APPENDIX A

PROCEDURES FOR SELECTING PROGRAMS AND COLLECTING DATA

A. SELECTING PROGRAMS TO STUDY

This appendix describes the steps used in selecting initiatives.

1. Gathering Nominations

First, in December 2002, we sent electronic letters to the directors of the seven FNS regional offices, to all 87 state and tribal WIC directors, and to representatives from the Food Research and Action Center and the National WIC Association seeking their nominations for appropriate programs for the study. We also contacted the California WIC Association and Public Health Foundation Enterprises Management Solutions in California for their input.[1] To encourage cooperation, officials from FNS headquarters notified the regional offices that MPR would be contacting them about the study and urged them to assist.

The letters explained the purpose of the study, our definition of "innovative," and the five types of programs in which we were particularly interested—breast-feeding promotion, obesity prevention, innovative service delivery, preventive health care, and staff training. (Appendix B contains the text of the letter.) We also invited program officials to bring other types of innovative programs to our attention. Thus, we allowed these officials considerable leeway in defining what they viewed as innovative within the five target areas. Programs were required at least to be partially funded with WIC dollars, but did not have to be solely funded by WIC. Because Special Project Grants and FIT WIC programs were already under study, we requested that officials omit any such programs from their list of nominations.

To effectively use the information from regional offices, state and tribal WIC directors, and other experts to choose 20 to 25 programs for further study, we asked officials to include (1) a description of the service(s) and the target population, (2) the factors that make it a promising or innovative program, (3) the name of the local WIC agency or agencies, and (4) appropriate contact information. We followed up by e-mail with all states that did not respond within two weeks, then followed up with a random sample of about half the remaining programs by telephone.

Table A.1 presents the approximate number of programs nominated from the seven FNS regions (including the state WIC agencies in those regions) and the number of tribal programs nominated. We received nominations from 32 states and three Indian Tribal Organization (ITO) WIC agencies.[2] We received them directly from state WIC staff, submitted by states through the regional offices, or from regional office staff. Nine states and three ITOs told us or their regional office that they had no programs they wished to nominate. Twelve states and the remaining

[1] The California WIC Association is a large, active local affiliate of the National WIC Association. Public Health Foundation Enterprises Management Solutions is the largest local WIC agency in the United States, covering the Los Angeles area, and is known for sponsoring innovative programs. It was the only local WIC agency contacted for nominations.

[2] Throughout this report, we include the territories of American Samoa, Puerto Rico, Guam, and Virgin Islands as "states."

TABLE A.1

GEOGRAPHIC RANGE OF NOMINATED PROGRAMS

FNS Administrative Regions	Number of Programs
Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont	3
Mid-Atlantic: Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania, Puerto Rico, Virginia, Virgin Islands, West Virginia	20
Southeast: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	16
Midwest: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	36
Southwest: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	7
Mountain Plains: Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming	6
Western: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Nevada, Oregon, Washington	14
Tribal Programs	5
Total Programs Nominated	**107**

ITOs did not respond. In a few cases, we contacted nominated programs by telephone to have brief conversations (15 to 30 minutes) to clarify some points and gather some information. We also called the contacts at several state agencies that had nominated many programs to obtain their impressions as to which of their programs were of the most national interest. We then reviewed lists of innovative programs on the WIC Works Website (compiled by the National WIC Association based on feedback from FNS regional offices). We selected a few programs from these lists (which added one state), after contacting the state agencies to ensure the program was still operating and was appropriate to include.[3] Because of resource and schedule constraints, we ended our efforts to obtain nominations in mid-February 2003.

We reviewed about 107 nominations from WIC officials and/or selected from the WIC Works Website.[4] The number of nominations per state ranged from 1 to 18. The nominations are not necessarily representative, since many states did not respond, and states varied in how they interpreted our request. Some states interpreted "innovative" broadly, while others interpreted it so narrowly they responded they had nothing to suggest. Some clearly saw "innovative" as within the context of their state, while others had a more national perspective.

