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Workplace learning for the public good

Implementation of a standardized, competency-based curriculum in Texas WIC

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Abstract

Purpose – The purpose of this study is to describe preceptors’ implementation experiences after implementing a workplace learning program in Texas WIC (women, infant, and children) agencies and identify implementation best practices.

Design/methodology/approach – This research used qualitative description methodology. Data collection consisted of 11 semi-structured interviews lasting approximately one hour with all preceptors who piloted a workplace learning program in five Texas local agencies to examine barriers, facilitating factors, best practices, and the workplace learning program’s impact.

Findings – This research identified several workplace learning implementation best practices, including the importance of planning at multiple organizational levels, candidate selection, flexible implementation design, managerial buy-in, preceptor knowledge and availability, open communication, and the establishment of clear expectations and timelines.

Originality/value – Examining implementation of a workplace learning program across a multi-level public health service organization using a multi-theoretical approach contributes to the existing workplace learning literature. Recommendations regarding implementation best practices are discussed.

Keywords Workplace learning, WIC, Implementation procedures, Qualitative description, Women, Children, Government agencies

Paper type Research paper

1. Introduction

During 2008, the Texas Department of State Health Services (DSHS) identified a need for standardized, competency-based training designed specifically for Women, Infants...
and Children (WIC) employees. WIC is a multifaceted nutrition program designed to assist low-income pregnant women, new mothers and young children through nutrition education, counseling and access to nutritious food and health care (Texas Department of State Health Services, 2010). Texas WIC is a federally funded, state administered public service program that is comprised of more than 70 local agencies, including governmental and non-profit organizations, controlling more than 545 clinics. Each agency and clinic operates somewhat differently to meet their contextual and client-based demands. State level decisions are passed directly to the local agencies that in turn relay them to the clinics. However, decision incorporation and implementation varies as a result of clinic level factors (e.g. operating structures, human capital, environmental constraints).

To train clerical staff as paraprofessional nutrition support staff, a University of Texas research team collaborated with DSHS to develop and implement a workplace learning project, the WIC Certification Specialist (WCS) Training Program. While the WCS position varies somewhat across local agencies, in general it requires an enhanced skill set (e.g. completing WIC certifications, counseling low risk participants and collecting anthropometric and biochemical data) that non-clinical WIC employees, such as clerks, are not expected to possess. The purpose of this research is to present all preceptors’ \( N = 11 \) implementation experiences. Although centered on the same training program, preceptors’ experiences varied due to each agency’s local variations, but produced consistent themes concerning best implementation practices during each implementation phase (prior, during, and after). These findings have relevance for organizations that implement workplace learning programs across diverse departments and geographic settings. Workplaces have expanded across traditional vocational and geographical boundaries, making development of educational and training programs that present consistent lessons and standardize occupational-relevant knowledge and procedures essential.

The WCS Training Program is intended to replace current locally-developed WCS training programs with standardized, state-approved competency-based materials. Previous WCS training material was not consistent across the state, and in some cases was outdated, contained inconsistent information and did not cover all the necessary training information. Overall, the certification of WCSs is designed to enhance clinic flow and efficiency and to improve clinical, office and customer service skills, as well as to bolster WIC paraprofessional employees’ problem solving and critical thinking abilities.

The WCS Training Program consists of 12 preceptor-administered self-paced modules. Preceptors are responsible for administering the training, testing and observing the candidates (i.e. the WIC employees undertaking the training), as well as assisting (i.e. answering questions and making themselves available for clarifications) the candidates throughout the training. The curriculum provides candidates the opportunity to build and enhance skills in rapport building, effective communication, anthropometric and biochemical data collection, classroom teaching strategies and best practices, ethics and professionalism. A number of learning tools matched to objective type and level, such as case studies, videos, hands-on activities, self-checks and module reviews, are used throughout the modules. To receive credit and advance to the next phase candidates must first pass a comprehensive exam, covering several modules, with a minimum grade of 80 percent and successfully demonstrate competency-based skills. The 12 modules are divided into four phases.
The WCS Training Program addresses the persistent gap between formal education and required vocational (e.g. clinical) skills (Kolb, 1984; Anderle, 2008) and provides clerical employees basic education through supervised, self-paced workplace education and competency-based certification. This research project, while acknowledging the importance, relevance and impact of workplace learning program design and development at the state level, is primarily concerned with program implementation at the agency level. Specifically, this paper examines the preceptors’ implementation experiences and their perceptions of implementation barriers and facilitators, best practices, and the training’s impact on the workplace environment. To achieve these goals, a multi-method qualitative descriptive study (Sandelowski, 2000; Miles and Huberman, 1994; Bernard and Ryan, 2010) was designed to examine preceptors’ experiences concerning workplace learning implementation and best practices.

