



WIC in a Click

Yavapai County Community Health Services WIC

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WIC in a Click Final Report

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Executive Summary

Nationally, there has been a steady decline in participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) for over ten years. WIC participation in Yavapai County follows the national trend. The USDA provided funding to the Hopkins/USDA Participant Research Innovation Laboratory for Enhancing WIC Services (HPRIL), which in turn provided funding and technical support to Yavapai County WIC to develop an innovative tool to address the issue of declining participation. The Yavapai County WIC program sought to improve client services by facilitating participant convenience and implemented a remote, on-demand option for nutrition, high risk, and mid-certification education sessions, named *WIC in a Click*. The goal of this project was to implement and evaluate this innovation in customer service delivery in terms of feasibility, acceptability, and impact on participation and retention of children in the WIC program.

A comparison site was chosen based on similarities to Yavapai County WIC. Mohave County WIC was determined to be comparable because of its size, location, and WIC operations. Best customer service practices were identified and implemented at both sites to ensure consistent operation throughout the project. Both the comparison and intervention sites used a client centered nutrition education approach, had similar document retrieval methods, and made appointment reminders through the same modalities. Additionally, protocols were developed and approved, the tool pre-tested, training materials developed, WIC staff trained in project protocol, and outreach materials developed prior to *WIC in a Click* implementation.

A quasi-experimental or plausibility design was used to evaluate *WIC in a Click* with Yavapai County WIC as the intervention site and Mohave County as the comparison site. The baseline or pre-implementation period was the calendar year of 2019, and the implementation period was April 1st, 2020-March 31, 2021. Project modifications were necessary because of the COVID-19 pandemic and included a delayed implementation start date, the addition of phone appointments, and the removal of group sessions. All other implementation components remained as previously developed.

Process implementation and the short-term impact of the *WIC in a Click* project were assessed. Process evaluation concluded *WIC in a Click* was implemented as intended with minor changes

due to the COVID-19 pandemic. There was consistent engagement with the innovative tool. All participants were offered the opportunity to receive services through *WIC in a Click* at least two times during a full certification period. Overall, the process evaluation showed success with implementation.

Short-Term results showed that participation did not significantly change during the implementation period compared to the pre-implementation period. Thirty-one percent of clients were seen through *WIC in a Click* each month. It is important to note that 31% is of all appointment types regardless of whether they were eligible for *WIC in a Click* or not. For example, certification appointments were included in this calculation even though these appointments do not qualify for a *WIC in a Click* appointments. Finally, the no show rate showed significant improvement from the pre-implementation period to the implementation period. Overall, the project showed success with client engagement and decreasing no show rates when comparing pre-implementation data to implementation data. However, despite positive results of process and short-term evaluation, outcome evaluation found that, although not significant, the implementation of this innovative tool was negatively associated with WIC recertification and retention.

The Lessons Learned from implementing this innovative tool include the need to have dedicated staff to answer phones and to provide *WIC in a Click* appointments. Without dedicated staff, on-demand appointments could be easily lost during standard WIC operations and protocol. Additionally, local agencies should utilize tools already available to ensure costs are minimal. It was found that phone appointments were the preferred method because videoconferencing required additional steps like downloading an app prior to the appointment while phone appointments did not. An integrated system could streamline the process and make on-demand appointments more feasible for larger agencies. Overall, the *WIC in a Click* project offered a successful customer service delivery method. However, because of the emergence of a global pandemic and the disruptions in project implementation, results pertaining to the impact that *WIC in a Click* had on retention and participation are not conclusive.

Introduction

Yavapai is a rural county about 125 miles northwest of the State capital of Phoenix. The Mingus Mountain divides Yavapai County into two distinct service delivery areas, referred to as West Yavapai County and the Verde Valley. Most Yavapai County residents reside in the communities of Prescott, Prescott Valley, Chino Valley, Cottonwood, and Camp Verde. However, many Yavapai County residents live in more remote areas, such as Ash Fork, Seligman, Congress, Bagdad, and other outlying communities. Several of these communities are over 60 miles away and the one-way commute times are about an hour and a half.

Yavapai County WIC had an assigned caseload of 3,300 participants for federal fiscal year 2020. Participation comprised 25% infants, 52% children, and 23% pregnant and postpartum women. There has been a steady decline in participation in all categories since 2018. The retention rate of all child categories is currently less than 50%.

WIC participants no longer participate in WIC for a variety of reasons. According to the Arizona Department of Health Services (AZDHS), WIC Attitudes, Barriers and Beliefs Study, the top reasons clients no longer participate in WIC are they no longer need help, no longer meet the income criteria, hassle at the store, and baby no longer needs formula or the child ages out of the program at age 5. Similarly, local agency staff have reported for clients the benefits do not weigh the effort put in when appointment times are not always convenient, they have difficulty bringing in their children, and busy schedules make it hard to come to the clinic. As previously mentioned, many Yavapai County residents live in remote areas, such as Ash Fork, Seligman, Congress, Bagdad, and other outlying communities. Transportation to clinics is even more difficult and expensive with increasing gas prices

To address barriers related to distance and inconvenience and to improve accessibility for the participants, the Yavapai County WIC program implemented a remote, on-demand option for nutrition, high risk, and mid-certification education sessions, named *WIC in a Click*. The goal of this project was to implement and evaluate this innovation in customer service delivery in terms of feasibility, acceptability, and impact on the participation and retention of children in the WIC program.

The logic model, found in appendix A, illustrates how acquiring remote platforms for client services, such as zoom and Textedly, affects WIC program operations, participation, and client satisfaction.

Methods

Best Practices

The following best practices were established and implemented to ensure customer services were consistent across all implementation and comparison sites. Arizona WIC has a participant-centered approach. All staff were trained in asking open-ended questions and providing affirmations, reflections, and summaries (OARS). Participant eligibility and other documentation was received through different modalities, which included in-person, email, or the Arizona WIC Participant Portal. Additionally, documents were reviewed through video-conferencing appointments.

Appointment reminders were sent via text message or email for participants who opted in. These reminders were managed through the Arizona WIC Management Information System (MIS), Health And Nutrition Delivery System (HANDS), and were sent out 24 hours in advance. Additionally, at the beginning of each month, text messages were sent by AZDHS to all participants who appeared on the *Enrolled but not Participating* report found in HANDS encouraging participants to schedule a WIC appointment. Missed appointments were contacted initially by phone on the same day they were missed. If a participant could not be reached by phone, a text and/or email was sent requesting them to call and schedule an appointment.

Innovative Tool

WIC in a Click is an innovation that allowed WIC participants to schedule and receive on-demand WIC services through two remote platforms, videoconferencing (Zoom) and phone. *WIC in a Click* was available to all participant categories with a focus on reaching families who have children ages 1 through 4. On-demand appointments consisted of clients requesting an appointment and, within 1 hour, being connected via phone to a WIC staff member or receiving an invite to a Zoom session. On-demand appointments were available for low-risk nutrition education and discussions, high-risk education, and mid-certification appointments. Once the

appointment was completed, food benefits were loaded onto the family's eWIC card. This innovation allowed WIC participants to seek WIC services when it was convenient for them and from the comfort of their own home, office, or on the go.

Implementation of Innovative Tool

To implement the innovation as a customer service option, protocols were developed and approved, pre-testing of the tool was completed, training materials were developed and participating WIC staff were trained, and materials to promote usage of *WIC in a Click* by participants were developed. These are detailed below.

Implementation Protocols

- *Caseload Management*- Policy updated to include HPRIL requirement on customer service activities.
- *High Risk Referrals*- Policy revised to include referrals to the Registered Dietitian via *WIC in a Click*. Another revision included high risk referrals to be made within 60 days, as height and weight must be redone if it is over 60 days old and a high-risk code pertains to weight.
- *Remote Issuance*- Yavapai County WIC was required to develop a remote issuance policy because an AZDHS approved policy is required to issue benefits remotely and, at that time, Yavapai did not have one.
- *Referral to WIC in a Click*- A procedure was developed to define who was eligible to receive services via WIC in a Click, how to schedule appointments, how to perform appointments, and how to document the appointment in HANDS.

Implementation Training Materials

A tri-fold brochure was developed to give clients a brief description of *WIC in a Click* and how to participate. This brochure included instructions on how to download and use Zoom. Posters and flyers were created to hang up in the lobbies and offices, and staff was instructed on how to inform clients of *WIC in a Click* and how to participate in the program.

Innovative Tool Pre-Test

Pre-test of *WIC in a Click* was performed in November 2019 by testing it amongst WIC staff members and with a WIC participant. For the staff pre-test, two project staff scheduled the session and invited the remaining staff to participate in sessions as if they were a WIC participant. Once the project staff felt comfortable with the Zoom technology, they tested it with a WIC participant who was identified as being interested in online education. This client was provided a tutorial on how to participate in *WIC in a Click* prior to the session. Feedback was then gathered from the participant and, as appropriate, guided future session modifications.

Changes due to COVID-19

Implementation of *WIC in a Click*, on-demand virtual appointments via Zoom began for nutrition education appointments in mid-January 2020 by offering clients who called to schedule their nutrition education appointments the option to do a virtual on-demand (within 1 hour) or traditional scheduled in-person appointment. Due to COVID-19 and the consequent FNS-approved physical presence waiver for the state of Arizona, clinic operations immediately shifted from in-person appointments to offering phone and Zoom appointments. Due to all appointments shifting to a remote option, phone appointments were added to the on-demand WIC services. Changes were made to the implementation period to allow the Yavapai County WIC staff to adjust operations to meet the safety concerns brought on by COVID. Therefore, the baseline or pre-implementation period was the calendar year of 2019, and the implementation period was modified to be April 1st, 2020-March 31, 2021. Furthermore, due to the increased strain on staffing brought on by COVID-19, scheduled group sessions were determined to be no longer feasible and removed from the project goal/deliverable.

Evaluation Design

The evaluation of *WIC in a Click* used a quasi-experimental or plausibility design with Yavapai County WIC being the intervention site and Mohave County being the comparison site. As noted above, the baseline or pre-implementation period was the calendar year of 2019, and the implementation period was April 1, 2020 - March 31, 2021.

Mohave County was chosen as the comparison site because it is similar in size to Yavapai County and is considered rural as is Yavapai. Both counties are in northern Arizona and have similar challenges such as forest fires, snow, flash floods, etc. Mohave county has an overall population of 212,181, while Yavapai County has an overall population of 235,099. In addition to the overall population, the WIC populations are also similar. Yavapai County serves 2,850 WIC clients including 650-700 women, 750-780 infants, and 1,500-1,600 children, while Mohave County serves 3,000 WIC clients including 650-700 women, 750-780 infants, and 1,600-1,700 children. Prior to COVID-19, both agencies scheduled in-person appointments and serviced walk-ins as the schedule permitted. Both agencies functioned with 1 WIC Director, 1 BFPC, 2 RDNs, and 7-10 Nutrition Education specialists. Individuals at each agency take on multiple roles (e.g., WIC Director is also the RDN). In addition, both agencies make reminder phone calls, texts, and mail letters to inform clients of needed appointments. Consequently, Mohave was chosen as the comparison site because of comparable populations and similarities in WIC operations.

Evaluation Questions and Indicators

Process Evaluation

Process evaluation consisted of three measures. First, was the project implemented as intended, according to workplan, intended completed documents, trained staff, and the development of the *WIC in a Click* process? This question was evaluated by examining documents that were created including protocols, MIS data, and training materials, as well as tracking the number of staff trained in *WIC in a Click*. Second, we explored the question: What appointment format did clients in the intervention sites choose (On-demand or traditional)? The indicators used to measure success were the number of appointments completed on-demand and the percentage of on-demand appointments. Third, we measured client and staff satisfaction with *WIC in a Click*. This was measured by sending a survey to WIC clients who participated in *WIC in a Click* and through discussion with staff members. The client survey included questions related to ease of use, possible technical difficulties, wait time and preferred method.

Short-Term Outcome Evaluation

The short-term evaluation question measured WIC participation during the implementation period compared to during the pre-implementation period. This was analyzed by examining monthly MIS reports obtained from HANDS during each period. The MIS also provided which appointments were most often attended. We measured this outcome by reviewing daily schedules and comparing appointment types. An additional measure was "no show" rates during each time period, which were tracked using a MIS report from HANDS.

Long-Term Outcome Evaluation

Prior to project implementation, HPRIL assisted Yavapai County WIC in identifying a comparison group to allow for a contemporaneous comparison evaluation design. Mohave County WIC, a neighboring local WIC agency, served as the comparison group. HPRIL obtained Management Information System (MIS) data from the State of Arizona to conduct statistical analyses to evaluate the impact of *WIC in a Click* on outcomes related to child retention and participation. Data were obtained for two time periods: a baseline period that was the 2019 calendar year and an implementation period that was from April 1, 2020 to March 31, 2021. The data request was for all infants and children who were active in WIC at the beginning of each period. The HPRIL evaluation sought to compare changes in each outcome over time for the innovation group (i.e., Yavapai County WIC) to changes for the comparison group (i.e., Mohave County WIC).

The MIS data set included variables from the USDA minimum data set (MDS) necessary for describing the characteristics of the participants as well as for calculating each of the outcome variables. Because the data set included all infants and children active at the start of the period, we can examine the pattern of participation of a cohort of WIC participants over time. During any given 12-month period, each participant has an end date for the prior certification period and can be expected to recertify (or not). Participants can leave the program by not re-certifying, or they may recertify and then leave the program, and some may move and enroll in another WIC agency. Thus, at the end of the year, a child may still be active in WIC (that is, retained), inactive because they left the program, or re-enrolled at another WIC agency (e.g., they moved out of the area) (HPRIL Table 1).

Each month benefits are issued for each WIC participant, and over a time period different patterns of issuance can be observed, with less than continuous benefit issuance indicating gaps in service due to, e.g., missed appointments. Although benefits are issued to a specific WIC participant, benefit redemption at the individual level is not generally available in MIS data, nor is partial redemption of benefits. Benefit non-use (i.e., expiration) is also not available in the Arizona MIS.

The analyses here focused on four core outcomes regarding retention and participation. First, child recertification was defined as documented recertification of the children during the 12-month period or during months 13-14 for those with certification end dates during the final 2 months of the period. Second, timely recertification was defined as recertification within 60 days of the end date of the prior certification period. Third, retention was defined by the child’s status at the end of each study period (i.e., active or terminated per the MIS). Fourth, child participation was measured by continuous benefit issuance (11 or 12 months).¹

HPRIL Table 1. Child Retention and Participation Outcomes

Outcome	Description
Recertification	The proportion of children in the dataset with a recertification date during the period. Note: includes children who left the agency and/or were not classified as “active” at the end of the period.
Timely recertification	The proportion of children (out of all children in the cohort) with a recertification date less than or equal to 60 days after the end of certification during the period.
Not-timely recertification	The proportion of children (out of all children in the cohort) with a recertification date greater than 60 days after the end of certification during the period.
Percent of recertifications that are timely	The proportion of children (only out of those with a recertification date) whose recertification date is less than or equal to 60 days after the end of the certification during the period.
Retention	The number of children active at the end of the data period at the innovation or comparison agency / (The number of children overall at the beginning of the period - children at another local agency at the end of the period)
Continuous benefit issuance	The proportion of children who were issued 11-12 months of benefits (out of 12)
Months of benefit issuance	Median and interquartile range of proportion of children issued benefits across the year
Percent of cohort issued benefits	Average proportion of children that were issued benefits each month

The analyses proceeded in stages. Descriptive analyses were conducted to describe the participant characteristics and outcomes for each group during each time period. We documented characteristics with a significant percentage of missing values (> 10%), which would limit their

usefulness during analysis. To assess comparability of the innovation and comparison groups within each time period, HPRIL compared participant characteristics, including participant category at the beginning and end of the data period; household size; number of WIC participants in the household; multiple birth status; race and ethnicity; primary language other than English; need for a translator; participation in other federal assistance programs such as TANF, SNAP, and Medicaid; and whether the participant was ever breastfed. Pearson chi-square tests were used to detect any significant differences between Yavapai and Mohave in terms of participant characteristics and outcomes for each time period. Logistic regression analyses were also conducted to compare outcomes between groups (Yavapai versus Mohave) within each time period adjusting for covariates. As noted above, reports of these analyses were created for each time period.^{1 2}

To estimate program impact, HPRIL employed a difference in difference (DID) approach. As noted above, this involves estimation of the changes over time in each outcome in the innovation versus the comparison group. Analyses were conducted for the overall sample as well as for infants (IBE, IFF and IBP categories) and children (C1, C2 and C3 categories). Because participants are not randomly assigned to the innovation or comparison group, analysis of the impact of *WIC in a Click* is not straightforward. Participants are assigned to a WIC agency based on residence which is determined by the participant's family and based on multiple factors. This may lead to the problem of selection bias, if these same factors also affect the likelihood of recertification, timely recertification, retention, or participation.

To address this issue, HPRIL employed propensity score weighting (PSW) to adjust for differences in participant characteristics between the innovation and comparison groups at each time period (labelled T1 and T2) as well as differences across the two time periods. Two common weighting approaches were used. In the first, weights were estimated using multinomial logistic regression in which observations are weighted as compared to the those in the innovation group during T1 as per Stewart et al., 2014.³ In the second, a kernel approach for repeated cross-sectional data was used to weight observations relative to the innovation group during T2 as per Villa 2016.⁴ To illustrate the balance in participant characteristics achieved through weighting, HPRIL compared the absolute standardized differences (ASD) for the means of each variable before and after weighting in the overall sample, for infants, and for children. This involved

comparing the balance achieved for Yavapai County over time (at T1 and T2), Yavapai at T1 and Mohave at T1, and Yavapai at T1 with Mohave at T2. This approach was repeated for analyses involving infants or children.

