during a pandemic. All states, except Colorado and Wisconsin, applied for and received physical presence waivers.[5]

In April of 2020, the USDA granted North Carolina a waiver eliminating the physical presence requirement for WIC appointments. The waiver allowed workers to collect information related to certification over the phone or through other forms of remote communication. The waiver also allowed WIC staff to issue benefits remotely (North Carolina Department of Health and Human Services (N.C.DHHS) 2020a). Local agencies could also defer anthropometric and bloodwork requirements—measures that are used to determine nutrition risk. Instead, workers could determine nutrition risk based on the information provided by applicants (N.C.DHHS 2020a, 2020b).

With regard to proof of residence and income, applicants could provide this information digitally. If they could not do so, WIC staff members could cite the COVID-19 pandemic as the reason why such information cannot be provided (N.C.DHHS 2020a, 2020b). In lieu of in person assessments, applicants could self report anthropometric measures from their most recent doctor's appointment, or workers could use measures from the participant's most recent WIC appointment. WIC staff could also rely on an imputed average of participants' height and weight—measures that correspond with the plot point at which the child would measure if they were at the 50th percentile for height for their age and the 50th percentile for weight for their age. Finally, the waivers allowed workers to defer bloodwork measures (N.C.DHHS 2020b).

Methods

To understand how participants view remote appointments as shaping the compliance costs of WIC, we took an interpretive approach to the design of this study, which emphasizes understanding how participants perceive their experiences (Haverland and Yanow 2012; Schwartz-Shea and Yanow 2012). Because meaning-making is the objective of the study rather than generalizability, we do not pursue a random sample of WIC participants for this study. We also offer no hypotheses to test or falsify which would require probability sampling (Schwartz-Shea and Yanow 2012). Our aim is to provide a rich description of a sample of WIC participants' experiences with remote appointments permitted through the CARES Act.

To that end, this study consists of 44 in-depth phone interviews with WIC participants across six counties in North Carolina. Counties were selected based on access, urbanicity, and the demographic makeup. For example, we selected three rural and three urban counties that varied in their regional location. All counties were racially and economically diverse, having a Black population of 15 percent or more and poverty rates, which ranged from 13 to 30 percent.

Participants were recruited through fliers that were distributed by mail through WIC offices. Given state confidentiality guidelines, we were not permitted to have a mailing list or identifying information of WIC participants who may have received the study fliers. Participants who were interested in the study called the study hotline to schedule and conduct the interview. After obtaining oral informed consent, interviews were conducted by phone and ranged 30–60 min. Study participants received a $30 e-gift card for participating in the interview. Table 1 displays WIC participant characteristics.

Our sample of WIC participants was predominately Black (77.3 percent) and non-Hispanic (93.2 percent). On average, participants were 33 years old and had 2.3 children. Most completed high school (36.4 percent) or some college (38.6 percent), while slightly more than one-fifth completed a bachelor's degree or higher. More than half of the sample of WIC clients were unemployed at the time of the interview. The average monthly income for this sample was $1,423. More than half (52.2 percent) were from rural counties and the remainder (48.8 percent) resided in urban counties. While North Carolina's coverage rate mirrors that national average (54 percent), the state has a large Black population (22.2 percent) relative to the US population (13.4 percent) and has a smaller Hispanic or Latino population (9.8 percent) relative to that of the United States (18.5 percent) (Kline et al. 2020). The racial and ethnic backgrounds of our sample are distinct from the North Carolina and national WIC population. See Table 2 for comparison.

Our sample reflects the greater share of African Americans in North Carolina and our county selection process in which we prioritized high-poverty counties with a diverse population. Given the growing evidence that African Americans are disproportionately affected by the health and economic crises stemming from the COVID-19 pandemic (Enriquez and Goldstein 2021), we believe that our sample is poised to offer some insights from families who are most vulnerable throughout this period.