While extensive work has been done to evaluate and define workplace learning in various settings (c.f. Malloch et al., 2011), public institutions, including public health institutions, have received less attention. These organizations are vital community assets that are being forced to meet a larger, more diverse (e.g. age, ethnicity, socioeconomic status) population’s demands on more stringent budgets. Such demands and budgetary restrictions are prompting governmental policymakers to call for more responsive and cost effective public institutions, often incorporating workplace learning programs. However, implementing workplace learning programs in public institutions, in particular WIC, has not received significant attention. As noted by Newes-Adeyi et al. (2004), WIC continues to be an understudied context. Further, little research examining workplace learning programs for non-physician health providers currently exist. This research addresses both concerns.

2. Literature review

According to Matthews (1999, pp. 19-20), workplace learning focuses on both individuals and organizations:

[... workplace learning involves the process of reasoned learning towards desirable outcomes for the individual and the organization. These outcomes should foster the sustained development of both the individual and the organization, within the present and future context of organizational goals and individual career development.

The workplace learning described in this paper aligns with two of Hodkinson and Hodkinson’s (2004) six types: planned learning which others know and planned/intended learning to refine existing capability. Workplace learning requires the integration of multiple theoretical approaches, since it is a multifaceted, complex phenomenon (Matthews, 1999; Marsick, 1987; Hodkinson and Hodkinson, 2004; Rylatt, 1994).

Social cognitive theory was used throughout the workplace learning program’s curriculum development and implementation processes. It was important to acknowledge each agency’s specific social and professional context when designing and implementing the training program, since these factors directly influence the implementation processes. Diffusion theory (Ryan, 1942; Wejnert, 2002; Rogers, 2003) was primarily utilized to inform the adoption and implementation processes across a complex organization. Complexity theory, as a holistic approach, can address multifaceted processes with interactions on multiple levels (i.e. state level and local agency level).
Diffusion theory was used to conceptualize the training program’s transition process from state level development into agency level implementation and to capture how information matriculates and “creeps” (Weiss, 1980). Following Rogers’ (2003) lead, diffusion theory was used as a meta-theory that incorporated several theoretical perspectives related to the overall concept of diffusion. Diffusion theory describes a process by which members of certain community (i.e. WIC agencies) adopt innovation (i.e. the workplace learning program) (Yates, 2001). Diverse disciplines, ranging from agriculture to marketing, have used diffusion theory to increase the adoption and implementation of innovative products and ideas (Surry and Farquhar, 1997). Specifically, four factors influencing the diffusion process were considered before implementing the program (Rogers, 2003):

1. the innovation itself;
2. the communication channels used to spread information about the innovation;
3. time; and
4. the nature of the Texas WIC community.

While the authors recognize the importance of program adoption and maintenance (Glasgow et al., 1999), this paper is primarily concerned with program implementation. Organizational readiness for change, fit of the innovation to the organization, and employee acceptance of the innovation are key to implementation (Weiner et al., 2009; Rogers, 2003). Implementation policies and practices that influence the intervention’s assimilation into the organization (Weiner et al., 2009, p. 297) include:

- training and technical support, rewards or incentives, persuasive communications, end-user participation in decision making, workflow or workload changes, alterations in staffing levels or mix, new reporting relationships and/or documentation (e.g. correspondence such as faxes and emails with both preceptors and WCS candidates during the program), monitoring or enforcement policies/procedures.

Complexity theory is particularly useful when evaluating workplace learning program implementation processes as it allows researchers to comprehend and account for complex interactions and multiple effects within nested systems. Texas WIC can be thought of as a multi-layered system composed of several interacting levels, including the United States federal government, Texas state government, Texas state agency (DSHS), local WIC agencies and local WIC clinics. These interact with each other to create, implement and regulate actions and decisions. Local WIC clinics are the lowest organizational level nested within the overall WIC system.