To fully present the results, the outcomes are shown and compared over time using both unweighted and weighted data. HPRIL conducted DID analyses for all four outcomes (recertification, timely recertification, retention, and participation/benefit issuance) overall, for infants, and for children. Beta coefficients and 95% confidence intervals were calculated using three models: (1) Crude, unweighted; (2) Adjusted Model 1 (A1): PSW-DID using logit for propensity score weighting (PSW) and ordinary least squares (OLS) for DID; and (3) Adjusted model 2 (A2): PSM-DID using Kernel for propensity score matching (PSM) and probit for DID with repeated cross-sectional option.

Data Collection/Analysis Plans

Various data sources were used to document implementation and conduct the process and outcome evaluation of *WIC in a Click*. These were: a) implementation program documents, including Caseload Management Policy, High Risk Referral procedure, Remote Issuance Procedure, and Referral to WIC in a Click Procedure; b) local agency monthly reports; c) project surveys with staff and clients; and d) MIS data extracted from the HANDS database. Reports came from both the local agency level and from Arizona Department of Health Services. AZDHS provided two data sets that reported WIC participation among children 1-4 years over the year-long baseline period prior to implementation and over the year-long period corresponding to the implementation phase of *WIC in a Click*. AZDHS also provided comparable data for each period for the comparison, Mohave County, to enable evaluation of the impact on child participation and retention.

Results

Process Evaluation

WIC in a Click was implemented as intended with minor changes due to the COVID-19 pandemic. The original implementation date was scheduled for January 1st, 2020, through December 31st, 2020, but was shifted to April 1st, 2020, through March 31st, 2021 to allow the Yavapai WIC clinics adjust to new guidelines put in place during the pandemic. Additionally,

phone appointments were added to *WIC in a Click* services to help keep up with the demand and to provide an efficient way for WIC participants to be serviced. Due to staffing modifications, online group nutrition education classes were withdrawn from the *WIC in a Click* protocol . All other components of the WIC in a Click protocol remained intact and were implemented as intended.

Project implementation documentation revealed that throughout the project, there was consistent engagement with the innovative tool. All participants were offered the opportunity to receive services through *WIC in a Click* at least two times during a full certification period. MIS data showed that from April to July, there was a steady increase in participation in *WIC in a Click* each month, with it leveling off in the following months. Client surveys were conducted mid-way through the project to measure the tool's ease of use, however, poor response rates excluded using these data in the evaluation.

Short-Term Outcome Evaluation

Short-term outcomes measured during the *WIC in a Click* project were increased participation in WIC, participation in *WIC in a Click*, decreased missed appointments, and increased WIC participation in outlying areas. The Yavapai WIC program saw no significant change in participation during implementation as compared to pre-implementation as seen in Figure 1. There was a monthly average of 2,839 clients participating per month during implementation as compared to 2,884 clients participating in the pre-implementation period. The MIS report used to measure this outcome was the *eWIC Caseload by Fiscal Month and Category*. This report was provided on a monthly basis.

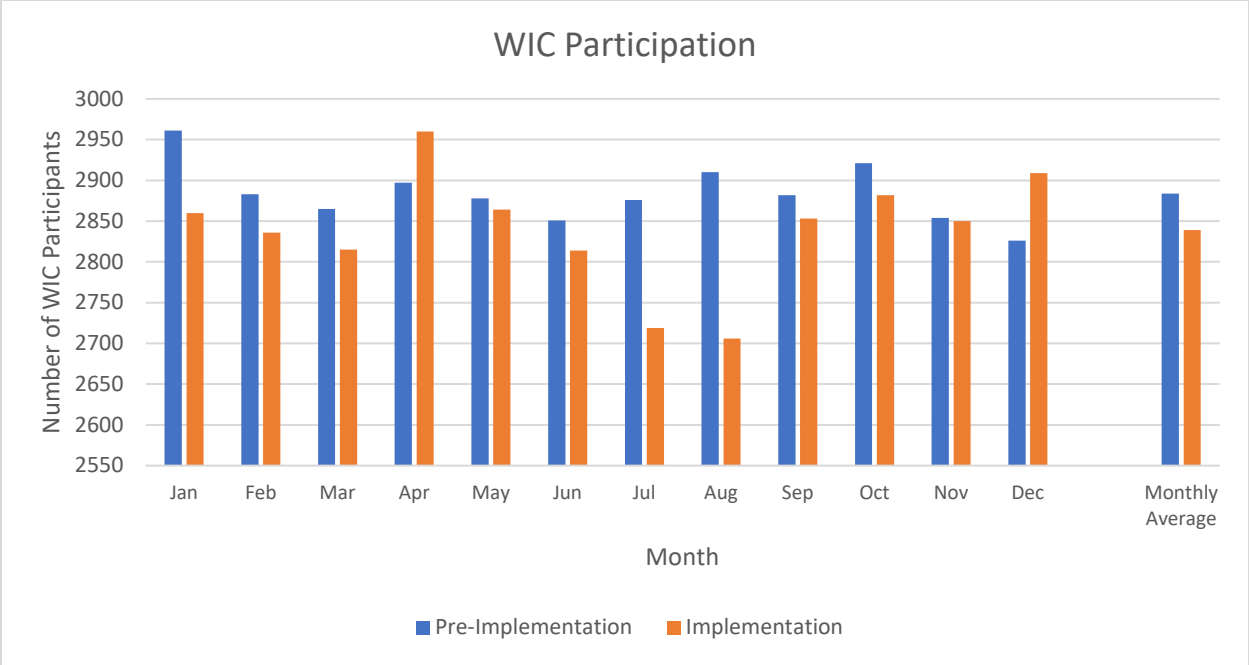


Figure 1. WIC Participation during Pre-Implementation and Implementation by month

Participation in *WIC in a Click* was measured by the total number of on-demand appointments fulfilled during the month divided by the total number of appointments, both on-demand and scheduled. The total number of appointments was comprised of all appointment types including those of participants not eligible for the intervention. As seen in Figure 2, the number of *WIC in a Click* appointments steadily increased from April to July 2020. In July the percentage of appointments leveled off with 31% being the median number serviced per month via *WIC in a Click*.

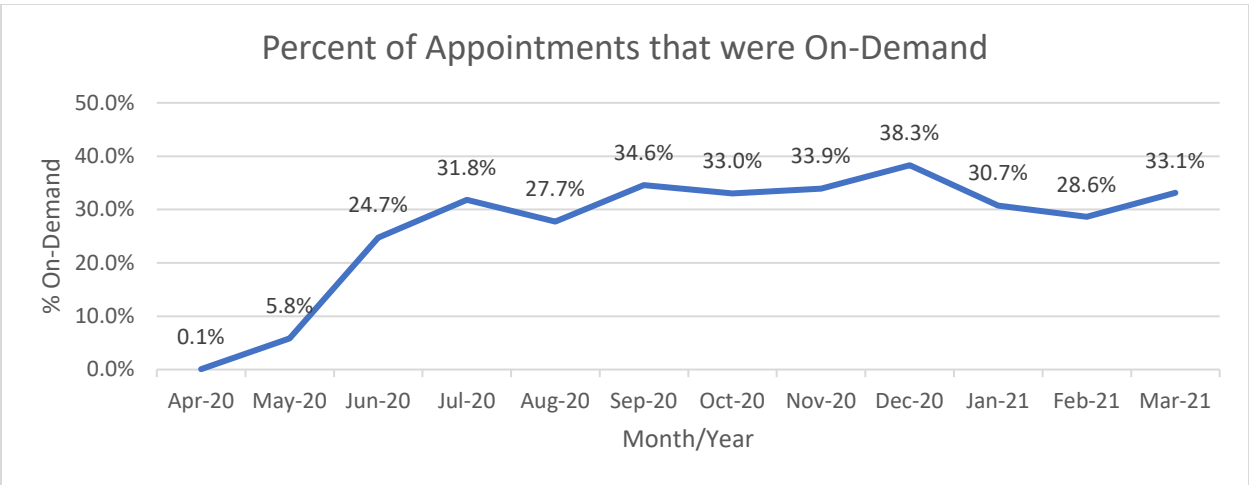


Figure 2. Monthly Percentage of Appointments seen via *WIC in a Click* by month and year

The *WIC in a Click* intervention was significantly associated with a decrease in the number of missed appointments. During the pre-implementation period, 7.8% of participants did not attend their scheduled appointments, while in the implementation period 4.8% of participants did not attend their appointments. To calculate these percentages, the *No Show Rate* report from HANDS was utilized and the number of “no shows” during each period was divided by the total number of appointments scheduled. These numbers and rates can be seen in Figure 3 below.

Pre-Implementation						Implementation					
Month	Year	Total Scheduled	# of No Shows	# of Attended	No Show Rate	Month	Year	Total Scheduled	# of No Shows	# of Attended	No Show Rate
January	2019	1170	94	1076	8.03%	April	2020	1144	63	1081	5.51%
February	2019	974	111	863	11.40%	May	2020	947	57	890	6.02%
March	2019	987	78	909	7.90%	June	2020	1016	44	972	4.33%
April	2019	1115	83	1032	7.44%	July	2020	952	57	895	5.99%
May	2019	1044	86	958	8.24%	August	2020	935	49	886	5.24%
June	2019	963	68	895	7.06%	September	2020	1098	52	1046	4.74%
July	2019	1124	89	1035	7.92%	October	2020	954	36	918	3.77%
August	2019	1119	88	1031	7.86%	November	2020	894	37	857	4.14%
September	2019	865	58	807	6.71%	December	2020	1206	47	1159	3.90%
November	2019	925	57	868	6.16%	January	2021	894	26	868	2.91%
December	2019	1056	75	981	7.10%	February	2021	992	40	952	4.03%
						March	2021	1102	75	1027	6.81%
Total		11342	887	10455	7.82%	Total		12134	583	11551	4.80%

Figure 3. No Show Rate Report

Long-Term Outcome Evaluation

HPRIL Table 2. Demographic Characteristics of Children 0-3 at Yavapai and Mohave at baseline (T1) and implementation (T2). Statistically significant differences by group within a time point are in **bold**.

		Baseline (T1)		Implementation (T2)	
		Mohave (n=2,374)	Yavapai (n=2,332)	Mohave (n=2,171)	Yavapai (n=1,997)
		%	%	%	%
Category at start of period	IBE*	4.9	6.8	5.5	6.3
	IBP	4.8	5.9	4.1	5.9
	IFF	27.4	21.8	22.3	21.8
	C1	23.9	25.4	27.9	26.5
	C2	20.9	20.9	22.5	20.8
	C3	18.1	19.2	17.7	18.6
Number of WIC participants	One	34.5	34.1	34.5	34.2

	Two	35.2	35.4	34.2	36.7
	Three or more	30.3	30.5	31.3	29.1
Race ^a	American Indian or Alaska Native	3.7	4.6	4.5	4
	Asian	1.9	1.2	1.9	1.8
	Black or African American	6.6	4.1	5.8	4.1
	Native Hawaiian or Other Pacific Islander	1.4	0.7	1.5	1.4
	White	96.1	96.6	95.7	96.4
	Hispanic	36.7	42.0	36.9	40.3
	Enrolled	TANF	1.1	0.3	1.2
	SNAP	28.6	17.8	34	20.8
	Medicaid	45.5	42.3	57.2	51.2
Primary language other than English		95.1	91.2	95.1	91.5
Ever breastfed	Yes	69.1	83.0	70.8	82.1
	No	30.9	17.0	29.2	17.9
Household size	0-4	63.6	62.0	59.1	61.5
	Greater than or equal to 5	36.4	38.0	40.9	38.5

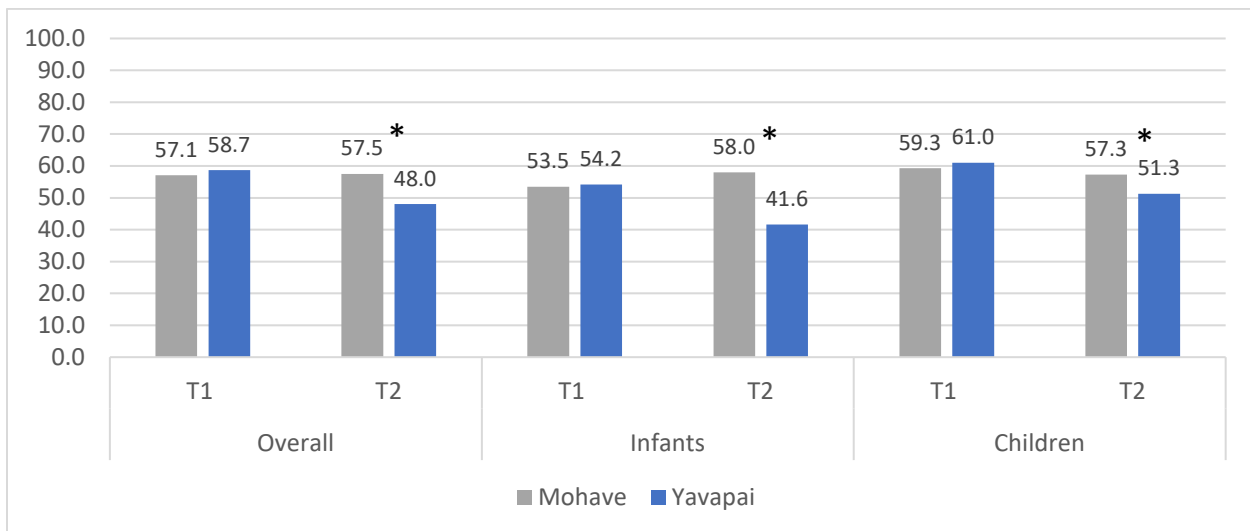
*Abbreviations: IBE: Infant, exclusive breastfeeding; IBP: Infant, partial breastfeeding; IFF: Infant, formula feeding; C1: Child category 1 (one year old); C2: Child category 2; C3: Child category 3; TANF: Temporary Assistance for Needy Families; SNAP: Supplemental Nutrition Assistance Program.

^a Participants can respond to more than one category so the total percentage may be greater than 100.

In general, the participants in the comparison and innovation groups were similar for most demographic characteristics at baseline (T1) and implementation (T2) and over time (HPRIL Table 2). Although there were statistically significant differences in many characteristics between groups during both time periods, there did not appear to be many clinically important differences. However, there were larger differences between groups in the proportion enrolled in SNAP, Medicaid and in the proportion that were ever breastfed both at T1 and T2. For example, during T1, the proportion enrolled in SNAP was 17.8% for Yavapai and 28.6% for Mohave (comparison). Between the two time periods, the proportion greater increases in Medicaid and SNAP enrollment are observed for Mohave (comparison) than for Yavapai. For Mohave, Medicaid enrollment increased from 45.5% in T1 to 57.2% in T2, while for Yavapai, enrollment increased from 42.3% to 51.2%.

Recertification

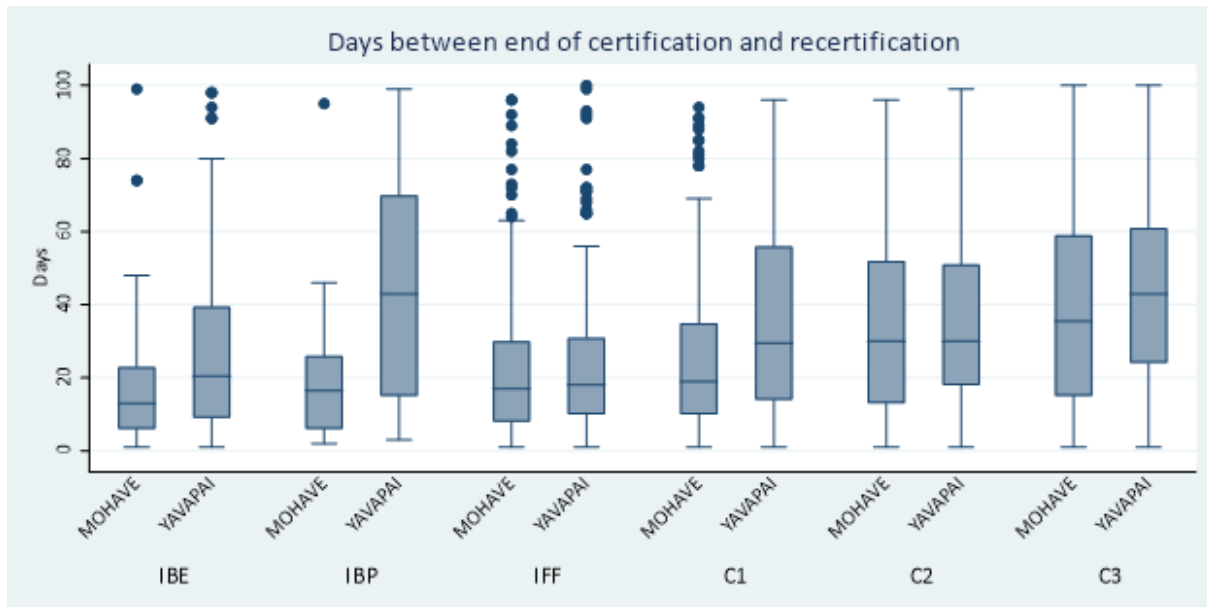
The crude, unweighted proportion of infants and children recertified in the innovation and comparison groups during baseline (T1) was not significantly different (58.7% and 57.1%, respectively), the proportions recertified during implementation (T2) were significantly different (48.0% and 57.5%, respectively) (HPRIL Figure 1). This was also true when studying infants and children separately. In all three cases (overall, infants, and children), the percentage recertified during T2 were significantly lower in the innovation group than in the comparison group (HPRIL Figure 1). For sample sizes of these groups, please see Appendix: HPRIL Table A.1.