A team of four interviewers conducted phone interviews lasting 30–60 min from March 2020 through August 2020. Pseudonyms are used for the participants to protect their identity. In the semistructured interviews, we asked WIC participants to describe

Table 1 WIC Participant Characteristics (*N* = 44)

	Mean (Min., Max.); Number (Percentage)
Age	32.95 (20, 62)
Gender	
Male	2 (4.5)
Female	42 (95.5)
Race/ethnicity	
Black	34 (77.3)
White	10 (22.7)
Hispanic	3 (6.8)
Number of children	2.3 (0, 5)
Pregnant	5 (11.4)
Age of children	1.8 (0, 4)
Education (*N*)	
HS or less	17 (38.6)
Some college	17 (38.6)
Bachelor's	7 (15.9)
Master's	3 (6.8)
Employment (*N*)	
Employed	21 (47.7)
Average monthly income	$1,423 ($0, $8,000)
Rural	23 (52.2)
Urban	21 (48.8)

Table 2 Comparisons Between WIC Sample and North Carolina, US WIC Populations

Race/Ethnicity	WIC Sample (*N* = 44)	NC WIC Population	U.S. WIC Population
Black	77.3 percent	35 percent	21.5 percent
White	22.7 percent	58.2 percent	58.8 percent
Hispanic	6.8 percent	25 percent	41.3 percent

Table 3 WIC Participants' Evaluations of Remote Appointments (*N* = 44)

Valence of evaluations	
Positive	40 (91 percent)
Negative	4 (9 percent)
Rationale	
Safety	12 (27 percent)
Convenience	25 (57 percent)

how they learned about the program and what their experiences were in the office and with staff members. We asked participants to describe their program experiences in light of the COVID-19 pandemic. For example, we noted the recent changes to WIC appointments due to the pandemic and asked the following: "What are your appointments like now?" "How are your appointments different from your office visits before the Coronavirus?" "What do you like about this change?" "What do you dislike about this change?" The appendix includes questions from the interview guide. Interviewers wrote memos after each interview, describing the interviewee, the context, and key themes. These memos formed the basis of the first stage analyses.

Analysis

All transcripts, memos, and field notes from the primary data were entered into a qualitative software package, NVIVO-12. As mentioned, we used an interpretive approach to analysis that paired a deductive analysis, informed by the administrative burden literature, and an inductive analysis, where we closely read interview transcripts to allow new concepts to emerge (Haverland and Yanow 2012).

We initially organized the data by a priori codes drawn from study objectives and interview questions. Deductively, we looked for compliance costs, which Moynihan et al. (2015, 46) defined as "the cost of applying for services," "the costs of completing forms," or "providing documentation of status." We examined participants' descriptions of the application and recertification process, WIC office visits, and the activities participants reported as required to maintain benefits. Inductively, we conducted a line-by-line reading of transcripts and looked for emergent themes within respondents' descriptions. We coded clients' responses by whether their experiences with remote appointments were positive or negative and then coded the reasons behind these evaluations. To refine these themes, we conducted iterative comparison of WIC participant responses across two coders and arrived at 90 percent agreement on all themes (Glaser and Strauss 1967; Miles and Michael Huberman 1994; Ryan and Russell Bernard 2003). We now turn to WIC participants' experiences with remote appointments.

Findings

We organized the findings around one research question: "How do WIC participants experience and evaluate remote appointments?" Table 3 summarizes key findings from the interviews.

Valence of Evaluations

Most of the WIC participants interviewed (*n* = 40, 91 percent) reported positive evaluations of remote WIC appointments. Positive evaluations were equally prevalent across urban and rural participants, across new and veteran program participants, and across racial groups. Only four WIC participants expressed mixed views of remote appointments, where they mentioned positive aspects of this change as well as drawbacks. For example, Rebecca, a veteran urban participant, preferred in-person appointments but also acknowledged the convenience of remote appointments for those who are "busy and they may not be able to come in." In-person appointments gave Rebecca the opportunity to ask questions about her child's well-being. Phone appointments were fast and more convenient, but at the expense of deeper conversations with WIC staff members.

> "I would rather have the interaction with the person… Because I just like talking to people and I like asking questions about different things that work, especially if they have children. And what they do with their children and what's worked for them as far as getting their children to eat certain – you know, getting them to eat certain vegetables."