Concepts from complexity theory, which are often applied to nested systems, can facilitate workplace learning implementation evaluation in multifaceted organizations. Structural determination refers to the constraints on elements within a system from the system as a whole, so a system’s present state influences its near future state. However, the system is coupled to its environment, allowing for the influence of one system upon another (structural coupling) (Keshavarz et al., 2010; Kremser, 2011). Complexity theory allows the researchers to acknowledge and account for the roles and interactions among organizational and environmental agents, recognizing how their prior interaction patterns impact information diffusion, implementation and the training program’s success (Anderson, 1999).
Using the lens of complexity theory, WIC clinics can be thought of as “social complex adaptive systems” (Keshavarz, 2010). The interactions among the system’s parts define the system as much as the individual parts, reinforcing the notion that complex systems cannot simply be thought of as the sum of its individual parts (Cilliers, 1998; Kremser, 2011). As a result, the researchers endeavored to understand the context of the training (i.e. the complex system), the implementation process and the effects of the system on the implementation process. Finally, the researchers assume that program implementation is directly related to candidate success and that workplace learning is more effective if programs are implemented in a strategic, workplace-appropriate manner. This research aims to contribute to the understanding of factors involved in effective implementation of a training program in a multi-level human services agency context.

Research question and purpose
The primary research question shaping this research was, “What organizational elements impacted the implementation process, and ultimately workplace learning?” The term, “organizational elements,” while somewhat vague, was used in an attempt to elicit responses about the impacts of state level decisions and agency level changes. This research question had two purposes:

(1) to contribute to the understanding of the workplace learning program implementation process; and
(2) to highlight the need to understand the system and interplay among the systems levels.

To focus this work and relate the research questions to the WCS Training Program and workplace learning within WIC, five secondary questions helped direct this research. These included:

(1) Describe your WCS Training Program implementation experience.
(2) Describe the implementation obstacles and facilitators that emerged throughout the program implementation?
(3) What impacts did the training have on co-workers and employee-participant relations?
(4) What impacts did the training have on the clinic work environment?
(5) How has the WCS training program personally and professionally affected training graduates?

3. Methodology
Sample and procedure
This research reports the findings from semi-structured interviews of all 11 preceptors in five separate agencies regarding the implementation process. Interviewees agreed to an after-implementation interview, when they voluntarily opted to undertake the workplace learning program. Interviews were conducted in three ways:

(1) face-to-face at the preceptors’ clinics (n = 3);
(2) face-to-face at a neutral/convenient location (n = 1); and
(3) by telephone (n = 7).
These semi-structured interviews, which ranged from 45 to 90 minutes, were conducted within six months of program completion.

The preceptors oversaw and administered the workplace learning program, including WCSs interactions with others, changes within the work environment, and changes among various aspects of program implementation. In many cases the preceptors currently work with the new WCSs on a day-to-day basis. Prior to conducting the preceptor interviews, researchers conducted face-to-face interviews, phone interviews, clinic visits, conference calls and written WCS Training Program field testing. These findings informed the preceptor interview protocol. Having these previous data allowed the researchers to determine when an account differed from what had been reported or observed earlier or when further clarification was beneficial.

Method
Qualitative description (Miles and Huberman, 1994; Bernard and Ryan, 2010) was used in this study. Sullivan-Bolyai et al. (2005), referencing Sandelowski (2000, p. 128), defined qualitative description as “a distinct method of naturalistic inquiry that uses low inference interpretation to present the facts using everyday language. The goal of qualitative descriptions is descriptive and interpretive validity”. Qualitative description endeavors to present the how, what, when and where (i.e. the facts) with little to no why (i.e. interpretation). Although qualitative description is a distinct methodology, it shares several features with other qualitative approaches. Sullivan-Bolyai et al. (2005) outline three major shared tenets of qualitative description:

1. seeks to understand complex experiences that are embedded in the human context;
2. uses data from multiple sources to describe the experience from the viewpoint of the person in the midst of the experience; and
3. incorporates basic strategies that are common to qualitative analysis.

The authors reviewed each of the 11 taped interviews and their respective verbatim transcripts. During analysis, each author used NVivo 9 qualitative software to code interviews, ensure inter-rater reliability, identify common themes, evaluate similarities and discrepancies, and develop relevant generalizations (c.f. Miles and Huberman, 1994). At the beginning, the authors coded the data into a multitude of categories and, subsequently, these categories were organized into patterns and themes (Creswell, 2003). To reduce bias and establish consistent themes (Saldana, 2009; Bernard and Ryan, 2010), the authors developed a codebook and performed first and second order coding on the data. Further, to ensure a high level of inter-rater reliability a third researcher served as an inquiry auditor (Lincoln and Guba, 1985). As a result of achieving a high level of inter-rater reliability and the continued occurrence of consistent themes, saturation was reached.