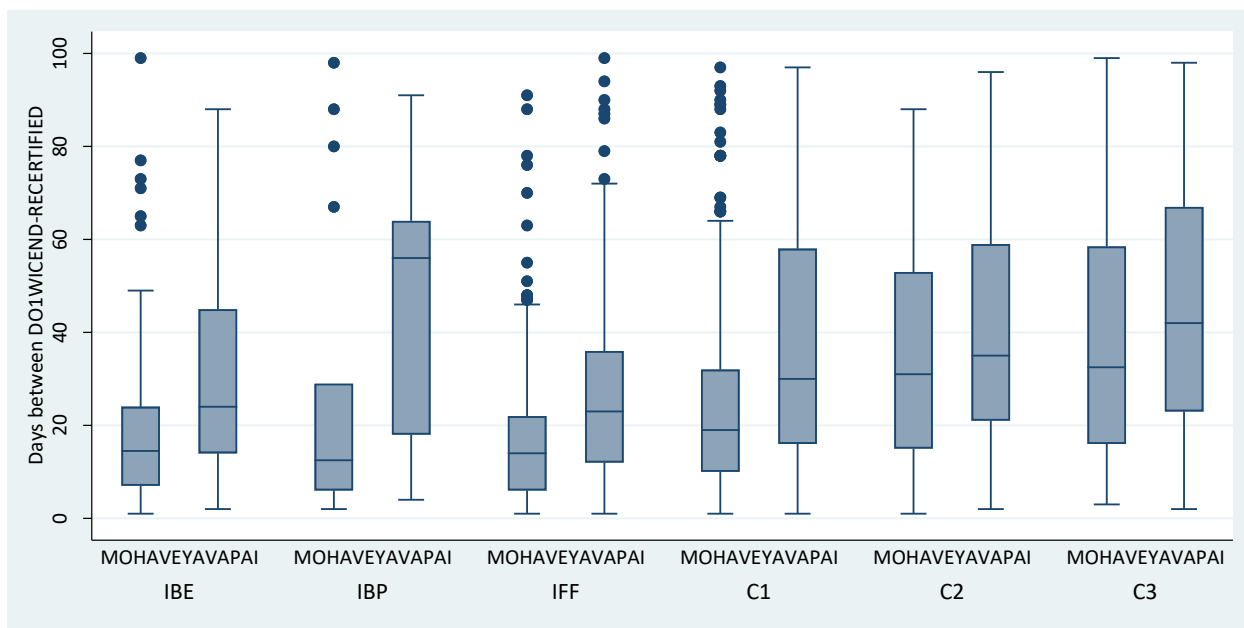
*HPRIL Figure 1. Proportion recertified (crude, unweighted) at baseline (T1) and implementation (T2) overall, for infants, and for children at Yavapai and Mohave. * $p < 0.05$.*

Timeliness of Recertification

Presented in Figures 2 and 3 are the distributions of time gap between the end of a child's certification period and their recertification (truncated at 100 days) for Yavapai and Mohave by WIC category group and time period. As shown, there are longer time gaps for children as compared to infants, and in Yavapai as compared to Mohave, and for T2 as compared to T1.



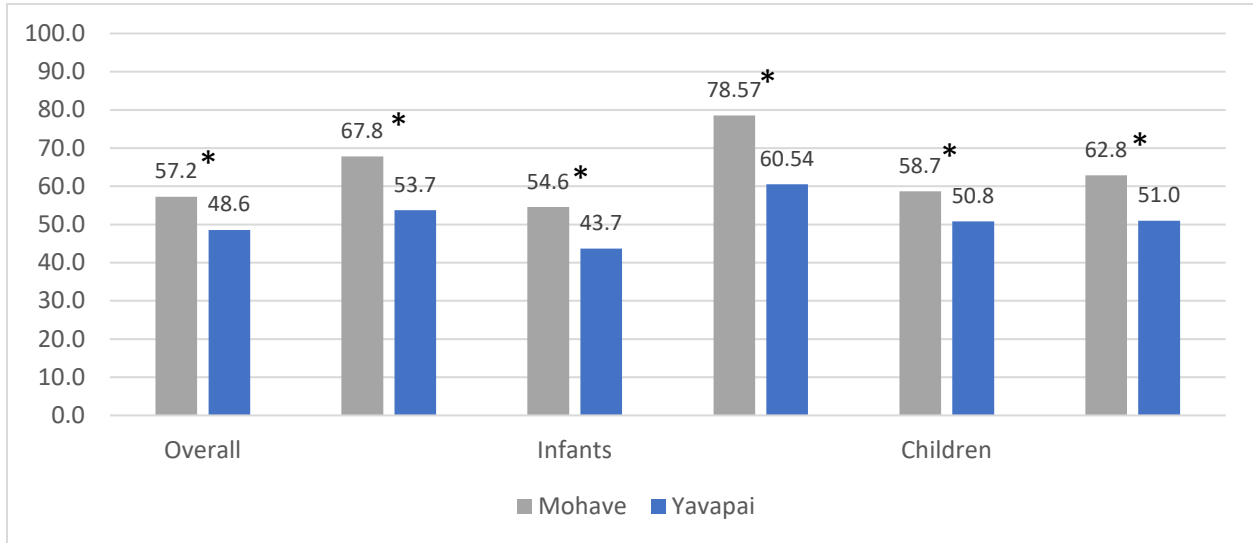
HPRIL Figure 2. Number of days between end of certification and recertification by participant category at Yavapai and Mohave during baseline (T1) (truncated at 100 days)



HPRIL Figure 3. Number of days between end of certification and recertification by participant category at Yavapai and Mohave during implementation (T2) (truncated at 100 days)

To examine this outcome further, HPRIL identified children as timely recertified or not and compared the percentage of timely recertification among those with a recertification data. Timely recertification was determined based on whether the time gap between the end of a child’s certification period and their recertification date was less than or equal to 60 days. At T1 and considering both infants and children with a recertification date, the proportion of timely

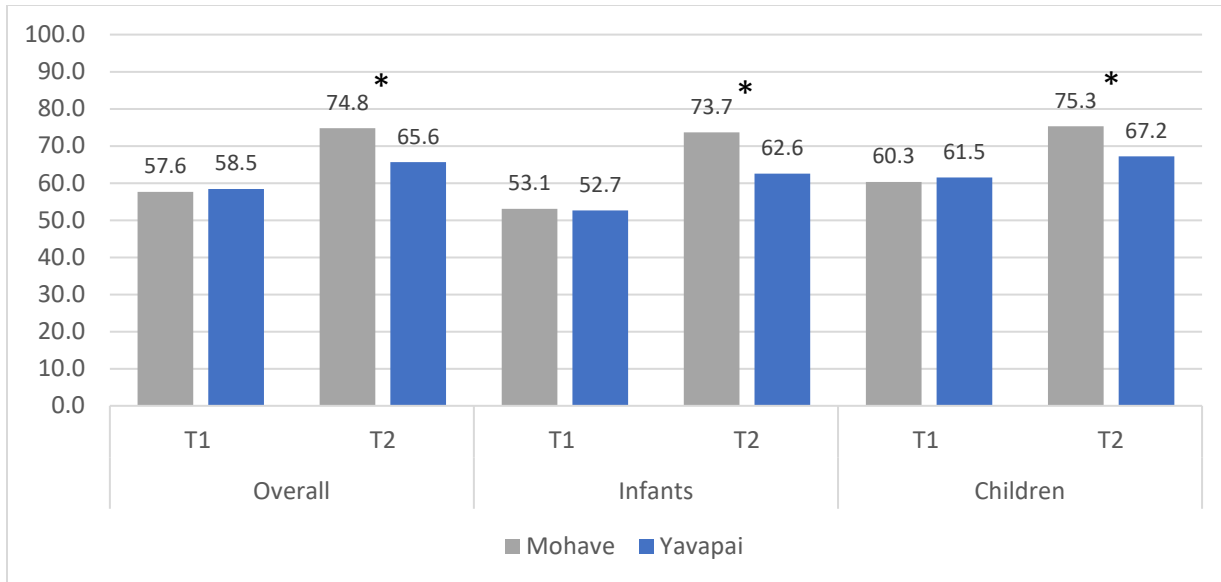
recertified was significantly lower in Yavapai County (48.6%) as compared to Mohave County (57.2%). The proportion of timely recertified increased during T2, and the differences between the two counties became greater. In Yavapai County, the proportion of timely recertified increased to 53.7%, while the proportion in Mohave County increased to 67.8%. These same trends (differences between counties and time points) were evident for both infants and children. For sample sizes of these groups, please see Appendix: HPRIL Table A.1.



*HPRIL Figure 4. Proportion timely recertified (crude, unweighted) at baseline (T1) and implementation (T2) overall, for infants, and for children at Yavapai and Mohave. * $p < 0.05$.*

Retention

Overall, and for infants and children, the differences in retention (active at the end of the period) between innovation and comparison were not statistically significant during T1 (HPRIL Figure 5). However, the proportions were significantly lower for the innovation group than the comparison group overall (65.6% vs. 74.8%, respectively), among infants (62.6% vs. 73.7%, respectively), and among children (67.2% vs. 75.3%, respectively) during T2. For sample sizes of these groups, please see Appendix: HPRIL Table A.1.



*HPRIL Figure 5. Proportion retained (crude, unweighted) at baseline (T1) and implementation (T2) overall, for infants, and for children at Yavapai and Mohave. * $p < 0.05$.*

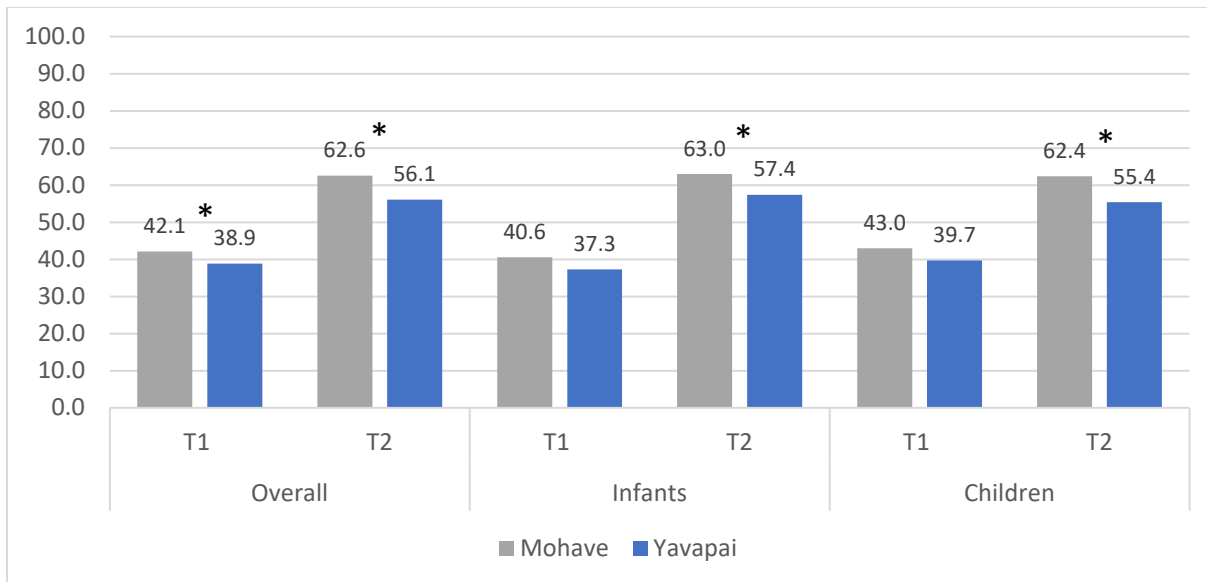
Participation (i.e., benefit issuance)

As shown in Table 3, the median months of benefit issuance was 9 for both groups at T1, and found to be higher at T2, with medians of 11 and 12 for Yavapai and Mohave, respectively. Over the period there was an increase in both groups in the percent of the cohort issued benefits.

HPRIL Table 3. Benefit Issuance at Yavapai and Mohave during Baseline and Implementation Periods

	Baseline (T1)		Implementation (T2)	
	Yavapai	Mohave	Yavapai	Mohave
Months of benefit issuance (median, IQR)	9 (4, 12)	9 (3, 12)	11 (6, 12)	12 (6, 12)
Percent of cohort issued benefits (%)	63.9	63.4	74.7	77.1

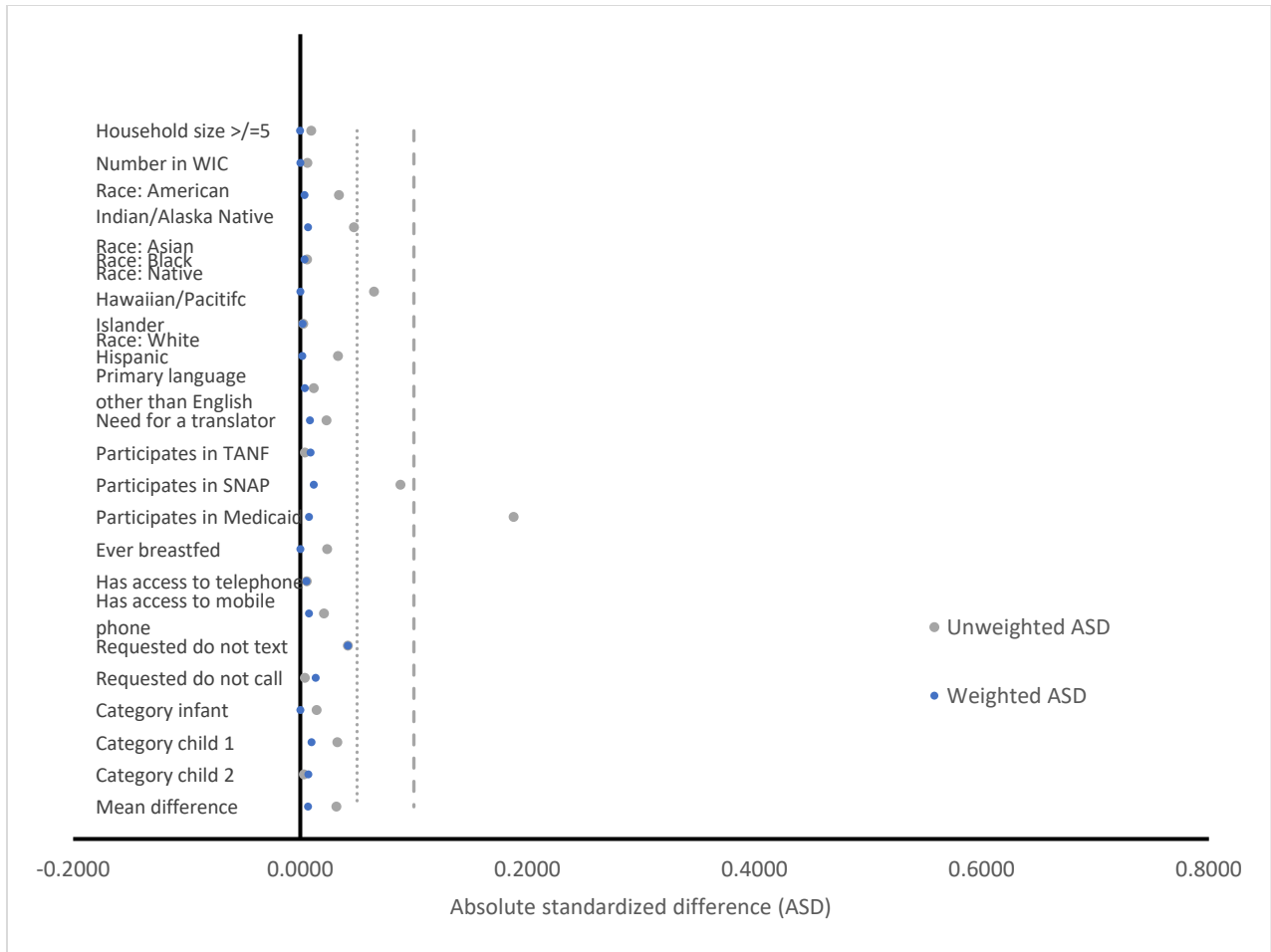
The proportion of children with continuous benefit issuance (defined as 11 or 12 months of issuance) was statistically lower in Yavapai than Mohave at T1 (38.9% versus 42.1%). During T2, the proportion of children with continuous benefit issuance rose in both groups but remained lower in Yavapai than Mohave (56.1% versus 62.6%, respectively). This same pattern was of differences was observed for both infants and for children. For sample sizes of these groups, please see Appendix: HPRIL Table A.1.