Shelia, an urban WIC participant, expressed concerns that remote appointments would reduce access to the program. WIC participants may not have access to cell service or internet to complete the online nutrition education modules. She recommended that the WIC office offer a range of options to maintain appointments, "So I just feel like we have to try to do stuff that's inclusive of everyone, and not take for granted that everyone is on the same level as everyone else." She explained:

> Well, they've been very helpful in the WIC office. They actually have been conducting the visits via phone. And you have to do modules, which is very good. And I would suggest them doing that even after COVID. Because even if they have the people that could come in that don't have access to a phone or internet can't do it, I would suggest them doing that at the office where people could come in and do the modules that would have to go to the library to do them and don't have access to a phone to be able to do them online. But I found it to be very convenient for me, because gratefully I have the access to the phone and the internet. So I'm able to do them at my convenience.

Gloria, from a rural county, appreciated the convenience of remote appointments and noted that WIC staff were still "warm and welcoming." However, she reported confusion about scheduling her next phone appointment. Rather than visiting the office at a specific time, she needed to "watch out" for a number when the WIC office called and was unsure of what time they would call:

> Well, my next appointment when I talked to her a couple days ago, she told me that the appointment would be at 8:00 A.M., but I was asking her, "Well, is that the appointment time or do I need to be by the phone at 8:00 A.M.?" And she was basically indicating they may call two days prior so just watch out for a number. I didn't understand that part because

I'm like usually if you have an appointment, you'll call at this time…for the appointment at 8:00?

Finally, Rosalynn regarded remote appointments as a breeze, but also viewed quarterly appointments as challenging to manage. If she forgot to "check back in" with the WIC office, she would lose benefits. Rosalynn would prefer staff to "load" her benefits on her card without the hassle of an appointment.

Yeah. I want to say I like the fact that they can just load up the card when it's time for your benefits to renew. But one thing that I feel like is pretty inconvenient is how often you have to check back in or recertify because there were times that I would forget to check back in with WIC. And then I would be in the supermarket, and I wouldn't have any benefits at all. And it would just be – I: Oh. R: Yeah. Because I haven't I don't know, I guess called them or let them know I still need it or something. But I think it will be easier if they just reload it unless you call and ask them not to, to stop it or something.

They send out a letter and let you know hey, your thing's coming to an end. You know, you need to check in by a certain date or whatever. But it's hard to do it all the time.

Rationales for Evaluations

While some WIC participants expressed the drawbacks of remote appointments, most viewed these appointments as an improvement to their program experiences. When asked to describe what they liked about the remote appointments, participants expressed safety concerns about in-person office visits and the convenience of the remote appointments. Seven participants did not express any rationales behind their evaluation of remote appointments.

Safety. Satisfaction with remote appointments emerged amidst participants' concerns about exposing themselves and their children to coronavirus. Many of the WIC participants interviewed (N = 12, 27 percent) expressed relief that they were not required to attend in-person appointments given their concerns about the coronavirus outbreak. Penelope, a rural WIC participant, shared her safety concerns, "I just feel kind of overwhelmed all about going out and taking my kids out in public right now."

Respondents viewed remote appointments as a way to reduce the risk of exposure and manage the coronavirus outbreaks. As this participant notes, "they've been doing a great job with that, not allowing people to actually go in and expose their kids. So I do like that, that they're doing everything over the phone." Francine, a rural long-term participant, shared this view. When asked to describe what she liked about her remote appointment, she commented, "I'd rather do an appointment over the phone anytime because it's like for my safety and my children's safety, you don't have to be in the office with nobody and nothing like that, so I'm straight with the phone appointments." This WIC participant from a rural county similarly emphasized safety concerns in her evaluation of remote appointments. Remote appointments reduced her children's risk of contracting the virus.