This research is grounded in post-positivism as it allows researchers to treat multiple versions of “the truth” as equitable. Researchers are able to entertain, present and investigate various versions of the truth in attempts to generate generalizable and transferable results. Understanding that an individual’s version of the truth impacts other facets of their life is critical to understanding social and organizational phenomena (Guba and Lincoln, 1994; Bailey, 1997).
Several steps were taken to ensure trustworthiness, because “every research study must be evaluated in relation to the procedures used to generate findings” (Graneheim and Lundman, 2004, p. 109). Qualitative research’s trustworthiness has been related to the intertwined concepts of credibility, dependability and transferability (Guba, 1981; Polit and Hungler, 1999; Berg and Welander Hansson, 2000).

Credibility was ensured through several means. First, a qualified research team reviewed and refined the interview protocol. Credibility was also enhanced through the coding process. Multiple researchers developed a codebook, decided on appropriate units of analysis and compared coding. Woods and Catanzaro (1988) sum up the goal of this process, stating that the purpose here is not to simply verify that data are labeled and sorted in exactly the same way, but to determine whether various researchers and experts would agree with the way those data were labeled and sorted.

Dependability was ensured through collecting the data from each preceptor within six months of program completion. This protects against the data changing over time and preceptors forgetting or misremembering and ultimately skewing the results. As more and more interviews are conducted over time, dependability becomes more of an issue (Lincoln and Guba, 1985). To help alleviate this concern the researchers followed a similar interview procedure (the content will be interviewee-dependent) and probed inconsistencies across interviews. The final aspect of trustworthiness is transferability, which refers to “the extent to which the findings can be transferred to other settings and groups” (Polit and Hungler, 1999, p. 717). These results should be directly transferrable to other Texas WIC agencies interested in implementing the WCS Training Program, as the agencies have comparable missions and resources. However, beyond that, the transferability will decrease, as agency characteristics become more distinct and powerful. However, this study’s findings have relevance to other public or state-based organizations that are implementing workplace learning programs.

4. Results
This study provided insights into the implementation process and showed support for continuing to examine training implementation from a complexity science perspective. All 11 preceptor interviews can be classified as extremely positive with interviewees praising the training materials’ depth, presentation, cognizance of different learning styles and the materials’ overall improvement compared to the previous non-standardized WCS materials (if any existed). Overall, the training materials were well received, and the preceptors found the training “well worth it.” One stated, “I really like the structure of the WCS training and how all of them (WCS candidates) have the same materials, all the same resources.”

Some statements provided overall impressions of the training program, but the majority of data can be divided into three chronologically overlapping categories: prior to starting the workplace training, during the workplace training and after the training. In addition, evidence supporting the use of complexity science as an interpretive lens is presented, especially relating to the presence of multiple organizational levels. This serves to remind the reader that findings within the three categories have to be considered as the incomplete parts of a system’s whole. Even though these findings present implementation barriers and best practices from individual perspectives, these practices are within a larger organizational system that can hamper and facilitate their success.
Complexity science support
During 2008, Texas State WIC decided to standardize the Texas WCS training and contracted a University of Texas research team to develop and implement this training. The state’s decision to update and standardize local agencies’ individual WCS trainings provides evidence for the existence of structural coupling (i.e. ongoing engagement between systems, resulting in structural change in each (Maturana and Varela, 1987). These changes were reflected in how WCSs would be trained, how the state would eventually administer and regulate WCS trainings and the new roles WCSs would play in TX WIC clinics. Structural coupling posits that systems relate to and influence other systems in their environment, but how systems react to this influence and their subsequent decisions are still more dependent on the composition of the system than on the environment (Luhmann, 1995). The state’s decisions regarding what the materials would cover and the implementation procedures demonstrates support for structural determination (i.e. the behavior and interactions of other system elements simultaneously constrain and expand possible actions (Maturana and Varela, 1987). This lends further support to Cilliers’ (1998) notion that system elements cannot determine everything and eventual system decisions, at any level, are highly dependent on the system itself.

These processes occurred at both the agency and clinic level with structural coupling occurring primarily prior to implementation, and structural determination during the second and third chronological phases. The interviewees said that changes at the state level impacted how they planned to implement their WCS trainings, and that these changes needed to be reviewed before implementation:

Yeah, that’s what I’m talking about, the state changes ... I mean I really have to stop and think, wait, we changed that already? We have to double check the policy and double check my forms. So much going on.