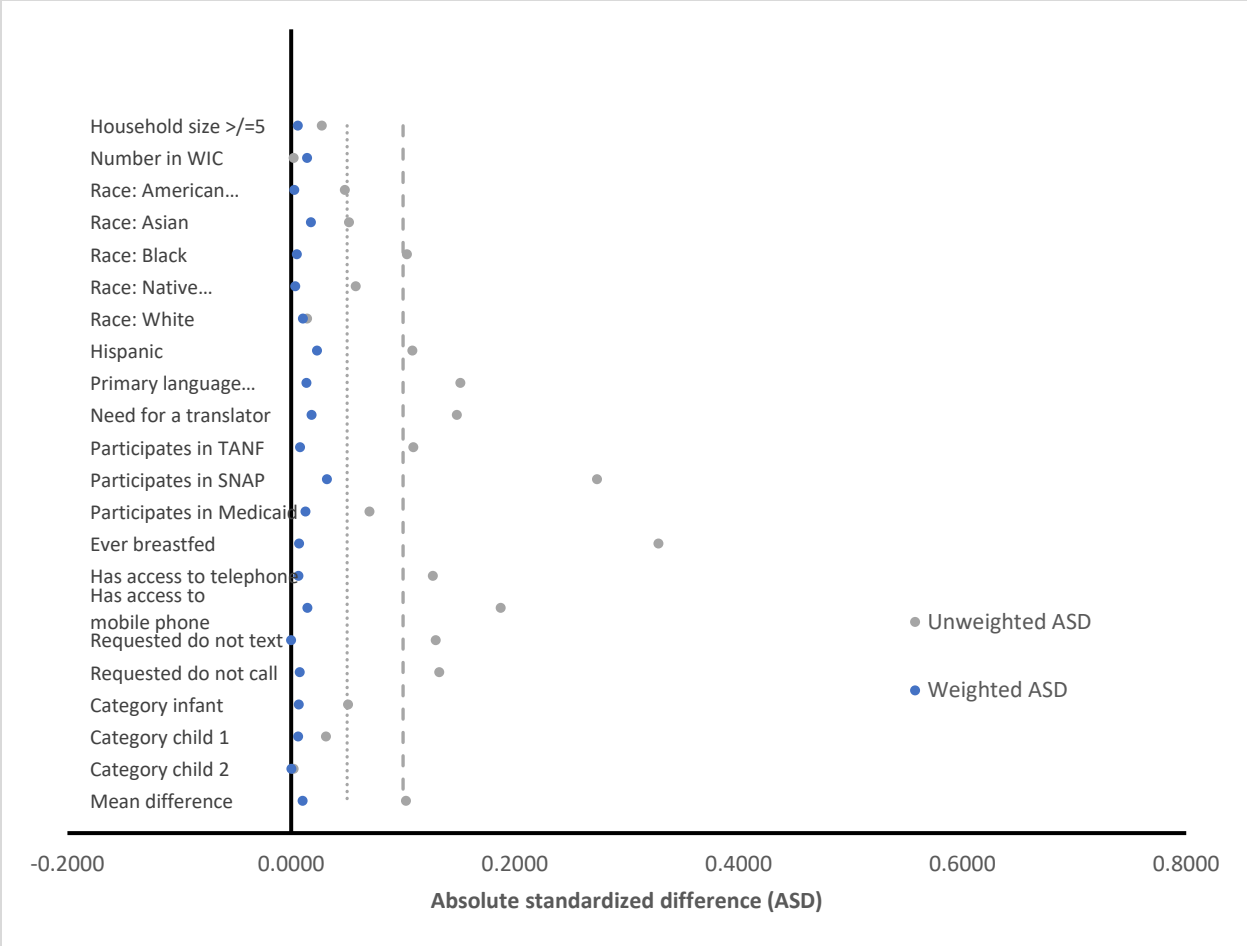
HPRIL Figure 6. Proportion with continuous benefit issuance (11-12 months) (crude, unweighted) at baseline (T1) and implementation (T2) overall, for infants, and for children at Yavapai and Mohave. * $p < 0.05$.

Balancing the groups using Propensity Score Weighting (PSW)

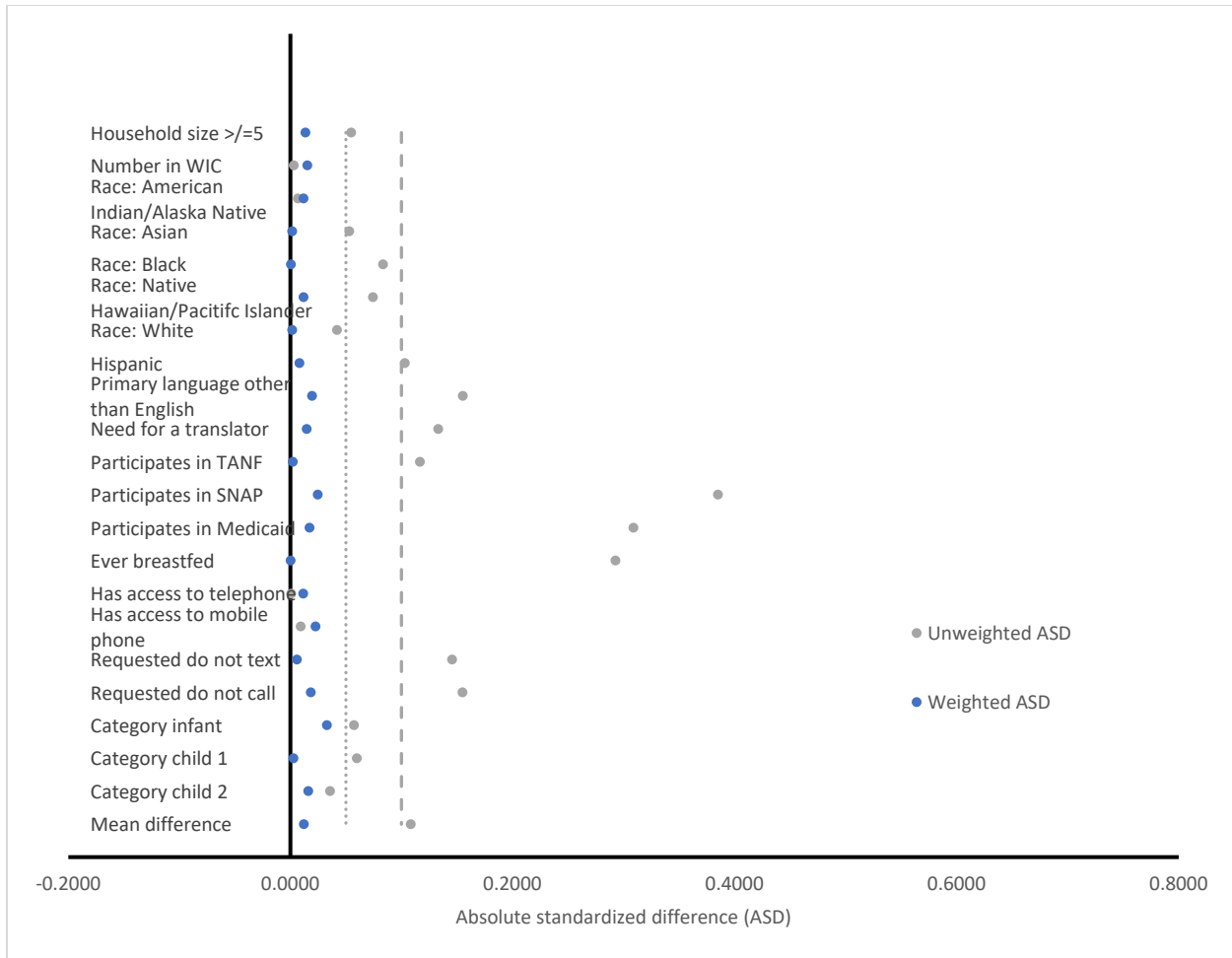
As mentioned in the methods section, we utilized two different weighting methods to balance the participant characteristics between groups and between time periods to evaluate the impact of *WIC in a Click*. For the PSW approach used for Model A1, the results in Figures 7-9 demonstrate the magnitude of the absolute standardized differences (ASD) between groups across characteristics and the balance achieved via weighting, and the overall mean ASD. The results are shown for each of the three relevant comparisons: Yavapai at T1 with Mohave at T1; Yavapai at T1 with Yavapai at T2; Yavapai at T1 with Mohave at T2. Through weighting, the mean ASD for each comparison are less than 5% and close to 0. Tables for the same comparisons for infants and children separately are in appendix (Table A.2). This same approach was used to demonstrate balance from the weighting procedures used for model A2, and those results will be added the Appendix during report revisions.



HPRIL Figure 7. Absolute Standardized Differences in Characteristics (unweighted and weighted) at T1 vs. T2 at Yavapai Overall: Infants and Children



HPRIL Figure 8. Absolute Standardized Differences in Characteristics (unweighted and weighted) at T1 at Yavapai vs. T1 at Mohave overall: Infants and Children

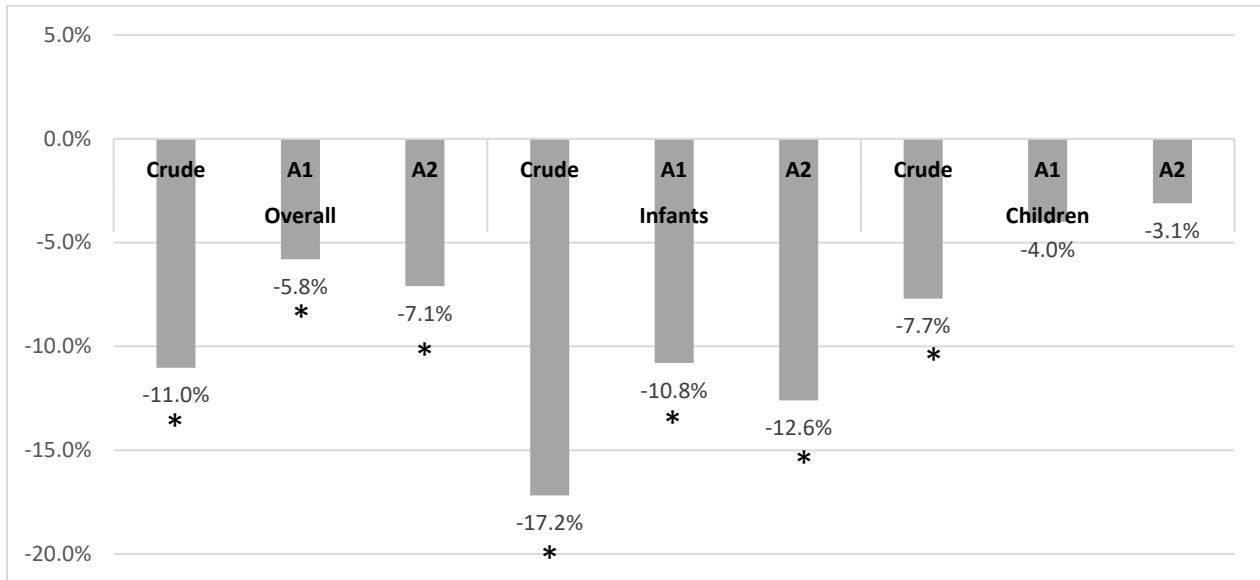


HPRIL Figure 9. Absolute Standardized Differences in Characteristics (unweighted and weighted) at T1 at Yavapai vs. T2 at Mohave overall: Infants and Children

Difference in Difference (DID) analyses

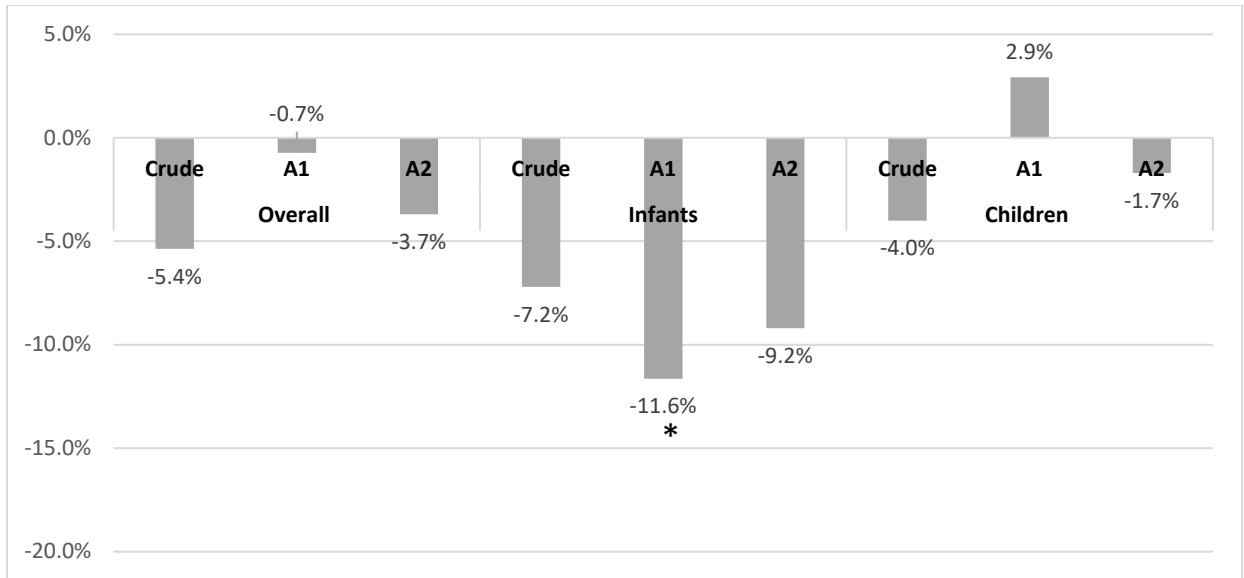
Using the unweighted data and a crude (unadjusted) DID analysis, being in the innovation clinics was associated with a lower recertification overall (-11.0%; 95% CI: -15.2 to -15.2%), among infants (-17.2%; 95% CI: -24.3 to -10.1%), and among children (-7.7; 95% CI: -12.8% to -2.6%) (all statistically significant) (HPRIL Figure 10, HPRIL Table 4). The negative association of *WIC in a Click* with recertification was diminished using the weighted data and adjusted model 1 (A1). In this model, being at the innovation clinics was associated with a -5.8% lower recertification rate overall (95% CI: -10.0% to -1.6%), a -10.8% lower recertification rate among infants (95% CI: -18.5% to -3.1%), and a -4.0% lower rate among children (95% CI: -8.7% to -0.8%) (all statistically significant). The results using the weighted data and the adjusted model 2 (A2) were similar in terms of statistical significance and were generally consistent in

terms of magnitude. For the beta coefficients and 95% confidence intervals, see HPRIL Table 4. For the sample sizes of each of these groups, see Appendix HPRIL Table A.3.



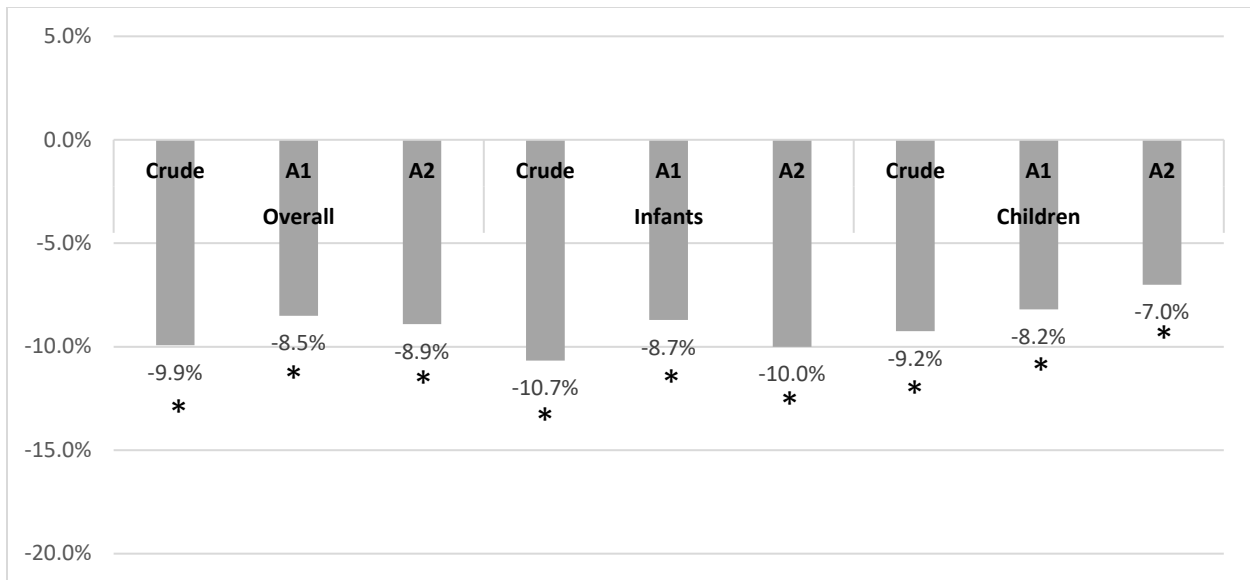
HPRIL Figure 10. Percentage point differences in recertification between Yavapai and Mohave overall, for infants, and for children using three models: Crude (unweighted) and two weighting analysis techniques: A1: PSW-DID using logit for propensity score weighting (PSW) and ordinary least squares (OLS) for DID; A2: PSM-DID using Kernel for propensity score matching (PSM) and probit for DID with repeated cross-sectional option. * $p < 0.05$.

Presented in Figure 11 are the results of the DID models for the proportion of timely recertified among those who recertified. In general, the results show negative but non-statistically significant differences in the proportion timely recertified. Qualitatively, the differences are greater for infants than for children, and for model A1 among infants, *WIC in a Click* is associated with a statistically significantly negative adjusted proportion of timely recertified of -11.6% (95% CI: -22.6% to -0.6%). For the beta coefficients and 95% confidence intervals, see HPRIL Table 4. For the sample sizes of each of these groups, see Appendix HPRIL Table A.3.



