

Chapter I: Methods Used to Identify Best Practices

The detailed methods for identifying best practices have been published and are available on the Web http://www.cdc.gov/pcd/issues/2006/jan/05_0133.htm free of charge.⁴ The methods are described briefly below.

1. WISEWOMAN PROGRAM BACKGROUND

The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program is funded by the Centers for Disease Control and Prevention (CDC) to screen women for risk factors associated with cardiovascular disease, provide lifestyle interventions to encourage reduction of and change in behavior risk factors, establish systems for accessing needed medications, and ensure that women receive needed follow-up care and return for a 1-year follow-up screening.

Congress established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) in 1991. In 1993, Congress authorized CDC to set up WISEWOMAN as a demonstration program within NBCCEDP. CDC funded three WISEWOMAN demonstration projects in 1995. At the time of publication, 15 WISEWOMAN projects operated in 14 states across the country.

CDC funds state and tribal organizations to develop either standard or enhanced projects. Both types of projects screen women for cardiovascular risk factors and administer lifestyle interventions. Enhanced projects also evaluate the effectiveness of lifestyle interventions by comparing outcomes for women who receive an enhanced intervention to women who receive a minimum intervention or usual care. At the time of publication, nine standard projects and six enhanced projects were operating.

Each state or tribal project oversees a number of local sites that deliver WISEWOMAN program services. Participants are low-income and under- or uninsured women aged 40-64 who do not qualify for Medicaid. All WISEWOMAN participants also must be enrolled in the Breast and Cervical Cancer Early Detection Program (BCCEDP).

All WISEWOMAN projects provide women with blood pressure and cholesterol screenings and some projects also screen them for diabetes and osteoporosis. In addition, all projects administer a lifestyle intervention targeted at improving cardiovascular disease risk factors. Projects have freedom in selecting an intervention that is culturally appropriate for their priority population as long as scientific evidence supports its effectiveness either in lowering blood pressure or cholesterol or in improving diet and physical activity.⁵ This freedom means that projects across the country offer different interventions. In addition, local sites within projects often have the flexibility to modify selected characteristics of their project's intervention to fit the needs of the local community in which they operate.

⁴ Besculides M, Zaveri H, Farris R, Will J. Identifying best practices for WISEWOMAN programs using a mixed-methods evaluation. *Prev Chronic Dis.* 2006;3(1):A07. Epub 2005 Dec 15. Available at: http://www.cdc.gov/pcd/issues/2006/jan/05_0133.htm.

⁵ Department of Health and Human Services. *The heart of the matter: chronic disease prevention guidance and resources for WISEWOMAN projects.* Atlanta (GA): Centers for Disease Control and Prevention; 2006. Available at: <http://www.cdc.gov/wisewoman>.

2. WISEWOMAN BEST PRACTICE STUDY BACKGROUND

“Best practices” is a popular term that, in the programmatic setting, refers to activities, practices, or processes that lead to the implementation of an intervention or other program activity using the most appropriate strategies for a given population and setting.⁶ For WISEWOMAN, best practices are project or local site activities, practices, or processes that are considered successful for delivering program services, as indicated by quantitative measures combined with systematically gathered qualitative data. Mathematica Policy Research, Inc. (MPR) identified best practices in selected WISEWOMAN projects.

The goal of the WISEWOMAN Best Practices Study was to identify a set of best practices related to risk factor screening and the delivery of this varied set of lifestyle interventions from which existing and new WISEWOMAN projects could learn. The practices identified are presented in this toolkit.

3. CASE STUDIES

Five of the 15 WISEWOMAN projects were chosen for in-depth case study. The selected projects were in Massachusetts, Michigan, Nebraska, North Carolina, and Southeast Alaska Regional Health Consortium (SEARHC).⁷ Four of these states or tribal organizations have standard projects. North Carolina has an enhanced project, but its research activities occur in one site and all of its other sites operate as standard sites. Collectively, these projects vary on multiple dimensions, including the type of local site, intervention delivered, and staff arrangements.

Project selection was based on the availability of quantitative re-screening data for at least 100 women per local site 10 to 14 months after program enrollment. Quantitative data from each local site were used to calculate measures of RE-AIM. A composite RE-AIM score that measured the overall public health impact (success) of each local site was determined, and the two highest- and one lowest-performing sites within each of the five projects were selected for case study. Sites were selected through a separate CDC contract with RTI International. To reduce potential bias, MPR researchers conducting the case studies were blinded to local site performance during data collection.

MPR collected qualitative data through review of program materials, preliminary telephone interviews with CDC WISEWOMAN staff and state and tribal project- and local-level staff, and site visits. Site visits were made to each local site and the state or tribal organization that oversaw the local sites. During site visits, in-person interviews were conducted with staff members who played a role in developing or delivering the lifestyle intervention. When possible, local program partners were also interviewed to learn about the staff’s perspectives on practices that were used to implement the lifestyle intervention. In one example, interviews were conducted with staff at a community swimming pool that offered discounted passes to WISEWOMAN participants as a way to increase their physical activity levels. The visits also entailed observations of the lifestyle intervention and focus groups with program participants.