I don't mind either one, but with the COVID going on, especially with WIC, a lot of times the last few appointments we've had before COVID they like to bring your kid in and they like to do weigh-ins and stuff like that and make sure that they're healthy and happy and stuff like that. So I do feel safer for my family's protection, not having to go physically there. But it doesn't really bother me either way. It's nice when he gets to go in and they can see his development from when he was a newborn to how he is now because he's grown so much. But with COVID going on and everything, I don't go anywhere so I'm really glad that they're willing to do it over the phone versus having to bring us in.

Convenience of WIC Appointments

Along with limiting exposure to the coronavirus, WIC participants (N = 24, 54.5 percent) emphasized the convenience of remote appointments. Many participants viewed appointments prior to COVID as lengthy and taxing. Respondents reported crowded offices, long waits, and shuffling back and forth from staff members. Lengthy, complicated appointments stem from the process of collecting anthropometric data, where staff members assess the height, weight, and iron levels of participants. Tabitha, an urban WIC participant, describes a pre-COVID appointment in this way. She commented that the appointment was, "a very long appointment that took over two hours." She detailed the multiple steps in the appointment and the kind of information that was collected at each stage:

And I feel like I spoke to two or three different people. There was the first person who took my basic information and then I think I had to do a finger prick and they checked my weight. And then the last person, the second to last person was a nutritionist and then at the very end it was the person who gave me the electronic card and a whole bunch of handouts. Information on breastfeeding and foods that qualify. I remember the waiting room; I remember I was one of the only pregnant people there… It was primarily [people] who were there with their kids, either babies or young children…..

She further explained that she spent 10–20 min in each interaction with WIC staff members in addition to wait times between those interactions. Taken together, these multiple steps added time to her appointment:

So it was probably about 20 minutes for the first person to come get me and take all my information, and then went back out and then wait another five or 10 minutes to do the finger prick. And then another five or 10 minutes after that to see the nutritionist, I was probably with the nutritionist for the longest. I would say at least 20 or 30 minutes. And then it was probably five minutes to activate the card to use my benefits.

In contrast, COVID policy waivers allowed WIC participants to self-report height and weight from their most recent doctor's appointment, or WIC staff can use the anthropometric data collected from the previous WIC office visit. Heather describes how much easier and "better" this process is for remote appointments. She was asked the same questions staff ask in a typical appointment, information that could be collected over the phone. She explained:

> It was actually pretty easy. She asked a few questions, the same questions she would ask in the office. The only difference in the office is they prick you – which you still have a choice, they'll prick you to check your iron levels. And weight, height, stuff like that. And if you had an option for taking shots or something like that they would do, but it was really the same process. I mean it was nothing different. I would think they should probably, if they can, keep people out of the office. I would try to do more things over the phone, more phone interviews then anything. If they just want to see face-to-face just to say yes, I still breastfeed, I mean, things like that. But, yeah, it was actually better.

Along with noting the easier intake process, many WIC participants interviewed commented on "saving a trip" to the office or eliminating the need to coordinate young children for WIC appointments. Scholars identify these factors as barriers to continued program use. As one WIC participant noted, remote appointments eliminated wait times and were "easier" because she does not have to "run to the [WIC] office." She explained,

> Well, when you go to the office sometimes you have to wait. Well, by doing it over the phone while they just let you know [inaudible] is much easier because then you don't have to run to the office, you don't have. It's much easier for everyone and safer.

This rural respondent also commented on the ease of remote appointments. When describing what she liked about phone appointments, she emphasized the convenience of not having to commute to the WIC office or "load up three kids."

> That you have to go into the office, to make that trip to go in, because it's like a 25-minute drive since I moved or whatever, but – yeah. Saved me a trip too. Oh, yeah. I definitely like them a whole lot more than having to go in, I'll say that, because trying to load up three kids in COVID is a task in itself.

In addition to the convenience of remote appointments, participants viewed appointments as faster. Appointments that usually ranged from 45 min to several hours are now 15 min. As Melanie, an urban participant commented: "It was just shorter. I didn't have to sit in there for about an hour. It lasted about 10, 15 minutes. That was it." Self-reporting information and not requiring multiple children to be seen in the office significantly shortened the appointment time.