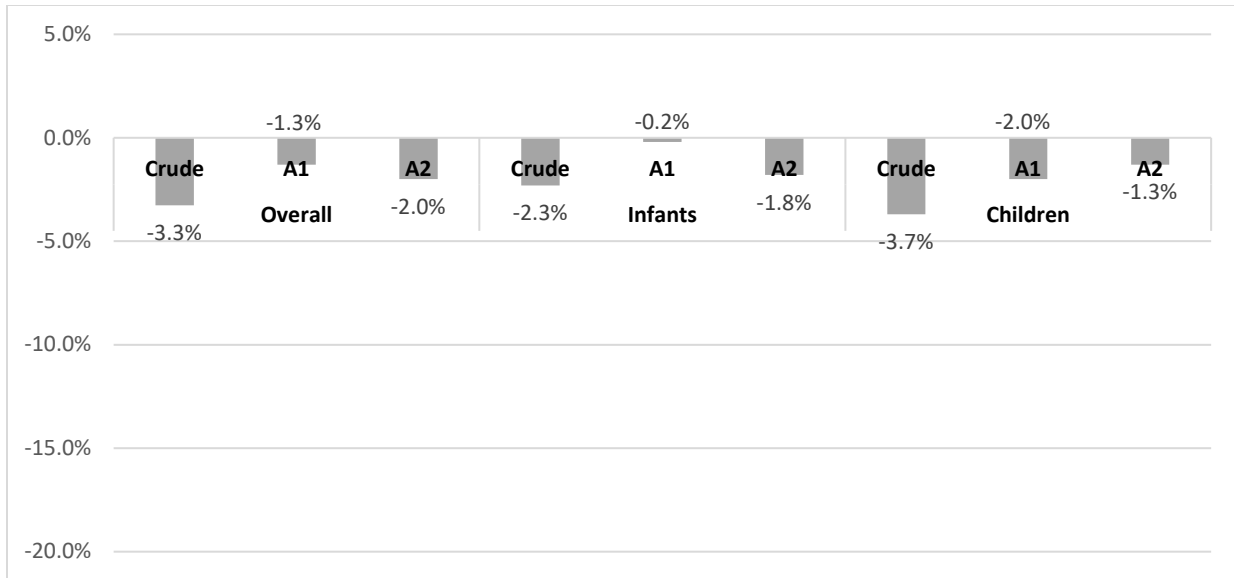
*HPRIL Figure 11. Percentage point differences in timely recertification between the Yavapai and Mohave overall, for infants, and for children using three models: Crude (unweighted) and two weighting analysis techniques: A1: PSW-DID using logit for propensity score weighting (PSW) and ordinary least squares (OLS) for DID; A2: PSM-DID using Kernel for propensity score matching (PSM) and probit for DID with repeated cross-sectional option. * $p < 0.05$.*

The DID results for the impact of *WIC in a Click* on child retention in WIC are found in Figure 12 and HPRIL Table 4. Consistent with results for recertification, being in the innovation clinic was associated with -9.9% (95% CI: -13.9% to -5.9%) lower retention rate in crude unweighted analyses, an adjusted -8.5% (95% CI: -12.6% to -4.3%) lower rate in Model A1, and -8.9% (95% CI: -12.8% to -5.0%) lower rate in Model A2. The results are generally consistent across models and for infants and children. For the beta coefficients and 95% confidence intervals, see HPRIL Table 4. For the sample sizes of each of these groups, see Appendix HPRIL Table A.3.



*HPRIL Figure 12. Percentage point differences in retention between the Yavapai and Mohave overall, for infants, and for children using three models: Crude (unweighted) and two weighting analysis techniques: A1: PSW-DID using logit for propensity score weighting (PSW) and ordinary least squares (OLS) for DID; A2: PSM-DID using Kernel for propensity score matching (PSM) and probit for DID with repeated cross-sectional option. All results are statistically significant. * $p < 0.05$.*

The results for continuous benefit issuance are shown in Figure 13 and HPRIL Table 4. The magnitude of the differences associated with *WIC in a Click* are negative, but small and not statistically significant. For the beta coefficients and 95% confidence intervals, see HPRIL Table 4. For the beta coefficients and 95% confidence intervals, see HPRIL Table 4. For the sample sizes of each of these groups, see Appendix HPRIL Table A.3.



HPRIL Figure 13. Percentage point differences in continuous benefit issuance between Yavapai and Mohave overall, for infants, and for children using three models: Crude (unweighted) and two weighting analysis techniques: A1: PSW-DID using logit for propensity score weighting (PSW) and ordinary least squares (OLS) for DID; A2: PSM-DID using Kernel for propensity score matching (PSM) and probit for DID with repeated cross-sectional option.

HPRIL Table 4. Difference-in-Difference Results of the Impact of WIC in a Click for Recertification, Retention, and Benefit Issuance Using Crude and Two Adjusted Models Overall and for Infants and Children

	beta	Overall		beta	Infants		beta	Children	
		95% CI	95% CI		95% CI	95% CI			
Recertification (crude, unweighted)	-0.110	-0.152	-0.069	-0.172	-0.243	-0.101	-0.077	-0.128	-0.026
Timely recertification (crude, unweighted)	-0.033	-0.074	0.008	-0.023	-0.093	0.047	-0.037	-0.088	0.014
Retention (crude, unweighted)	-0.099	-0.139	-0.059	-0.107	-0.176	-0.037	-0.092	-0.141	0.044
Benefit issuance (crude, unweighted)	-0.054	-0.110	0.0027	-0.072	-0.170	0.0261	-0.040	-0.109	0.0287
Recertification:									
Model A1	-0.058	-0.100	-0.016	0.108	-0.185	-0.031	-0.040	-0.087	0.008
Model A2	-0.071	-0.112	-0.030	-0.126	-0.197	-0.055	-0.031	-0.082	0.020
Timely recertification:									
Model A1	-0.007	-0.071	0.056	-0.116	-0.226	-0.006	0.029	-0.046	0.105
Model A2	-0.037	-0.094	0.020	-0.092	-0.192	0.008	-0.017	-0.086	0.052
Retention:									
Model A1	-0.085	-0.126	-0.043	-0.087	-0.163	-0.011	-0.082	-0.130	-0.035
Model A2	-0.089	-0.128	-0.050	-0.100	-0.169	-0.031	-0.070	-0.119	-0.021
Continuous benefit issuance:									
Model A1	-0.013	-0.056	0.030	-0.002	-0.079	0.075	-0.020	-0.072	0.032
Model A2	-0.020	-0.061	0.021	-0.018	-0.089	0.053	-0.013	-0.064	0.038

Discussion

Interpretation of Results

Process Evaluation Results

The process evaluation indicates that the *WIC in a Click* project was generally implemented as intended, although minor changes were made in normal WIC operations in response to the COVID-19 pandemic. It appears that the inclusion of phone appointments helped maintain and/or increase engagement by providing a convenient and easy option for on-demand appointments. The exclusion of group sessions decreased the number of options to receive WIC services in general, and in their absence, we were unable to include an evaluation of their impact.

Short-Term Evaluation Results

The Yavapai WIC program saw no significant change in participation during implementation compared to pre-implementation, as seen in Figure 1 above. The engagement in *WIC in a Click* project remained stable once the project was established and standardized training was provided to both WIC staff and participants. Engagement showed a leveling off in month three of the implementation period. In addition to engagement, providing on-demand appointments was associated with a decrease in no-show appointments. Overall, success was seen in the short-term evaluation except for caseload, which was not positively or negatively associated with the availability of on-demand appointments.

Long-Term Evaluation Results

Overall, the results suggest that *WIC in a Click* negatively affected the recertification and retention of children in WIC. When examining the proportion of those timely recertified, the results, although negative, were largely non-significant, and no differences in continuous benefit issuance were found. In general, the results were similar for infants and for children in stratified analyses.

The results are surprising and need to be interpreted with caution. The implementation period occurred during the COVID-19 pandemic. Because WIC operations transitioned to virtual appointments by phone, the barrier to WIC participation related to the need to travel to the clinic for an in-person appointment was removed. Because the relative value of having an appointment

without pre-scheduling was reduced during the implementation period, one might expect to estimate no impact of *WIC in a Click* on the outcomes, and this was found for both continual benefit issuance and the percent timely recertified. Using weighted data in adjusted analyses reduced the magnitude of the negative findings for recertification and retention, but they were statistically significant. Although we were able to successfully balance the differences in participant characteristics between groups and over time, the question must be asked as to whether there were operational differences between the clinics over time. Differences in clinic operations and staffing during the implementation period are likely because of COVID-19.

Conversations with the Mohave County WIC leadership concluded that Mohave operated with seven full-time Nutrition Education Specialists during the implementation period, while Yavapai only operated with four. Nutrition Education Specialists see the majority of the recertifications and the difference in staffing could explain the variances in timely recertification and retention. Additionally, different modalities were used when completing certification appointments. Mohave completed certifications via the phone and Yavapai completed certifications via videoconferencing. There may have been differences as well in how participants coped with the pandemic and their perceptions of the benefits offered through WIC participation. Yavapai WIC nutritionists commented that participants mentioned not being able to purchase WIC food online as an important barrier to WIC participation.

Limitations

Project limitations were overwhelmingly associated with the unavailability of specific MIS data. The first limitation was being able to track participation in outlying areas while maintaining confidentiality. Second, measuring the distance that participants were saved from traveling to the nearest clinic could not be completed because of time constraints, staffing, and resource allocation. Third, some project data was not available through a MIS report and necessitated analysis to be done by hand versus running a report. Consequently, inconsistencies may have occurred. Finally, the percentage of on-demand appointments was lower than expected due to the total number of appointments, including those that did not meet the criteria for *WIC in a Click*.

Lessons Learned

We found that phone appointments were easier and more efficient than zoom appointments, allowed for a warm handoff, and decreased the number of no shows. A dedicated WIC employee to answer phones facilitated the uptake of on-demand scheduling as these staff were well-versed in both WIC and *WIC in a Click* and were better able to educate and assist participants. During the implementation period, WIC employees shared that performing the many steps needed to complete a *WIC in a Click* appointment could be cumbersome. It was determined that developing or using integrated technology would make this process easier in the future. Finally, outreach was created to be shared with medical offices, dental offices, at health fairs and with other community partners who share a similar clientele as WIC, however, was not implemented due to safety concerns brought on by the COVID 19 pandemic.

Implications

WIC in a Click shows promise for improving client services and associated outcomes. Recommended changes for future implementation include incorporating integrated technology linking phone, texting, email, and video capabilities. This ease of access to all modalities will allow staff to focus on providing participants with best practice customer services. Furthermore, permanent policy changes allowing remote certifications would greatly expand the eligible services to WIC participants. Finally, introducing group nutrition education sessions would allow for more clients to be seen at one time, opening more appointment times in the schedules for in depth one on one sessions.

Plans for Sustainability

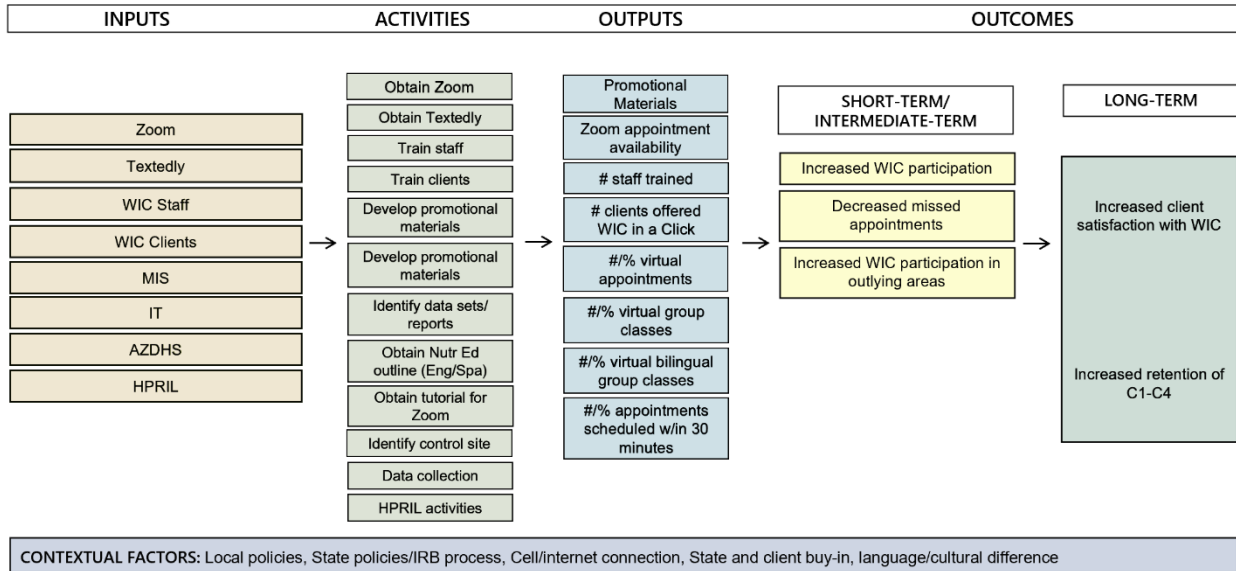
Overall, the *WIC in a Click* appointments were well received by WIC staff and WIC participants and will continue to be offered in Yavapai County. Implementation was relatively affordable and could easily be done with tools available at the local agency. While current technologies worked well during the implementation of the project, funding for integrated technology could make the process even more efficient. We will continue to investigate funding opportunities to continue and expand this project.

Recommendations

Recommendations for WIC agencies exploring and considering implementing on-demand appointments include assessing local agency capabilities. For example, can phones be used in the office as well as remotely? Is there video-conferencing technology available? Designating staff to answer phones and manage schedules is vital to ensure all participants are provided with the same high-quality services. Once the process has been implemented and proven effective and efficient, on-demand appointments can be expanded to all staff. Overall, start small and build upon the unique foundation, resources, and staff at each local agency.

Appendices

Appendix A. WIC in a Click Logic Model



Appendix B. Process Evaluation Questions and Indicators

Process Evaluation Questions and Indicators

Question: Was the project implemented as intended, according to workplan, intended completed documents, trained staff, and the development of the WIC-in-a-Click process?

Indicator	Definition	Source	Frequency of Data Collection	Expectation	Analysis
Documents Obtained/ Completed	<ul style="list-style-type: none"> • Vendor agreement • Caseload management policy • High risk referrals policy • Remote issuance policy • Referral to WIC-in-a-Click policy • Training/education/marketing materials for clients about WIC-in-a-Click • Data/reports: MIS, vendor data, Survey Monkey client and employee surveys. 	N/A	N/A	Completed documents	Documentation
Implementation Documentation	<ul style="list-style-type: none"> • # Staff trained on WIC-in-a-Click (7 + 4 who offer and walk the client through) 	N/A	N/A	Record-keeping throughout the project	Documentation

Question: What appointment format did clients in the intervention sites choose: On-Demand or traditional?

Indicator	Definition	Source	Frequency of Data Collection	Expectation	Analysis
# of on-demand appointments completed	# of on-demand appointments completed	MIS/ Vendor data	Monthly	Increase over time	Description and graphs visually showing trends over time
% of on-demand appointments completed	# of on-demand appointments completed/ total number of appointments completed *100	MIS	Monthly	Increase over time and eventual plateau	Description and graphs visually showing trends over time
On-Demand show-rate percentage	# on-demand appointments completed/ # of on-demand appointments made *100	MIS/ Vendor data	Monthly	Increase over time and eventual plateau	Description and graphs visually showing trends over time

% of scheduled traditional appointments completed	# of traditional appointments completed/ total # of appointments completed *100	MIS/ Vendor data	Monthly	No prediction	Description and graphs visually showing trends over time
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Question: How did clients and staff like WIC-in-a-Click?

Indicator	Definition	Source	Frequency of Data Collection	Expectation	Analysis
# of miles traveled (one-way) to get to clinic	Reported- 0-10 mi., 11-20 mi., 21-30 mi., over 30 mi.	Clinic Online Survey	Weekly (01/2021- 03/2021)	No Prediction	Description and graphs visually showing reported responses.
Ease of completing appointment (videoconferencing vs. phone)	Reported- Very easy, easy, somewhat difficult, very difficult	Clinic Online Survey	Weekly (01/2021- 03/2021)	Very easy to easy	Description and graphs visually showing reported responses.
Technical difficulties	Reported- Yes or no	Clinic Online Survey	Weekly (01/2021- 03/2021)	No	Description and graphs visually showing reported responses.
Wait time	Reported 0-15 min, 16-30 min, 31-60 min, over 60 min	Clinic Online Survey	Weekly (01/2021- 03/2021)	0-15 mins	Description and graphs visually showing reported responses.
Preferred method	Reported In-clinic, videoconferencing, phone	Clinic Online Survey	Weekly (01/2021- 03/2021)	Phone	Description and graphs visually showing reported responses.

Appendix C. Short-term Outcomes Evaluation Questions and Indicators

Short-Term Outcome Evaluation Questions and Indicators

Question: Which appointments are most attended?

Indicator	Definition	Source	Frequency of Data Collection	Expectation	Analysis
# on-demand (virtual) appointments completed	# on-demand (virtual) appointments completed	MIS	Monthly	On-demand appointments better attended.	Description and graphs visually showing trends over time
% on-demand (virtual) appointments completed	# of on-demand appointments completed/ # of on-demand (virtual) appointments scheduled *100	MIS	Monthly	On-demand appointments better attended.	Description and graphs visually showing trends over time
# on-demand (phone) appointments completed	# on-demand (phone) appointments completed	MIS	Monthly	On-demand appointments better attended.	Description and graphs visually showing trends over time
% on-demand (phone) appointments completed	# of on-demand appointments completed/ # of on-demand (phone) appointments scheduled *100	MIS	Monthly	On-demand appointments better attended.	Description and graphs visually showing trends over time
# traditional/scheduled appointments completed	# traditional/scheduled appointments completed	MIS	Monthly	On-demand appointments better attended.	Description and graphs visually showing trends over time
% traditional/scheduled appointments completed	# of traditional/scheduled appointments completed/ # of scheduled/traditional appointments scheduled *100	MIS	Monthly		Description and graphs visually showing trends over time

Question: Did WIC-in-a-Click improve benefit redemption?

Indicator	Definition	Source	Frequency of Data Collection	Expectation	Analysis
Complete benefit issuance	# clients 1-4 y with benefits issued <u>each month</u> / (# clients 1-4 y in the program) * 100	MIS	annual	Greater positive change in the intervention vs comparison over time	Difference in differences; stratification by client category

Benefits not issued	# clients 1-4 missing at least one month of benefits/ (# clients in the program) * 100	MIS	annual	Greater decrease between pre and post in intervention vs comparison	Difference in differences; stratification by client category
Complete benefit redemption	# clients 1-4 y with no expired benefits each month/ (# clients 1-4 y issued benefits in the program) * 100	MIS	annual	Greater increase between pre and post in intervention vs comparison	Difference in differences; stratification by client category
Expired benefits	# clients 1-4 y with at least one month of expired benefits/ (# clients 1-4 y issued benefits in the program) * 100	MIS	annual	Greater decrease between pre and post in intervention vs comparison	Difference in differences; stratification by client category
Expired benefit rate	# benefits expired/ (# benefits issued) * 100	MIS	annual	Greater decrease between pre and post in intervention vs comparison	Difference in differences; stratification by client category

Appendix D. Long-Term Outcomes Evaluation Questions and Indicators

Long-Term Outcome Evaluation Questions and Indicators

Question: Did WIC-in-a-Click contribute to improved retention rates of C1-C4 in the intervention sites vs. the comparison sites?