2. Selecting Programs for Telephone Interviews

After compiling nominations, the research team began the process of selecting 20 to 25 programs to investigate further through telephone interviews with appropriate program contacts. One goal was to include programs that were geographically diverse and covered the range of services of interest—programs that promote breast-feeding, seek to reduce overweight and obesity, coordinate with preventive health care, or use alternative service delivery models or training approaches. We interpreted geographic diversity as programs from a range of states and regions, and from both urban and rural settings. A second goal was to include some programs that targeted high-risk groups. In addition, we sought to include programs that were beyond their start-up phase, so we asked for nominations of programs that had been operating for at least one year. We made a few exceptions to this rule for programs that seemed to have a lot to offer. Similarly, although we had planned to include only programs still in operation, we decided to include two that had ended or were about to end but that had a sufficient history of success to learn from. We dropped some nominations because they were for small interventions, not likely to make much difference in themselves, although many were good ideas.

[3] See www.nal.usda.gov/wicworks/sharing_center/statedevrqns.html.

[4] We say "about" 107 nominations because there was a certain amount of judgment involved in determining what to count. In general, if there was a mention of a program in an e-mail or list but no details about the program, we did not count it. When one regional office sent very detailed lists of activities in the region, we made judgments about which could be considered to be ongoing "programs" for the purposes of the study, and only counted those. In addition, we did not count an intrastate program to prevent fraud that involved several states and ITOs, because it seemed unrelated to the focus of this study and would artificially inflate the number of agencies with nominations considered.

We received many nominations of breast-feeding programs (about half of the total) and relatively few in other areas. One reason for this is that WIC programs have had targeted funding for breast-feeding promotion since the late 1980s, so they have had substantial experience in developing these programs. More recently, WIC programs have received permission to use food funds to purchase breast pumps for breast-feeding clients, which has led to development of breast pump programs in many agencies. On the other hand, other nutrition services funds are limited, and USDA's RQNS initiative is relatively new. Therefore, programs concerning other aspects of nutrition education, including obesity prevention, are not as well developed. The FIT WIC grants—the major USDA initiative concerning WIC and obesity prevention—are out of the scope of this study. Furthermore, WIC agencies are somewhat reluctant to discuss partnerships with other agencies related to other types of preventive health services, for fear they may be given "unfunded mandates"—new service requirements without additional funding to support them.

To reflect the nominations received, breast-feeding support programs were about half of the programs selected, with the rest divided among the other categories of interest (and some programs falling into more than one category). However, all five categories were represented. Because of the abundance of breast-feeding programs, we could be more selective. We decided to focus on well-established, multifaceted programs, as well as on programs that have developed unique ways of reaching hard-to-reach populations, such as teenagers, rural mothers, or mothers of premature infants. We also included programs representing most of the major approaches to breast-feeding services that go above and beyond the core WIC requirements. In the other topic areas, we had few nominations to choose from. To obtain a range of interesting programs, we sometimes needed to bend our other requirements (for example, selecting a dental health program in operation for less than one year). We also sought out programs in the target areas other than breast-feeding on the WIC Works Web site; three of the final selections came from this source.

In March 2003, MPR developed a list of potential programs for study that was somewhat larger than needed, then met with ERS and FNS staff members and obtained their feedback on which programs to drop and whether to add others. After several rounds of discussions, we came up with a list of 22 programs for telephone interviews. We selected more than 20 programs at this stage because we were concerned that some of the programs would not wish to be part of the study or would prove not to be good candidates when we spoke with them further. As it turned out, we completed interviews with all 22 programs, but decided to drop 2 programs because they were having implementation problems.

B. DATA COLLECTION

Because this study is an exploration of innovative practices in the WIC program, as opposed to a test of their effectiveness, we relied primarily on qualitative data. We used two main data sources for this study: telephone interviews and site visits. Gathering descriptive information and perspectives from various stakeholders was an effective way to answer our research questions. For example, interviewing program officials and line staff helped us identify key implementation successes and challenges, as well as lessons for future replication. This section describes the data collection procedures we followed for the study, including discussion guides

for telephone interviews and site visits and procedures for conducting the telephone interviews and site visits. We did not analyze administrative data on any of the programs, nor did we interview clients.

1. Telephone Interviews

To obtain more detailed information on the design and operations of innovative WIC programs, we developed discussion protocols for conducting the telephone interviews. The protocols were organized according to topics related to the three main research questions. The topics included (1) program goals and development, (2) services provided, (3) organizational structure, (4) outreach, (5) clients' perspectives, (6) funding, (7) implementation successes and challenges, (8) evaluation efforts, (9) lessons learned, and (10) likelihood for replication. The questions were tailored based on the type of program. For example, some specific questions asked of a local director operating a home visitation program would differ from those asked of a local breast-feeding coordinator overseeing a peer counseling program. Project members reviewed the protocols, tested them with several telephone interviews, discussed how effective they were in collecting the needed information, and made minor modifications. Table B.1 in Appendix B presents the protocol template that was used for the interviews. We adjusted, added, or eliminated questions for particular respondents, as appropriate.