Participants' concerns about COVID transmission are likely related to the context of the pandemic and may not reflect participants' perceptions of appointments beyond the current crisis. But the COVID transmission fear was one component of participants' positive evaluation. Participants emphasized the convenience of these appointments relative to in-person office visits. These views are not directly related to COVID-19 concerns, but demonstrate that reducing the compliance costs associated with maintaining WIC benefits improves beneficiary satisfaction with the program and has the potential to increase take-up rates and improve long-term program use. This is critical for low-income families who face acute economic hardship and food insecurity as a result of the pandemic. But reducing compliance costs is critical beyond the present moment given the positive effects of WIC participation on child and maternal health (Bersak and Sonchak 2018; Bitler and Currie 2005; Buescher et al. 2003; Siega-Riz et al. 2004).

Discussion

WIC policy waivers enabling remote appointments due to COVID-19 offer a novel policy context to examine changes in participants' perceptions of administrative burden—individuals' onerous experiences with policy implementation (Burden et al. 2012). The USDA waivers under the CARES Act enabled states to conduct quarterly appointments remotely, collect clients' self-reports of anthropometric data, and issue benefits remotely.

Previous studies of WIC participation have suggested that frequent appointments and intensive, detailed intake processes—forms of compliance costs—are barriers to continued program use (Liu and Liu 2016; Rosenberg, Alperen, and Chiasson 2003). Reducing these kinds of compliance costs can boost program enrollment (Herd et al. 2013).

This qualitative study of WIC participants in six North Carolina counties examines how WIC participants evaluate reductions in compliance costs due to the CARES Act. Participants confirmed the findings of previous studies highlighting WIC's pre-COVID compliance costs—quarterly appointments (Rosenberg, Alperen, and Chiasson 2003), which require scheduling (Woelfel et al. 2004), the need to arrange travel for children (Panzera et al. 2017), and, often, long and burdensome wait times in the office (Rosenberg, Alperen, and Chiasson 2003). We find that most WIC participants interviewed viewed remote appointments as an improvement to their program experiences and emphasized the convenience of self-reporting anthropometric data. Remote appointments also alleviated fears of contracting the coronavirus and were faster than pre-pandemic in-person appointments.

The purpose of this study is to offer rich descriptive insights into how WIC participants perceive their experiences with COVID-19 policy changes—changes that removed key compliance costs of the program. Our focus on a small sample of North Carolina WIC participants meets this goal but is limited in providing externally valid insights beyond our sample (Nowell and Albretch 2019).

Nevertheless, this study begins to make the case for additional research that examines the merits of WIC-related COVID policy changes on program enrollment, continuity, quality of program experiences, and participant outcomes. Qualitative and quantitative research could further probe the extent to which remote appointments change the nature of staff–participant relationships, relationships that many participants perceive as personal and socially supportive (Barnes, Michener, and Rains 2017). Studies should examine how these relationships can potentially buffer the psychological distress many parents have experienced during the pandemic. In addition, research could examine how effective remote models of nutrition education are on improving healthful eating and maternal and child health outcomes.

Notwithstanding the growing demand for nutrition assistance, WIC participation has increased since the coronavirus outbreak (Food

Research and Action Center 2020). This uptick can be partially attributed to easier access to the program under the COVID-19 policy waivers. Given increased uptake, remote appointments may offer a remedy to recent declines in WIC participation and discontinuity in WIC receipt (Kline et al. 2020). We recommend extending this policy to maintain the compliance cost reductions observed in this study.

Given the boost in program participation due to COVID remote appointment waivers, state agencies and advocates have also proposed extending tele-health models for WIC appointments and additional investments in WIC technology infrastructure to facilitate information sharing across healthcare providers and WIC clinics. For example, a recent report from the National WIC Association recommends streamlining the certification process and extending eligibility periods to prevent the 21 percent dip in participation at the 1-year mark (National WIC Association 2021). The National WIC association also recommends enabling remote certifications by altering the physical presence requirements for appointments and investing in technological advances that support telehealth models and streamline electronic health information sharing (National WIC Association 2021). In addition, the recent American Rescue Plan Act of 2021 provides $390 million from 2021 to 2024 to support outreach, innovation, and program modernization that aims to boost WIC participation and benefit redemption. Thus, the COVID-19 pandemic and related policy waivers have ushered in new—potentially long-term—policy changes to reduce the compliance costs of WIC program participation.