Indicator	Definition	Source	Frequency of Data Collection	Expectation	Analysis
Re-certification rate	Re-certification = # clients 1-4 years who re-certified during the time period/# clients 1-4 years who were eligible to be re-certified during the time period	MIS	Pre/post implementation period	Greater positive change in re-certification rate in the intervention vs comparison over time	Difference in differences; stratification by client category;
Timely re-certification rate	Timely Re-certification = # clients 1-4 years who re-certified within 14 months/# clients who were eligible to be re-certified during the time period	MIS	Pre/post implementation period	Greater positive change in re-certification rate in the intervention vs comparison over time	Difference in differences; stratification by client category;

Question: Did WIC-in-a-Click contribute to improved participation rates of C1-C4 in the intervention sites compared with the comparison sites?

Indicator	Definition	Source	Frequency of Data Collection	Expectation	Analysis
Monthly participating caseload	Monthly caseload = # clients with active benefits each month	LA MIS reports	Monthly	Greater positive change in the intervention vs comparison over time	Description and graphs visually showing trends over time; significance testing of change pre vs post
Median (IQR) Average monthly caseload for the year	Sum of monthly caseload/ 12	LA MIS Reports	Monthly	Greater positive change in the intervention vs comparison over time	Difference in differences; stratification by client category;
Monthly participation percentage	# clients with active benefits/ #enrolled * 100	LA MIS reports	Monthly	Greater positive change in the intervention vs comparison over time	Description and graphs visually showing trends over time; monthly difference in differences; stratification by client category
Average monthly participation percentage	Sum of monthly participation percentages/ 12 * 100	LA MIS Reports	Monthly	Greater positive change in the intervention vs comparison over time	Difference in differences; stratification by client category

Appendix E. HPRIL Tables/Figures

HPRIL Table A.1. Sample sizes at Yavapai and Mohave: Crude, unweighted

	Overall T1	Overall T2	Infants T1	Infants T2	Children T1	Children T2
Yavapai	2,272	1,985	786	673	1,486	1,312
Mohave	2,349	2,167	870	691	1,479	1,476
Yavapai Timely Recertification Analysis	1,305	908	414	261	891	647
Mohave Timely Recertification Analysis	1,333	1,204	462	378	871	826

HPRIL Table A.2. Absolute Standardized Differences (ASDs) for Model A1 for infants and children separately

	Infants: Unweighted					
	Mean	Standard Deviation	Mean	Standard Deviation	Difference in Standard Deviations	Absolute Value of Difference
	Yavapai at T1		Yavapai at T2			
Household size >=5	0.3422	0.4748	0.3447	0.4756	-0.0052	0.0052
Number in WIC	0.7875	0.4093	0.8053	0.3962	-0.0442	0.0442
Race: American Indian/Alaska Native	0.0471	0.2119	0.0312	0.1740	0.0818	0.0818
Race: Asian	0.0115	0.1065	0.0267	0.1615	-0.1118	0.1118
Race: Black	0.0369	0.1886	0.0357	0.1856	0.0066	0.0066
Race: Native Hawaiian/Pacific Islander	0.0038	0.0617	0.0178	0.1324	-0.1356	0.1356
Race: White	0.9631	0.1886	0.9688	0.1740	-0.0314	0.0314
Hispanic	0.3982	0.4898	0.4086	0.4919	-0.0212	0.0212
Primary language other than English	0.9249	0.2637	0.9242	0.2648	0.0027	0.0027
Need for a translator	0.0191	0.1369	0.0193	0.1377	-0.0017	0.0017
Participates in TANF	0.0051	0.0712	0.0045	0.0667	0.0092	0.0092
Participates in SNAP	0.2252	0.4180	0.2660	0.4422	-0.0948	0.0948
Participates in Medicaid	0.6069	0.4888	0.6909	0.4625	-0.1767	0.1767
Ever breastfed	0.8537	0.3536	0.8410	0.3659	0.0352	0.0352
Has access to telephone	0.0115	0.1065	0.0178	0.1324	-0.0531	0.0531
Has access to mobile phone	0.9911	0.0940	0.9941	0.0769	-0.0345	0.0345
Requested do not call	0.0000	0.0000	0.0015	0.0385	-0.0545	0.0545
Average Standardized Absolute Mean Difference						0.0530
	Yavapai at T1		Mohave at T1			
Household size >=5	0.3422	0.4748	0.3356	0.4725	0.0139	0.0139

Number in WIC	0.7875	0.4093	0.7690	0.4217	0.0447	0.0447
Race: American Indian/Alaska Native	0.0471	0.2119	0.0391	0.1939	0.0394	0.0394
Race: Asian	0.0115	0.1065	0.0161	0.1259	-0.0398	0.0398
Race: Black	0.0369	0.1886	0.0575	0.2329	-0.0971	0.0971
Race: Native Hawaiian/Pacific Islander	0.0038	0.0617	0.0138	0.1167	-0.1069	0.1069
Race: White	0.9631	0.1886	0.9621	0.1911	0.0055	0.0055
Hispanic	0.3982	0.4898	0.3529	0.4781	0.0937	0.0937
Primary language other than English	0.9249	0.2637	0.9575	0.2019	-0.1386	0.1386
Need for a translator	0.0191	0.1369	0.0034	0.0587	0.1485	0.1485
Participates in TANF	0.0051	0.0712	0.0172	0.1302	-0.1158	0.1158
Participates in SNAP	0.2252	0.4180	0.3724	0.4837	-0.3257	0.3257
Participates in Medicaid	0.6069	0.4888	0.6322	0.4825	-0.0521	0.0521
Ever breastfed	0.8537	0.3536	0.7172	0.4506	0.3369	0.3369
Has access to telephone	0.0115	0.1065	0.0345	0.1826	-0.1541	0.1541
Has access to mobile phone	0.9911	0.0940	0.9747	0.1571	0.1265	0.1265
Requested do not call	0.0000	0.0000	0.0115	0.1067	-0.1524	0.1524
Average Standardized Absolute Mean Difference						0.1171

	Yavapai at T1		Mohave at T2			
Household size >=5	0.3422	0.4748	0.3719	0.4837	-0.0619	0.0619
Number in WIC	0.7875	0.4093	0.7945	0.4044	-0.0171	0.0171
Race: American Indian/Alaska Native	0.0471	0.2119	0.0463	0.2103	0.0036	0.0036
Race: Asian	0.0115	0.1065	0.0203	0.1410	-0.0705	0.0705
Race: Black	0.0369	0.1886	0.0709	0.2569	-0.1510	0.1510
Race: Native Hawaiian/Pacific Islander	0.0038	0.0617	0.0116	0.1071	-0.0888	0.0888
Race: White	0.9631	0.1886	0.9450	0.2281	0.0865	0.0865
Hispanic	0.3982	0.4898	0.3546	0.4787	0.0901	0.0901
Primary language other than English	0.9249	0.2637	0.9595	0.1973	-0.1483	0.1483
Need for a translator	0.0191	0.1369	0.0087	0.0928	0.0889	0.0889
Participates in TANF	0.0051	0.0712	0.0101	0.1002	-0.0580	0.0580
Participates in SNAP	0.2252	0.4180	0.4501	0.4979	-0.4892	0.4892
Participates in Medicaid	0.6069	0.4888	0.8075	0.3945	-0.4518	0.4518
Ever breastfed	0.8537	0.3536	0.7033	0.4571	0.3679	0.3679
Has access to telephone	0.0115	0.1065	0.0174	0.1307	-0.0496	0.0496
Has access to mobile phone	0.9911	0.0940	0.9870	0.1135	0.0395	0.0395
Requested do not call	0.0000	0.0000	0.0188	0.1360	-0.1957	0.1957
Average Standardized Absolute Mean Difference						0.1446

Infants: Weighted						
	Mean	Standard Deviation	Mean	Standard Deviation	Difference in Standard Deviations	Absolute Value of Difference
	Yavapai at T1		Yavapai at T2			

Household size >=5	0.3422	0.4748	0.3469	0.4763	-0.0099	0.0099
Number in WIC	0.7875	0.4093	0.7965	0.4029	-0.0220	0.0220
Race: American Indian/Alaska Native	0.0471	0.2119	0.0460	0.2097	0.0051	0.0051
Race: Asian	0.0115	0.1065	0.0130	0.1133	-0.0139	0.0139
Race: Black	0.0369	0.1886	0.0404	0.1971	-0.0183	0.0183
Race: Native Hawaiian/Pacific Islander	0.0038	0.0617	0.0036	0.0602	0.0031	0.0031
Race: White	0.9631	0.1886	0.9628	0.1894	0.0017	0.0017
Hispanic	0.3982	0.4898	0.3972	0.4897	0.0021	0.0021
Primary language other than English	0.9249	0.2637	0.9297	0.2558	-0.0185	0.0185
Need for a translator	0.0191	0.1369	0.0174	0.1307	0.0128	0.0128
Participates in TANF	0.0051	0.0712	0.0071	0.0840	-0.0257	0.0257
Participates in SNAP	0.2252	0.4180	0.2326	0.4228	-0.0177	0.0177
Participates in Medicaid	0.6069	0.4888	0.6144	0.4871	-0.0154	0.0154
Ever breastfed	0.8537	0.3536	0.8481	0.3592	0.0158	0.0158
Has access to telephone	0.0115	0.1065	0.0111	0.1048	0.0034	0.0034
Has access to mobile phone	0.9911	0.0940	0.9945	0.0740	-0.0403	0.0403
Requested do not call	0.0000	0.0000	0.0013	0.0364	-0.0514	0.0514
Average Standardized Absolute Mean Difference						0.0163

	Yavapai at T1		Mohave at T1			
Household size >=5	0.3422	0.4748	0.3447	0.4755	-0.0051	0.0051
Number in WIC	0.7875	0.4093	0.7836	0.4120	0.0096	0.0096
Race: American Indian/Alaska Native	0.0471	0.2119	0.0485	0.2150	-0.0069	0.0069
Race: Asian	0.0115	0.1065	0.0074	0.0857	0.0419	0.0419
Race: Black	0.0369	0.1886	0.0341	0.1815	0.0154	0.0154
Race: Native Hawaiian/Pacific Islander	0.0038	0.0617	0.0031	0.0553	0.0129	0.0129
Race: White	0.9631	0.1886	0.9664	0.1804	-0.0177	0.0177
Hispanic	0.3982	0.4898	0.3918	0.4884	0.0132	0.0132
Primary language other than English	0.9249	0.2637	0.9273	0.2598	-0.0089	0.0089
Need for a translator	0.0191	0.1369	0.0202	0.1406	-0.0078	0.0078
Participates in TANF	0.0051	0.0712	0.0052	0.0719	-0.0013	0.0013
Participates in SNAP	0.2252	0.4180	0.2302	0.4212	-0.0120	0.0120
Participates in Medicaid	0.6069	0.4888	0.6137	0.4872	-0.0141	0.0141
Ever breastfed	0.8537	0.3536	0.8565	0.3508	-0.0080	0.0080
Has access to telephone	0.0115	0.1065	0.0126	0.1115	-0.0103	0.0103
Has access to mobile phone	0.9911	0.0940	0.9877	0.1105	0.0335	0.0335
Requested do not call	0.0000	0.0000	0.0013	0.0367	-0.0518	0.0518
Average Standardized Absolute Mean Difference						0.0159

	Yavapai at T1		Mohave at T2			
Household size >=5	0.3422	0.4748	0.3393	0.4738	0.0062	0.0062
Number in WIC	0.7875	0.4093	0.7892	0.4082	-0.0041	0.0041

Race: American Indian/Alaska Native	0.0471	0.2119	0.0537	0.2256	-0.0302	0.0302
Race: Asian	0.0115	0.1065	0.0112	0.1054	0.0022	0.0022
Race: Black	0.0369	0.1886	0.0444	0.2062	-0.0381	0.0381
Race: Native Hawaiian/Pacific Islander	0.0038	0.0617	0.0037	0.0605	0.0024	0.0024
Race: White	0.9631	0.1886	0.9624	0.1903	0.0035	0.0035
Hispanic	0.3982	0.4898	0.3851	0.4870	0.0269	0.0269
Primary language other than English	0.9249	0.2637	0.9341	0.2483	-0.0358	0.0358
Need for a translator	0.0191	0.1369	0.0180	0.1332	0.0077	0.0077
Participates in TANF	0.0051	0.0712	0.0051	0.0711	0.0002	0.0002
Participates in SNAP	0.2252	0.4180	0.2400	0.4274	-0.0350	0.0350
Participates in Medicaid	0.6069	0.4888	0.6179	0.4863	-0.0226	0.0226
Ever breastfed	0.8537	0.3536	0.8490	0.3583	0.0131	0.0131
Has access to telephone	0.0115	0.1065	0.0108	0.1032	0.0066	0.0066
Has access to mobile phone	0.9911	0.0940	0.9906	0.0966	0.0053	0.0053
Requested do not call	0.0000	0.0000	0.0012	0.0339	-0.0480	0.0480
Average Standardized Absolute Mean Difference						0.0169

Children: Unweighted

	Mean	Standard Deviation	Mean	Standard Deviation	Difference in Standard Deviations	Absolute Value of Difference
	Yavapai at T1		Yavapai at T2			
Household size >=5	0.4024	0.4906	0.4078	0.4916	-0.0109	0.0109
Number in WIC	0.5855	0.4928	0.5831	0.4932	0.0048	0.0048
Race: American Indian/Alaska Native	0.0458	0.2090	0.0434	0.2039	0.0112	0.0112
Race: Asian	0.0128	0.1124	0.0137	0.1164	-0.0082	0.0082
Race: Black	0.0424	0.2016	0.0412	0.1987	0.0062	0.0062
Race: Native Hawaiian/Pacific Islander	0.0087	0.0932	0.0114	0.1064	-0.0269	0.0269
Race: White	0.9664	0.1804	0.9627	0.1897	0.0200	0.0200
Hispanic	0.4307	0.4953	0.4002	0.4901	0.0620	0.0620
Primary language other than English	0.9051	0.2932	0.9108	0.2851	-0.0197	0.0197
Need for a translator	0.0276	0.1639	0.0221	0.1471	0.0352	0.0352
Participates in TANF	0.0007	0.0259	0.0008	0.0276	-0.0033	0.0033
Participates in SNAP	0.1474	0.3546	0.1799	0.3842	-0.0879	0.0879
Participates in Medicaid	0.3197	0.4665	0.4207	0.4939	-0.2104	0.2104
Ever breastfed	0.8170	0.3868	0.8102	0.3923	0.0173	0.0173
Has access to telephone	0.0276	0.1639	0.0229	0.1495	0.0301	0.0301
Has access to mobile phone	0.9919	0.0895	0.9931	0.0826	-0.0141	0.0141
Requested do not text	0.0013	0.0367	0.0000	0.0000	0.0519	0.0519
Requested do not call	0.0013	0.0367	0.0008	0.0276	0.0180	0.0180
Category child 1	0.3863	0.4871	0.4040	0.4909	-0.0362	0.0362
Category child 2	0.3210	0.4670	0.3155	0.4649	0.0117	0.0117

Average Standardized Absolute Mean Difference 0.0343

	Yavapai at T1		Mohave at T1			
Household size >=5	0.4024	0.4906	0.3874	0.4873	0.0307	0.0307
Number in WIC	0.5855	0.4928	0.5869	0.4926	-0.0029	0.0029
Race: American Indian/Alaska Native	0.0458	0.2090	0.0352	0.1842	0.0538	0.0538
Race: Asian	0.0128	0.1124	0.0203	0.1410	-0.0588	0.0588
Race: Black	0.0424	0.2016	0.0669	0.2500	-0.1081	0.1081
Race: Native Hawaiian/Pacific Islander	0.0087	0.0932	0.0122	0.1097	-0.0336	0.0336
Race: White	0.9664	0.1804	0.9628	0.1893	0.0191	0.0191
Hispanic	0.4307	0.4953	0.3746	0.4842	0.1146	0.1146
Primary language other than English	0.9051	0.2932	0.9459	0.2263	-0.1558	0.1558
Need for a translator	0.0276	0.1639	0.0081	0.0897	0.1474	0.1474
Participates in TANF	0.0007	0.0259	0.0074	0.0859	-0.1066	0.1066
Participates in SNAP	0.1474	0.3546	0.2394	0.4268	-0.2344	0.2344
Participates in Medicaid	0.3197	0.4665	0.3489	0.4768	-0.0620	0.0620
Ever breastfed	0.8170	0.3868	0.6761	0.4681	0.3280	0.3280
Has access to telephone	0.0276	0.1639	0.0507	0.2195	-0.1194	0.1194
Has access to mobile phone	0.9919	0.0895	0.9581	0.2005	0.2180	0.2180
Requested do not text	0.0013	0.0367	0.0095	0.0969	-0.1109	0.1109
Requested do not call	0.0013	0.0367	0.0108	0.1035	-0.1220	0.1220
Category child 1	0.3863	0.4871	0.3800	0.4855	0.0129	0.0129
Category child 2	0.3210	0.4670	0.3320	0.4711	-0.0234	0.0234
Average Standardized Absolute Mean Difference						0.1031