After the ERS project officer gave final approval of the 22 programs, we contacted the appropriate regional FNS offices by e-mail to let them know the programs that MPR would be contacting in their jurisdiction. Next, we arranged times for telephone interviews with the appropriate people from the 22 programs (see Table A.2). For state-level programs, we typically spoke with the state WIC director or a specialized official, such as a state nutrition education coordinator. For local programs, we spoke with individuals such as local agency directors and local breast-feeding coordinators. In a few cases, state officials were respondents for local programs that covered several local agencies. For one statewide program, we spoke with a state official and a breast-feeding coordinator from one of the local programs. Interviews lasted between 1 and 1.5 hours and were conducted by a single member of the research team. Sometimes, more than one official involved in the program participated in the interview.

We began the conversation by explaining the purpose of the study, then proceeded through the protocol topics as described earlier. At the same time, many respondents provided information on a range of questions before they were asked, and we adjusted the flow of the discussion accordingly. In general, we covered most topics. At the end of the interviews, we asked respondents if they would welcome a site visit from MPR to examine their programs more in depth and if they would agree to have their contact information included in the final report. Everyone agreed to both requests. Table A.2 lists the selected programs and whether the officials with whom we spoke were at the state or local level, for the 20 programs that remained in the study. All interviews took place in April or May 2003. The interviewers prepared write-ups of each interview, arranging the information from their interview notes into answers to the questions in the protocol.

TABLE A.2

CHARACTERISTICS OF PROGRAMS CHOSEN FOR TELEPHONE INTERVIEWS

Program Name	State	Telephone Interview Respondent(s)		Program Area
		State-level	Local-level	
Steps Ahead/WIC Coordination—Cullman County	AL		✓	Service Delivery
WIC Nutrition Education Model for Prevention of Early Childhood Caries	AL	✓		Preventive Health
Breast Pumps for Mothers of Premature and Seriously Ill Infants	AR	✓		Breast-feeding
Cease Alcohol Related Exposure (CARE)	CA		✓	Preventive Health
Expanded Breast-Feeding Peer Counselor Program	CA		✓	Breast-feeding
Loving Support Breast-Feeding Helpline—Riverside County	CA		✓	Breast-feeding
Lactation Consultant Services—Sacramento County	CA		✓	Breast-feeding
WIC RD: Adjunct to Pediatric Health Care	CA	✓		Infant feeding/Training
Breast-Feeding Promotion and Support Program—Miami-Dade County	FL		✓	Breast-feeding
Mooove to Lowfat or Fat Free Milk Campaign	FL	✓		Obesity Prevention
Pumps in the Schools (PITS)	HI	✓		Breast-feeding
Coordination of WIC with Maternal and Infant Support Services	MI	✓		Service Delivery
The Learn Together Approach	MI	✓		Training
WIC Services in the Workplace—Eastern Band of Cherokee Indians	NC		✓	Service Delivery
Infant Feeding Classes for Pregnant Teens	OH		✓	Breast-feeding
Get Fit With WIC	OK	✓		Obesity Prevention
Obesity Prevention Modules	PA	✓		Obesity Prevention/Training
Telephone Peer Counseling by Volunteers	PA		✓	Breast-feeding
Breast-Feeding Peer Counselor Program	TX	✓	✓	Breast-feeding
Bilingual Training Program	WI	✓		Training

2. Site Visits

The team reviewed the interview write-ups—along with written materials provided by several programs—to determine which WIC initiatives would be most appropriate for a site visit. We used several criteria to select the five programs. First, we sought to visit programs that represent a diversity of geographic regions, urbanicity, and types of interventions. For example, we did not want to include four breast-feeding programs and only one program of another type. We also decided not to visit more than one program in a state. Moreover, we decided to select initiatives that were ongoing, that were complex enough for us to substantially add to our knowledge by going on-site, and that had good potential for being replicable. We discussed our selections with ERS and FNS staff, and they approved our final five selections.