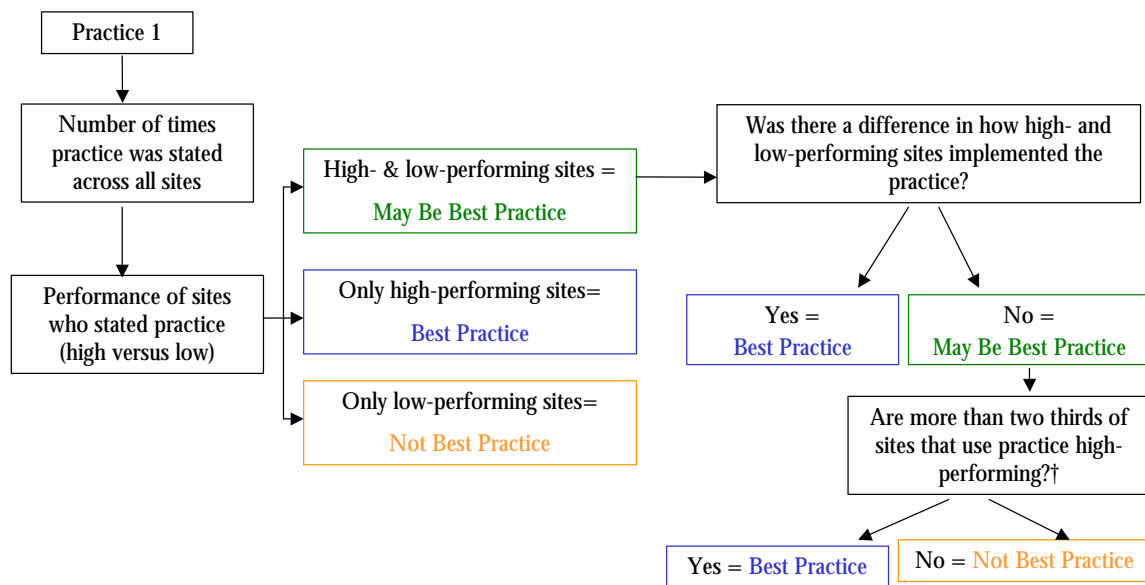
⁶ Green L. Generalizing from idiosyncratic research to “best practices” in other settings and populations. Presented at the Second International Symposium on the Effectiveness of Health Promotion, May 28, 2001. Toronto, Ontario, Canada: University of Toronto. Available at: <http://www.utoronto.ca/chp/download/2ndSymposium/L.%20Green.doc>.

⁷ Brief descriptions of the five case study projects and their lifestyle interventions are provided in Appendix A.

4. BEST PRACTICE IDENTIFICATION

Analysis of qualitative data involved writing site reports, developing theme tables, identifying practices of interest, and applying an algorithm to determine best practices. To ensure the accuracy of the data that were collected, site reports were verified by each site from which data were collected. Practice themes were then identified from the site reports. Next, potential best practices were identified from the theme tables through a consensus-building process between the CDC and MPR teams. The best practices algorithm (Figure 1) was then applied to each identified practice to assess whether it was a best practice. The application of this algorithm has been described in detail previously and can be viewed on the web http://www.cdc.gov/pcd/issues/2006/jan/05_0133.htm.

Figure 1
Algorithm for Determining Best Practices in Selected WISEWOMAN Programs



† If only one high- and one low-performing site stated practice, it is not a best practice because only 50% who stated practice were high-performing.

5. CAVEATS

To facilitate accurate interpretation of the practices described in this toolkit, we note several caveats about the methods used in the Best Practices Study.

First, only projects with sufficient data for local site analysis were included in the study. Thus, projects and local sites not included in the study might also have best practices. The WISEWOMAN Best Practices Study is ongoing and, if funding permits, additional case studies will be conducted to identify more best practices as data become available.

Second, high- and low-performing sites were selected based on an average composite score across the RE-AIM dimensions. A best practice related to a given RE-AIM dimension (e.g., Reach) could therefore be

identified from a high-performing site that had a mediocre score on the Reach dimension if its scores on other RE-AIM dimensions were high enough to counterbalance its Reach score.

Third, at least one high-performing site must have used a practice for the practice to be considered a best practice. It is possible that a low-performing site had a good practice, but unless high-performing sites also used the practice, it was not considered a best practice. Both high- and low-performing sites were selected so that differences in how sites used the same practice could be identified.

Fourth, we identify in the toolkit whether each practice is applicable to the project, local site, or both. In some cases, a practice might appear to apply to both the project and local site, but the description only highlights one of these levels. This reflects the methods used to collect and analyze data. A seemingly applicable practice might only have been identified at one of these levels during data collection, or it might have been identified at both levels but only met the criteria for best practice at one level.

Fifth, best practices are listed under only one dimension (the primary dimension to which they apply) for clarity and simplicity. Practices could, however, apply to more than one dimension. When this is the case, the secondary dimension is listed in parentheses after the practice name in the section entitled Details of Practices from Selected WISEWOMAN Projects.

Sixth, some of the participating projects have undergone significant transition during their period of funding, including a transition from enhanced to standard project. This transition could have had an impact on the way services are delivered. For example, during the enhanced project phase, women might have received a more intensive lifestyle intervention than during the period of standard operation.

Finally, activities and examples described for some best practices were made possible through additional resources that the project or local site obtained from agencies other than CDC. These additional resources allowed sites to supplement traditional WISEWOMAN activities and provide incentives or services not covered by CDC funding. For instance, local sites might pay for a participant's family members to attend events such as weekly swimming nights using non-CDC funds.