	Yavapai at T1		Mohave at T2			
Household size >=5	0.4024	0.4906	0.4255	0.4946	-0.0468	0.0468
Number in WIC	0.5855	0.4928	0.5881	0.4923	-0.0053	0.0053
Race: American Indian/Alaska Native	0.0458	0.2090	0.0440	0.2052	0.0083	0.0083
Race: Asian	0.0128	0.1124	0.0183	0.1341	-0.0445	0.0445
Race: Black	0.0424	0.2016	0.0528	0.2238	-0.0491	0.0491
Race: Native Hawaiian/Pacific Islander	0.0087	0.0932	0.0163	0.1265	-0.0676	0.0676
Race: White	0.9664	0.1804	0.9627	0.1895	0.0195	0.0195
Hispanic	0.4307	0.4953	0.3760	0.4845	0.1116	0.1116
Primary language other than English	0.9051	0.2932	0.9472	0.2238	-0.1612	0.1612
Need for a translator	0.0276	0.1639	0.0075	0.0860	0.1539	0.1539
Participates in TANF	0.0007	0.0259	0.0129	0.1128	-0.1491	0.1491
Participates in SNAP	0.1474	0.3546	0.2879	0.4530	-0.3456	0.3456
Participates in Medicaid	0.3197	0.4665	0.4614	0.4987	-0.2935	0.2935
Ever breastfed	0.8170	0.3868	0.7093	0.4542	0.2551	0.2551
Has access to telephone	0.0276	0.1639	0.0244	0.1543	0.0201	0.0201
Has access to mobile phone	0.9919	0.0895	0.9925	0.0860	-0.0071	0.0071

Requested do not text	0.0013	0.0367	0.0129	0.1128	-0.1375	0.1375
Requested do not call	0.0013	0.0367	0.0122	0.1098	-0.1325	0.1325
Category child 1	0.3863	0.4871	0.4099	0.4920	-0.0483	0.0483
Category child 2	0.3210	0.4670	0.3299	0.4704	-0.0191	0.0191
Average Standardized Absolute Mean Difference						0.1038

Children: Weighted

	Mean	Standard Deviation	Mean	Standard Deviation	Difference in Standard Deviations	Absolute Value of Difference
	Yavapai at T1		Yavapai at T2			
Household size >=5	0.4024	0.4906	0.4011	0.4903	0.0026	0.0026
Number in WIC	0.5855	0.4928	0.5813	0.4935	0.0085	0.0085
Race: American Indian/Alaska Native	0.0458	0.2090	0.0454	0.2082	0.0019	0.0019
Race: Asian	0.0128	0.1124	0.0130	0.1133	-0.0019	0.0019
Race: Black	0.0424	0.2016	0.0404	0.1969	0.0101	0.0101
Race: Native Hawaiian/Pacific Islander	0.0087	0.0932	0.0087	0.0930	0.0003	0.0003
Race: White	0.9664	0.1804	0.9655	0.1825	0.0045	0.0045
Hispanic	0.4307	0.4953	0.4334	0.4957	-0.0055	0.0055
Primary language other than English	0.9051	0.2932	0.9034	0.2956	0.0060	0.0060
Need for a translator	0.0276	0.1639	0.0260	0.1592	0.0099	0.0099
Participates in TANF	0.0007	0.0259	0.0010	0.0312	-0.0105	0.0105
Participates in SNAP	0.1474	0.3546	0.1504	0.3576	-0.0084	0.0084
Participates in Medicaid	0.3197	0.4665	0.3250	0.4686	-0.0115	0.0115
Ever breastfed	0.8170	0.3868	0.8215	0.3831	-0.0119	0.0119
Has access to telephone	0.0276	0.1639	0.0264	0.1603	0.0075	0.0075
Has access to mobile phone	0.9919	0.0895	0.9908	0.0955	0.0122	0.0122
Requested do not text	0.0013	0.0367	0.0000	0.0000	0.0519	0.0519
Requested do not call	0.0013	0.0367	0.0003	0.0161	0.0384	0.0384
Category child 1	0.3863	0.4871	0.3934	0.4887	-0.0146	0.0146
Category child 2	0.3210	0.4670	0.3173	0.4656	0.0080	0.0080
Average Standardized Absolute Mean Difference						0.0113

	Yavapai at T1		Mohave at T1			
Household size >=5	0.4024	0.4906	0.4060	0.4912	-0.0072	0.0072
Number in WIC	0.5855	0.4928	0.5966	0.4907	-0.0226	0.0226
Race: American Indian/Alaska Native	0.0458	0.2090	0.0463	0.2101	-0.0024	0.0024
Race: Asian	0.0128	0.1124	0.0122	0.1097	0.0054	0.0054
Race: Black	0.0424	0.2016	0.0422	0.2010	0.0012	0.0012

Race: Native Hawaiian/Pacific Islander	0.0087	0.0932	0.0093	0.0962	-0.0062	0.0062
Race: White	0.9664	0.1804	0.9675	0.1774	-0.0064	0.0064
Hispanic	0.4307	0.4953	0.4169	0.4932	0.0279	0.0279
Primary language other than English	0.9051	0.2932	0.9101	0.2862	-0.0171	0.0171
Need for a translator	0.0276	0.1639	0.0235	0.1514	0.0262	0.0262
Participates in TANF	0.0007	0.0259	0.0013	0.0361	-0.0201	0.0201
Participates in SNAP	0.1474	0.3546	0.1604	0.3671	-0.0361	0.0361
Participates in Medicaid	0.3197	0.4665	0.3244	0.4683	-0.0102	0.0102
Ever breastfed	0.8170	0.3868	0.8111	0.3915	0.0149	0.0149
Has access to telephone	0.0276	0.1639	0.0277	0.1643	-0.0009	0.0009
Has access to mobile phone	0.9919	0.0895	0.9908	0.0957	0.0125	0.0125
Requested do not text	0.0013	0.0367	0.0011	0.0338	0.0057	0.0057
Requested do not call	0.0013	0.0367	0.0013	0.0362	0.0009	0.0009
Category child 1	0.3863	0.4871	0.3922	0.4884	-0.0122	0.0122
Category child 2	0.3210	0.4670	0.3227	0.4677	-0.0037	0.0037
Average Standardized Absolute Mean Difference						0.0120

	Yavapai at T1		Mohave at T2			
Household size >=5	0.4024	0.4906	0.3915	0.4883	0.0223	0.0223
Number in WIC	0.5855	0.4928	0.5962	0.4908	-0.0218	0.0218
Race: American Indian/Alaska Native	0.0458	0.2090	0.0463	0.2102	-0.0026	0.0026
Race: Asian	0.0128	0.1124	0.0125	0.1111	0.0027	0.0027
Race: Black	0.0424	0.2016	0.0390	0.1937	0.0171	0.0171
Race: Native Hawaiian/Pacific Islander	0.0087	0.0932	0.0075	0.0862	0.0142	0.0142
Race: White	0.9664	0.1804	0.9667	0.1795	-0.0019	0.0019
Hispanic	0.4307	0.4953	0.4283	0.4950	0.0049	0.0049
Primary language other than English	0.9051	0.2932	0.9095	0.2870	-0.0151	0.0151
Need for a translator	0.0276	0.1639	0.0302	0.1712	-0.0155	0.0155
Participates in TANF	0.0007	0.0259	0.0012	0.0340	-0.0160	0.0160
Participates in SNAP	0.1474	0.3546	0.1524	0.3596	-0.0142	0.0142
Participates in Medicaid	0.3197	0.4665	0.3202	0.4667	-0.0012	0.0012
Ever breastfed	0.8170	0.3868	0.8197	0.3846	-0.0070	0.0070
Has access to telephone	0.0276	0.1639	0.0302	0.1712	-0.0155	0.0155
Has access to mobile phone	0.9919	0.0895	0.9897	0.1010	0.0233	0.0233
Requested do not text	0.0013	0.0367	0.0015	0.0389	-0.0045	0.0045
Requested do not call	0.0013	0.0367	0.0019	0.0441	-0.0148	0.0148

Category child 1	0.3863	0.4871	0.3804	0.4856	0.0121	0.0121
Category child 2	0.3210	0.4670	0.3218	0.4673	-0.0018	0.0018
Average Standardized Absolute Mean Difference						0.0114

HPRIL Table A.3. Sample sizes for DID analyses at Yavapai and Mohave

	Overall	Infants	Children
Crude, unweighted – Recertification	8,773	3,020	5,753
Crude, unweighted – Timely recertification	8,773	3,020	5,753
Crude, unweighted – Retention	8,773	3,020	5,753
Crude, unweighted – Benefit issuance	4,750	1,515	3,235
Recertification model A1	8,773	3,020	5,753
Recertification model A2	8,738	3,004	5,717
Timely recertification model A1	4,750	1,515	3,235
Timely recertification A2	4,750	1,509	3,220
Retention model A1	8,773	3,020	5,753
Retention model A2	8,738	3,004	5,717
Benefit issuance model A1	8,773	3,020	5,753
Benefit issuance model A2	8,738	3,004	5,717

Appendix F. Implementation Protocols and Tools

**Yavapai County Community Health Services
Policy Section: WIC and Breastfeeding Programs
High Risk Referrals and Special Formula Request**

Applies to: YCCHS WIC and Breastfeeding Program employees.

Purpose:

Certain participants are identified to be at higher risk and have counseling needs beyond the scope of paraprofessional staff. These participants benefit from more in-depth counseling provided by a Registered Dietitian.

Policy:

- A. If a WIC participant is triggered as High Risk (HR), in the HANDS computer system, the Nutrition Education Specialist will refer the participant to the Registered Dietitian (RD).
- B. If a WIC participant is triggered with HR Codes, 602 or 603, the Nutrition Education Specialist (NES) should contact an International Board Certified Lactation Consultant (IBCLC) IMMEDIATELY for additional support and guidance. If an IBCLC is not available for codes 602 or 603 the NES should immediately contact an RD for additional support and guidance.
- C. If a WIC participant is triggered as a HR Code 201.1 the NES should IMMEDIATELY contact an RD for support and guidance.
- D. If based on their assessment and discretion, the Nutrition Education Specialist strongly feels a client should be referred to the RD for any reason they should do so. This will be documented in the TGIF note.
- E. If a formula approval is needed for a WIC client, the Nutrition Education Specialist will contact the RD on the day of service to assess the formula request and follow through accordingly.
- F. The High Risk Report will be monitored monthly by a clinic supervisor or the WIC Section Manager to ensure staff are appropriately documenting and referring high risk clients. Lack of compliance with this policy will result in additional training and/or disciplinary action.

High Risk Referral Policy

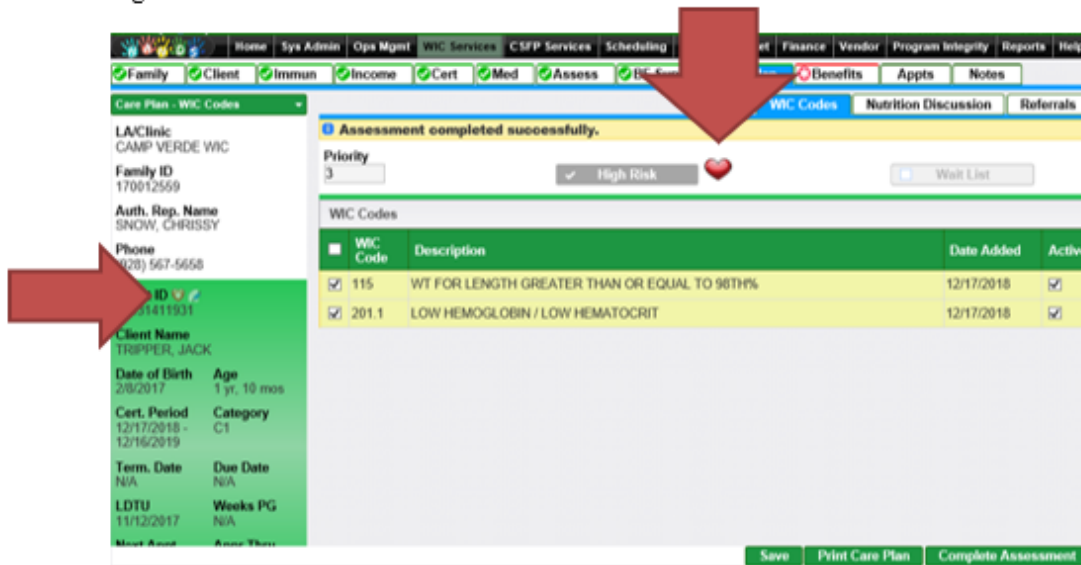
Procedure:

High Risk Referrals

1. High risk codes that are auto assigned by HANDS or manually assigned during the assessment will add a red heart to the record indicating that the client needs to be referred to the Registered Dietitian (RD). See Figure one.

Note: Clients assigned codes 602 or 603 can also be seen by an IBCLC for high risk counseling.

Figure 1



- a. A client may be issued up to 2 months of benefits before being seen by the RD. The referral must be written in the F portion of the TGIF note, and staff will specify that the client's next appointment will be with the RD.
- b. If a client has been issued 2 months of benefits and is not able to be seen by the RD at their appointment, they are to be issued 1 month of benefits and scheduled with the RD.
- c. If a client has less than 3 months left in their certification, they are to be issued 1 or 2 months and scheduled with the RD before the end of their certification period.
- d. If a client's certification period will end in less than a month, staff is to document that in their TGIF note that the client was not able to be referred due to the client's

certification ending in less than 1 month.

2. Once an RD sees a client they will turn the red heart green, indicating that the client has been seen.
 - a. An RD may sign off on a code and will enter a staff alert that the client no longer needs to be referred for that code.
 - b. New high risk codes may be added over the course of the certification. If the occurs, HANDS will not turn the heart back to red, but the client will still need to be referred if a new high risk code has been added.
3. A list of the high risk codes can be found at:
<https://www.azdhs.gov/documents/prevention/azwic/manuals/when-to-refer-to-dietitian.pdf>

Special Formula and Food Request

1. "Formula and Food Request" forms can be received in-person or thru efax|(866-721-0455).
 - a. Forms received in-person will be given to the RD for processing.
 - b. Forms received thru efax will be forwarded, via email, to WIC Supervisors and Section Manager for processing.
 - c. All medical documentation for requested formula/foods shall be evaluated and approved by Local Agency designated RDs/State-approved Nutritionist.
 - d. If an approval is needed immediately, and RD is not available in the clinic, staff will attempt to contact an RD/State-Approved Nutritionist at another WIC clinic within the local agency for approval.
 - e. If an RD/State-Approved Nutritionist at another WIC clinic within the local agency cannot be reached, attempt to contact a WIC Nutrition Consultant at the AZ WIC State Office for approval.
 - f. Only in the event that an RD/State-Approved Nutritionist/WIC Nutrition Consultant is not able to be reached for approval, issue a one-month supply of the requested formula (may be any formula type listed in Section A with the exception of non-contract formulas) and foods pending the Local Agency RD/State-Approved Nutritionist's approval.
2. When medical documentation for a standard contract formula has been provided, and current approved medical documentation exists in HANDS, it must be approved by an RD/State-Approved Nutritionist, who may approve it for up to the length of the time requested by the prescriptive authority

If no medical documentation, or partially completed medical documentation is received, RDs/State-Approved Nutritionist shall follow the procedure on page 9 and 10 in the Chapter 4 of the Arizona WIC policy and procedure manual.

Caseload Management Policy

Yavapai County Community Health Services Policy Section: WIC Program

Caseload Management

Applies to: YCCHS WIC Program employees.

Purpose: Caseload Management is intended to support the tracking and monitoring of actual participation against assigned caseloads at the Local Agency level.

Policy: The Yavapai County WIC Director will use caseload management to estimate, plan and track the program's objectives, as well as to make changes in the way services are allocated to improve program efficiency and effectiveness

Procedure:

1. The WIC Section Manager (WIC Director) or WIC Supervisor will run the eWIC caseload by fiscal month and category report in HANDS.
 - a. Updated numbers will be entered onto an excel spreadsheet at a minimum weekly.
 - b. Total caseload for each month will be calculated against assigned caseload and a percentage of how many participants were served will be documented on this spreadsheet.
 - c. Staff will receive monthly updates on the caseload percentages.
2. The WIC staff and front office clerks will utilize the reports generated in HANDS to contact clients and schedule appointments.
 - a. Reports used: No-show report, risk of benefit loss, enrolled, but not participating, client due for certification, and list of appointment from three months back.
 - i. Each staff has been assigned clinic and report to complete by the end of the month.
 - ii. Staff will call any client who missed their appointment on the same day the appointment was missed.

Remote Services and Issuance of WIC Benefits Policy

Yavapai County Community Health Services Policy Section: WIC Program

Remote Services and Issuance of WIC Benefits

BACKGROUND

All WIC participants will be offered the opportunity to receive quarterly participant-centered nutrition education, mid-certifications, and high-risk contacts during a certification period. An appointment that does not require physical presence may be conducted in-person/face to face, by video conference using an approved virtual platform, or by telephone. A nutrition education session requiring a height and weight may be conducted in-person/face to face or by video conference using an approved virtual platform if participant can provide height and weight from a provider that has been taken within the last 60 days or hgb within 90 days. All methods of conducting a nutrition education session require adherence to the guidelines in Arizona WIC Policy and Procedures Manual, Chapter 7: Participant and Staff Education.

REFERENCES

Arizona WIC Policy and Procedures Manual, Chapter 2: Certification

Arizona WIC Policy and Procedures Manual, Chapter 3: Food Package – General

Arizona WIC Policy and Procedures Manual, Chapter 4: Food Package – Formula

Arizona WIC Policy and Procedures Manual, Chapter 7: Participant and Staff Education

Enrolled But Not Participating Detail Report in HANDS

APPLICABILITY

Yavapai County Community Health Services (YCCHS) WIC Program

DEFINITIONS

LDTU – Last Day to Use. This refers to the last day for every 30-day food benefit issuance period that benefits are available before the next 30 day food benefit issuance period begins.