In June 2003, we contacted the sites to notify them of their selection. All program staff were pleased and enthusiastic to have been chosen for on-site study. The lead site visitor collaborated with a key program contact—in each case, a person who participated in the telephone interview—to identify appropriate individuals to interview and program services to observe. The site visitor developed an agenda for the visit in collaboration with the key program contact. Table A.3 presents an example of an agenda.

In preparation for the site visits, we developed customized protocols for the five programs, which were based on the telephone interview protocol presented in Appendix B. Again, this was to ensure consistent data collection during the visit. Although the topics covered were similar to those discussed during the telephone calls, issues were covered in much greater detail and from a range of perspectives. Protocols included interview questions for specific program staff members, as well as an observation sheet on which to systematically record observations of program activities (see Appendix B for a sample observation sheet). Interview respondents varied according to the specific program, but included such individuals as (1) the local agency WIC director, (2) any key program managers (if different from the local agency WIC director and if different from telephone interview participants), (3) the local breast-feeding coordinator (if a breast-feeding program), (4) WIC nutritionists and/or nurses, (5) peer counselors, (6) other relevant staff in the WIC clinics who are involved in delivering innovative services, and (7) staff at associated health programs who interacted with WIC staff. We tried to speak with as many people as possible while on-site.

One person took the lead on drafting the protocols for each program, then circulated the documents to other team members for comments, making adjustments as needed. As with the telephone interviews, we adjusted, added, or eliminated some questions for particular respondents once on-site, when that was appropriate. To improve the quality of the site visit data, we conducted two of the five site visits in teams of two, and we drafted our notes as soon as possible after returning from the visits. Thus, we could follow up quickly with the local program staff if there were gaps in the information gathered. Further, traveling in teams, when possible, allowed for firsthand accounts of program operations from two perspectives. Upon return, we reviewed each other's notes to ensure data consistency.

TABLE A.3

SAMPLE SCHEDULE FOR SITE VISIT

WIC NUTRITION EDUCATION MODEL FOR THE PREVENTION
OF EARLY CHILDHOOD CARIES
BIRMINGHAM, ALABAMA, AND VICINITY
JUNE 25-26, 2003

Time	Activity
Wednesday, June 25	
4:30-5:30	Interview with Professor and Chairman, Department of Pediatric Dentistry at the University of Alabama at Birmingham
Thursday, June 26	
8:00-8:15	Arrive and meet staff at the Calhoun County Health Department
8:15-8:30	Observe dental nutrition education class at Calhoun County Health Department
8:30-9:15	Interview with WIC nutritionist who taught dental nutrition education class
9:30-10:00	Arrive and meet staff at the Anniston Head Start Center; tour center
10:00-10:15	Observe dental nutrition education class at the Head Start Center
10:30-11:30	Interview with WIC nutrition area coordinator who taught Head Start class
LUNCH	
12:30-1:30	Travel to the Jefferson County Department of Health, tour facilities
1:45-2:00	Observe individual dental nutrition education contact at the Central Health Center
2:00-2:45	Interview with WIC nutritionist who taught dental nutrition education class
2:45-3:45	Group interview with four WIC nutrition area coordinators
3:45-4:30	Interview with Assistant Professor, Department of Health Behavior at the University of Alabama at Birmingham

We conducted the five site visits from June through September 2003. Most visits were 1.5 to 2 days long, although one visit was completed in one afternoon and the following morning. All visits involved interviews with program staff and community partners (if relevant) and observations of services and/or training activities. Table A.4 presents the five programs visited, the dates of the visits, and whether they were conducted by one or two team members.

TABLE A.4

CHARACTERISTICS OF WIC SITE VISITS

Program	State	Dates of Site Visit
WIC Nutrition Education Model for the Prevention of Early Childhood Caries[a]	AL	June 25-26, 2003
Home Visiting for WIC Certification and Counseling[a]	MI	August 6-7, 2003
Loving Support Breast-Feeding Helpline[b]	CA	August 12-13, 2003
Statewide Peer Counseling Program[b]	TX	September 16-17, 2003
Get Fit With WIC[a]	OK	September 22-23, 2003

[a]One site visitor.

[b]Two site visitors.

3. Final Review

We asked all key contacts from the telephone interviews and site visits to examine the first draft of the profiles of their programs. After drafting the profiles, we sent electronic copies to our contacts and asked them to review the documents to determine if we recorded details about the program accurately and to provide any missing information needed to make the profile complete. All of our program contacts provided comments and corrections, if necessary.