We recommend continuing reductions in WIC compliance costs with some caution. While most WIC participants interviewed reported satisfaction with program changes, a small portion of the sample raised concerns about the diminished quality of customer service and personal connections with staff, who provide a source of advice for nutrition and parenting. Further, remote appointments might be a form of administrative exclusion (Brodkin and Majmundar 2010), excluding a portion of the WIC population from the program altogether. This group may be families who are most disadvantaged: families who lack consistent and reliable phone and internet services. In addition to examining how remote options expand enrollment, future research should assess who is left out of programs when remote options are adopted because of limited access to technology, phone, and internet services.

With this in mind, remote appointments could be one of many options for parents accessing the WIC program. Other means-tested programs like SNAP and Medicaid offer multiple ways of accessing benefits that include in-person applications, mail-in options, and online applications. Offering remote appointments as one option in addition to in-person clinic visits may provide the convenience some WIC participants prefer while supporting participants who prefer personal connections with WIC staff members.

As a public health program designed to reduce nutrition risks of mothers and young children, WIC places importance on collecting anthropometric data from participants. Monitoring anthropometric changes remains important for the population of WIC participants. As mentioned, evidence shows the positive effects of WIC participation on child and maternal health (Bersak and Sonchak 2018; Bitler and Currie 2005; Buescher et al. 2003; Hoynes, Page, and Stevens 2011; Lee et al. 2004; Siega-Riz et al. 2004). To support the health benefits of the program while maintaining compliance costs reductions North Carolina and other states can leverage administrative systems that integrate information across health and social services. North Carolina has implemented NC 360, a digital interface that connects healthcare providers, community organizations, and social service agencies. NC 360 is designed to streamline referral processes to improve health outcomes, meaning this tool may enable WIC agencies to schedule WIC contact around participants' doctor appointments. If this system linked anthropometric data on WIC participants, it could be useful in verifying the information needed to determine nutrition risk for program eligibility and to monitor health outcomes. North Carolina's success with relying on healthcare providers to manually confirm this kind of information under the COVID-19 policy waivers may help make the case for a more formal, institutionalized way of sharing this information.

In keeping with these recommendations, North Carolina is now participating in a telehealth pilot program for WIC appointments in partnership with the THIS-WIC team at Tufts University. North Carolina is developing telehealth strategies to reduce barriers to program participation and deliver nutrition education and breastfeeding support. The pilot consists of a participant portal app that streamlines the certification process, video chat for remote appointments, kiosks that enable certification process, and TeleWIC Service for short-staffed WIC clinics.

Reducing WIC compliance costs can increase access and increase participant satisfaction with this program. Further research is needed to determine whether, if these changes are adopted, overall WIC enrollment and continuity of WIC receipt increase, especially during key periods when WIC participation dips.

Notes

1. https://www.ncwica.org/fall-2018-wic-research-to-practice.
2. Nutrition risks can also include nutrition related medical conditions such as obesity, diabetes, and dietary deficiencies; and conditions that compromise nutrition related health like alcoholism, drug abuse, or homelessness.
3. In many states, intake software indicates whether applicants are currently receiving SNAP, Medicaid, or TANF.
4. https://www.fns.usda.gov/resource/families-first-coronavirus-response-act.
5. https://www.fns.usda.gov/disaster/pandemic/covid-19/wic-physical-presence-waiver.
6. https://www.ncdhhs.gov/news/press-releases/north-carolina-wic-program-receives-telehealth-intervention-strategies-grant.

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Appendix

Sample Interview Questions

I. We know that there have been recent changes to WIC appointments due to the Coronavirus. Now you do not have to go to the office to pick up your benefits.
   a. What are your appointments like now?
   b. How are your appointments different from your office visits before the Coronavirus?
   c. What do you like about this change?
   d. What do you dislike about this change?