HANDS – Health and Nutrition Delivery System. This is the computer information management system used by the WIC program to deliver food benefits and document client information and nutrition education.

TGIF, SOAP, ADIME – Different methods for documenting a nutrition education contact. More details are available on these note types in the Arizona WIC Policy and Procedures Manual, Chapters 2 and 7.

POLICY

- A. **The preferred method of nutrition education is in-person/face to face/video conferencing, where a WIC nutrition professional and a WIC client can interact face to face for a nutrition discussion appointment.** These methods of nutrition education should be offered first. Video conferencing (either group or one-on-one) must be completed using an approved virtual platform (Zoom).
- B. To decrease barriers to service, an individual secondary nutrition education contact over the telephone is allowable when the participant or authorized representative (AR) is unable to come into the clinic, chooses phone as the preferred method of receiving nutrition education, has missed the original scheduled face to face appointment, or does not have any food benefits, and rescheduling the face-to-face appointment is not possible.
- C. When benefits are issued remotely, WIC staff will follow the guidance outlined in the procedures listed below. Any remote issuance outside of these guidelines will be approved on a case-by-case basis by the WIC Director or Supervisors.
- D. Both virtual and phone services WIC staff will verify AR with two identifiers (DOB, Phone number, or address)

PROCEDURE – VIRTUAL NUTRITION EDUCATION CONTACTS

- A. Virtual nutrition education contacts shall occur in an environment that promotes effective communication between the participant and the WIC staff and ensures active involvement in the interaction and the confidentiality of participant information. The technology used for virtual nutrition education contacts shall be HIPPA compliant to ensure that confidential client information is protected.
- B. Virtual contacts shall occur on-demand (within 1 hour) or a time when the participant is scheduled and available. If the participant is not available at the designated time, the staff will attempt to reschedule the contact.
- C. Virtual contacts may use a group or a one-on-one format. Breastfeeding assessments may be completed using a virtual platform but must be done in a one-on-one format. Breastfeeding education for pregnant participants may be done in a group format.
- D. For a virtual group contact, WIC staff shall:
 - a. Follow an approved curriculum for group contacts.

- b. Engage and encourage all group members to participate.
 - c. Avoid asking or discussing any personal confidential information specific to any participants.
 - d. Follow up with each AR individually before or after the group contact to discuss benefit issuance. Discuss how the AR would like to receive a copy of the benefit issuance summary (the EzWIC app should be offered first, but the AR may choose to receive a copy of the Family Balance Summary electronically or by mail). The next appointment expectations should be addressed.
 - e. Ensure the virtual group nutrition education contact is captured in the participant Care Plan in HANDS by marking clients as attended in HANDS.
 - i. NOTE: If only one person attends a group session a TGIF note must be written in that participants files.
- E. For a virtual one-on-one contact, WIC staff shall:
- a. Review recent information collected in the participant's record.
 - i. Mid-certifications require WIC staff to update phone number
 - b. Address specific risk(s) or concerns identified at the previous certification or nutrition education contact.
 - i. Mid-certification Requirements
 - 1. Ht and wt obtained by provider and taken within the last 60 days or hgb within last 90 days.
 - a. Can be obtained virtually, faxed or verbally.
 - b. Documentation of how ht, wt and hgb obtained must be documented in TGIF note.
 - c. Medical screen should be updated to date ht, wt and hgb taken.
 - 2. Full nutrition assessment must be completed.
 - c. Acknowledge any success or progress the participant has made towards nutrition goals or health improvements.
 - d. Acknowledge concerns or barriers the participant may have tried to achieve their goals.
 - e. Discuss how the AR would like to receive a copy of the benefit issuance summary (the EzWIC app should be offered first, but the AR may choose to receive a copy of the Family Balance Summary electronically or by mail). The next appointment expectations should be addressed or exit counseling provided, as applicable.

- f. Ensure the virtual one-on-one nutrition education contact is captured in the participant Care Plan in HANDS by selecting the appropriate virtual nutrition contact and documenting the interaction with the appropriate note type (TGIF, SOAP, ADIME).

PROCEDURE – TELEPHONE NUTRITION EDUCATION CONTACTS

- A. Telephone nutrition education contacts shall occur in an environment that promotes effective communication between the participant and the WIC staff and ensures active involvement in the interaction and the confidentiality of participant information. Telephone contacts shall occur at a time when the participant is scheduled and available. If the participant is not available at the designated time, the staff will attempt to reschedule the contact.
- B. For a telephone contact, WIC staff shall:
 - a. Review recent information collected in the participant’s record.
 - b. Address specific risk(s) or concerns identified at the previous certification or nutrition education contact.
 - c. Acknowledge any success or progress the participant has made towards nutrition goals or health improvements.
 - d. Acknowledge concerns or barriers the participant may have tried to achieve their goals.
 - e. Discuss how the AR would like to receive a copy of the benefit issuance summary (the EzWIC app should be offered first, but the AR may choose to receive a copy of the Family Balance Summary electronically or by mail). The next appointment expectations should be addressed or exit counseling should be provided, as applicable.
- C. Ensure the nutrition education telephone contact is captured in the participant Care Plan in HANDS by selecting the appropriate telephone nutrition contact and documenting the interaction with the appropriate note type (TGIF, SOAP, ADIME).

PROCEDURE – REMOTE ISSUANCE OF BENEFITS

- A. The following are different scenarios and guidance for handling remote issuance of eWIC benefits:
 - a. The family participated in a virtual or telephone nutrition education contact today/yesterday, and they have already received their eWIC card.
 - 1. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.

- b. The AR did not have proof of ID, residency and/or income at the time of the certification.
 - 1. WIC staff will offer an AR the opportunity to submit missing documents electronically through the Secure File Share System or viewable by virtual platform.
 - 2. HANDS will be updated with the appropriate documentation. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
- c. The family has all required nutrition education contacts for the certification period and needs additional benefits.
 - 1. This is allowable if each client in the family has received at least two contacts for each 6-month portion of a certification period, as long as the AR is offered the opportunity to receive nutrition education at a quarterly rate based on last date of issuance. If the AR declines nutrition education, this must be documented in the Notes screen.
 - 2. Staff may not remote issue for this purpose if 2 contacts have not been completed within a 6-month portion of a certification period.
 - 3. Staff must ensure if issuing benefits for multiple family members that each individual WIC participant has received the 2 required contacts for each 6-month portion of a certification period and has been offered nutrition education at a quarterly rate based on last date of issuance.
 - 4. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
 - 5. Staff will document the remote issuance in the Notes section of HANDS.
- d. The family has been identified on the Enrolled but Not Participating Detail Report and is unable to return to the clinic in time to receive their benefits for late pick-up.
 - 1. Staff speak with the authorized representative and the authorized representative states they cannot come to the clinic within the time frame.
 - 2. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits. Staff will only issue the late pick-up month.

**Note: Benefits shall not be issued for consecutive months for this purpose.*

3. An appointment is offered for the client based on their LDTU or client is informed when to return to the clinic.
 4. Staff will document the remote issuance in the Notes section of HANDS.
- e. The family is unable to come into the clinic due to transportation, illness, inclement weather, etc.
1. Staff speak with the authorized representative and the authorized representative states they cannot come to the clinic within the time frame.
 2. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits. Only 1 month of benefits may be issued.

**Note: Benefits shall not be issued for consecutive months for this purpose.*
 3. An appointment is offered for the client based on their LDTU or client is informed when to return to the clinic.
 4. Staff shall document the remote issuance in the Notes section of HANDS.
- f. The family missed an appointment, and the clinic is unable to fit them into the appointment schedule prior to them losing a month of benefits.
1. Staff speak with the authorized representative and the authorized representative states that they cannot come to the clinic within the time frame.
 2. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits. Only 1 month of benefits shall be issued.

**Note: Benefits cannot be issued for consecutive months for this purpose.*
 3. An appointment is offered for the client based on their LDTU or client is informed when to return to the clinic.
 4. Staff will document the remote issuance in the Notes section of HANDS.
- g. There was an error when client benefits were issued while they were in clinic that can be changed in HANDS. For example, the child was supposed to get soy milk, but cow's milk was accidentally loaded onto the eWIC card.

1. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
 2. Staff will note in HANDS what was done and who requested the change.
- h. The family has benefits, but something needs to be changed in the current food package. For example, the child received cow's milk but in the meantime an allergy was diagnosed so they want to change it to soy milk.
1. If no prescription is required, staff will note in HANDS what was done and who requested the change.
 2. If a prescription is required, clinic staff may issue one month without prescription remotely and follow the policies laid out in the Arizona WIC Policy and Procedures Manual: Chapter 3, Section M and Chapter 4, Section B. If a prescription was received by clinic, clinic staff may issue remote benefits following the policies listed above.
 3. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
- i. The family has benefits but staff have received complete medical documentation for a change in the type of formula. For example, the infant was assigned Similac Advance but now the doctor has changed the type of formula but the amount of formula being requested has not changed.
1. The Nutritionist/RDN shall speak with the AR via phone regarding feeding changes and document the conversation in the notes section of HANDS.
 2. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
 3. WIC staff shall notify client that benefits have been updated/issued.
- j. The RDN/State-approved Nutritionist only approved one month of benefits due to missing or incomplete Formula and Food Request Form (FFR) and the completed FFR has now been received.
1. The updated FFR will be scanned into HANDS.
 2. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
 3. WIC staff will notify the AR that the form has been received and benefits have been updated/issued.
 4. Staff will document the client notification in HANDS in Notes.

- k. Client was provided one month of benefits while waiting for completed Formula and Food Request Form (FFR) from the healthcare provider. The 30 days has passed, and no completed medical documentation has been received for the requested formula.
 - 1. Staff may issue 1 month remotely if they have approval from the state to extend the formula approval per Arizona WIC Policy and Procedures Manual, Chapter 4: Food Package – Formula.
 - 2. Staff shall work with the healthcare provider and client in efforts to obtain completed medical documentation.
 - 3. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
 - 4. Staff will document all issuance and formula activity in HANDS in Notes.

- l. Client has been on monthly issuance awaiting AHCCCS approval to cover special formula. Client states they still have not received approval.
 - 1. Staff may issue 1 month remotely. Staff will ensure that the client is receiving their regular nutrition education contacts either in-person, online or phone.
 - 2. WIC staff shall speak with the AR and appropriately tailor benefits for the family **before** issuing benefits.
 - 3. After two months, WIC staff shall contact the State Food Package Specialist in attempt to expedite the application for the client. Staff may continue to issue 1 month remotely (while still ensuring required nutrition education contacts are completed).
 - 4. Staff will document all issuance and formula activity in HANDS in Notes.

CONTACT US

Yavapai County WIC



Talk to your WIC worker from the convenience of your home, office, or on the go.

Download Zoom Cloud Meeting onto your smart phone, tablet, or computer.

Any WIC client can participate!

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WIC IN A CLICK**

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HEALTHY KID.
HAPPY MOM.**

How to Start

1. Download the Zoom Cloud Meeting App on your phone or tablet.
2. Call 928.771.3138 to set up virtual services.
3. An email or text will be sent to you within an hour.
4. Click on the link.
5. Type your name and follow the steps.
6. Allow audio and video on your device.
7. Have your Virtual WIC appointment!

To download the free app, go to the App Store or Google Play and Search for Zoom Cloud Meeting.



You **DO NOT** need to set up a Zoom account.



ANYTIME IS WIC TIME!

With WIC in a Click you can have your broccoli and eat it too while you talk with your WIC worker from the comfort of your own home or any place that is convenient for you.



Frequently asked questions:

What is a virtual service?

- It is a face to face video appointment.

How far in advance do I need to schedule virtual services?

- Virtual services will be offered within an hour from your call. Please call when you are free to participate.

How long does a virtual service video appointment last?

- Appointment times vary but will last the same amount of time as if you were in the clinic.

Who is eligible for WIC in a Click?

- Currently enrolled families may qualify. Please call for details.

How will my benefits be issued?

- Benefits will be issued on the day we virtually see you. They will be available on your usual start date.





Puede hablar con un trabajador de WIC cuando le resulte conveniente.



Baje la aplicación de Zoom Cloud Meeting en su celular, tableta, o computadora.



Cualquier cliente puede participar.

CONTACTENOS Yavapai County WIC



Lunes a Viernes
8:00am a 5:00pm

Prescott

1090 Commerce Drive
Prescott, AZ 86305

Prescott Valley

3212 Windsong Drive, 2nd Floor
Prescott Valley, AZ 86314

Cottonwood

10 S. Sixth Street
Cottonwood, AZ 86326

Chino Valley

1951 Voss Drive
Chino Valley, AZ 86323

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HEALTHY KID.
HAPPY MOM.**

Llámenos para servicios virtuales:

(928)771-3138



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LA COMUNIDAD DE YAVAPAI
PRESENTA:

WIC IN A CLICK

Como Comenzar

1. Baje la aplicación de Zoom Cloud Meeting en su celular o tableta.
2. Llame 928.771.3138 para hacer su servicios virtuales.
3. Va a llegar un mensaje de correo electronico o mensaje de texto en el lapso de una hora que nos pidió los servicios
4. Haga clic en el enlace.
5. Escriba sun nombre y siga los pasos.
6. Active el audio y video a su dispositivo.
7. ¡Proceda con su cita virtual de WIC!

Para bajar la aplicación gratis necesita ir a el App Store o Google Play y busque Zoom Cloud Meeting.



NO necesita tener una cuenta de Zoom para que pueda usar WIC in a Click.



¡WIC en cualquier momento!

Mientras tiene su cita con WIC in a Click usted puede disfrutar su comida mientras platica con su trabajadora de WIC ya sea de su propio hogar o de donde sea mas conveniente para usted.



Preguntas Frecuentes:

¿Cuales son los servicios virtuales?

- Los servicios virtuales son una cita cara a cara por medio de video.

¿Cuanto tiempo tarda en tener mi cita despues de llamarles?

- Va a tener sus servicios virtuales en el lapso de una hora que nos pidió los servicios. Hagamos el favor de llamar cuando este disponible.

¿Cuanto tiempo va a tomar?

- Las citas pueden variar pero pueden tomar mas o menos el mismo tiempo que si hubiera venido a la clinica.

¿Quien puede usar WIC in a Click?

- Familias actualmente inscritas en WIC pueden participar en WIC in a Click. Llamenos, por favor si tiene alguna pregunta.

¿Como voy a tener mis beneficios?

- Vamos a renovar sus beneficios el día que la miremos por medio de WIC in a Click pero, van a estar disponibles en su día de comienzo normal.



Client Survey

How did you complete your most recent WIC appointment?

- a. In-Clinic
- b. Videoconferencing (Zoom)
- c. Phone

In-Clinic Survey

No further questions, thank you for taking this survey

Video-Conferencing Survey

1. Estimate the miles you travel to get to the WIC clinic you usually go to. (one-way)
 - a. 0-10 miles
 - b. 11-20 miles
 - c. 21-30 miles
 - d. Over 30 miles.
2. How easy was it to complete your appointment through videoconferencing (Zoom)?
 - a. Very Easy
 - b. Easy
 - c. Somewhat Difficult
 - d. Very Difficult
3. Did you have any technical difficulties?
 - a. Yes
 - b. No
4. How long did you wait for your appointment to start from the time you called to request an appointment?
 - a. 0-15 minutes
 - b. 16-30 minutes
 - c. 31-60 minutes
 - d. Over 60 minutes
5. What is your preferred method to complete your WIC appointments?
 - a. In-Clinic
 - b. Videoconferencing (Zoom)
 - c. Phone
6. Have you thought about dropping out of WIC and would using your preferred method help you remain in the program?
 - a. Yes, I have thought about dropping out and my preferred method would help me to remain on the program.

- b. Yes, I have thought about dropping out and my preferred method would NOT help me to remain on the program.
 - c. No, I have not thought about dropping out of WIC.
7. Any additional comments?

Phone Appointment Survey

1. Estimate the miles you travel to get to the WIC clinic you usually go to. (one-way)
 - a. 0-10 miles
 - b. 11-20 miles
 - c. 21-30 miles
 - d. Over 30 miles.

2. How easy was it to complete your appointment over the phone?
 - a. Very Easy
 - b. Easy
 - c. Somewhat Difficult
 - d. Very Difficult

3. Did you have any technical difficulties?
 - a. Yes
 - b. No

4. How long did you wait for your appointment to start from the time you called to request an appointment?
 - a. 0-15 minutes
 - b. 16-30 minutes
 - c. 31-60 minutes
 - d. Over 60 minutes

5. What is your preferred method to complete your WIC appointments?
 - a. In-Clinic
 - b. Videoconferencing (Zoom)
 - c. Phone

6. Have you thought about dropping out of WIC and would using your preferred method help you remain in the program?
 - a. Yes, I have thought about dropping out and my preferred method would help me to remain on the program.
 - b. Yes, I have thought about dropping out and my preferred method would NOT help me to remain on the program.
 - c. No, I have not thought about dropping out of WIC.

7. Any additional comments?

¹ Eppes, E, Kang, Y, Gross, S, Paige, D, Caulfield, L. Hopkins Participant Research Innovation Laboratory for Enhancing WIC Services (HPRIL) Baseline Period Characteristics Report. 2022.

² Eppes, E, Kang, Y, Gross, S, Paige, D, Caulfield, L. Hopkins Participant Research Innovation Laboratory for Enhancing WIC Services (HPRIL) Implementation Period Characteristics Report. 2022.

³ Stuart E, Stuart EA, Huskamp HA, Duckworth K, et al. Using propensity scores in difference-in-differences models to estimate the effects of a policy change. *Health Services and Outcomes Research Methodology*. 2014;14(4):166-182. doi:10.1007/S10742-014-0123-Z/TABLES/5.

⁴ Villa JM. diff: Simplifying the estimation of difference-in-differences treatment effects. *Stata Journal*. 2016;16(1):52-71. doi:10.1177/1536867X1601600108.