Another interviewee noted the state’s need to acknowledge individual agency’s structurally determined characteristics and incorporate flexibility into training designs and implementation guidelines:

I know it’s different from agency to agency. Like some agencies that have a lot of clinics that are spread far apart from each other are going to have to do things differently than what we do. I guess flexibility from the state’s standpoint is a key factor in letting agencies fit it into their operation the way it works for them the best.

At some point in every interview, the interviewees commented upon or referred to planning and operations at the clinic, agency and state levels, and how changes at one level can impact the other level. It was clear that the preceptors viewed the system as a whole, while simultaneously understanding the competing and complementary processes occurring and interacting at different levels. These findings support the use of complexity science when implementing and evaluating workplace training at WIC:

While the state’s having to make their decision, I’m having to get everyone’s agendas and make sure that everybody’s in the same boat and make sure this suits where we’re going, what we’re doing and what pay grade is it going to be and where are we going to stand. This is all through my agency, it has nothing to do with WIC. It has everything to do with my agency. As far as (state) WIC I’m not real sure. I think probably at some point they will have some policies that are more clear.
Phase 1: prior to implementation

The interviewees perceived a number of implementation barriers prior to the start of training. These barriers ranged from the logistical (e.g. training candidates at multiple sites) to the procedural (e.g. how to cover the candidates’ duties while training) to the informational (e.g. uncertainty about the training materials’ topics and their depth). A number of the interviewees talked about not receiving the state WCS training materials in time to review them before implementing the training. Not having the materials hampered the local agency directors’ ability to plan for the upcoming implementation process and created ambiguity about the state’s expectations as well as the training program’s structure and content.

Scheduling and allocating time for the candidates to study, complete assignments, take exams and complete competency-based observations, while covering clinic operations, was an initial concern for many agencies. The preceptors highlighted the importance of pre-planning, candidate selection and allocating time (a set schedule) for WCS training as a way to overcome uncertainty and ensure clinic coverage.

Pre-planning. All 11 interviewees noted the importance of pre-planning. This included setting clear expectations and timelines to creating flexible schedules that would allow WCS candidates time to study, observe and take exams during business hours. It also meant creating a conducive training environment both in terms of physical space and co-worker interactions. For example, several interviewees commented upon making all staff aware of the training process and its impacts (e.g. covering WCS candidate’s job duties during training activities), and setting aside physical space:

I would consider the pre-planning to be very important. Expectations of the outcome to be very clear to the WCSs and to the other staff– what’s going to happen and what’s going to change in the clinic.

We’ve always had a problem having enough people to certify clients. And I think all the staff thought this [the training program] was a solution to the problem and they were positive about it.

One critical pre-planning activity was allotting time for training activities. Interviewees emphasized allocating time to perform training activities during the workday, as candidates were not allowed to take the study materials home. One exemplar local agency designated the first hour of each workday to training activities including bringing all the candidates together as a group to share their experiences, opinions, questions and concerns

As far as best practices I would definitely say allowing the staff a time that’s set aside on whatever determined schedule . . . definitely the staff needs a designated time to study.

We allotted an hour before the day began, for them to do their reading and their assignments and if they needed any help . . . but again, we plan ahead . . . I think the need to really plan to implement is something I personally bought into and believed in and we just made it work.

Candidate selection. Interviewees identified several characteristics they looked for when selecting potential training candidates. These included some education beyond high school, clinic experience, health knowledge, customer service skills, and leadership abilities:
The staff I selected were already kind of in those roles [in the clinic]... The staff you want to be a WCS, they’re already leaders.

There’s just a difference between someone that has just a little bit of college and someone that has 20, 30 hours of college coursework. I just think they were able to comprehend things a lot more quickly and are more responsible and more professional.

**Phase 2: during implementation**

Interviewees overwhelmingly classified their training experience as positive; however they identified several internal and external implementation barriers that are discussed below. The mere presence of barriers illustrates limitations of pre-planning, i.e. it cannot eliminate all potential pitfalls. Therefore, while pre-planning is considered a best practice, it cannot effectively minimize all barriers. Thus, providing support to the idea of conceptualizing pre-planning as a reflective process that should incorporate prior knowledge and lessons from previous trainings. Interviewees indicated adjusting future plans to account for the following barriers.

**Internal barriers.** Internal barriers consisted of obstacles within the clinic setting and standard operating procedures. The clinics had more control of these factors and could often take direct action to overcome them. These barriers include staff attendance, candidates feeling guilty about taking time to perform training activities, training becoming less of a priority, and preceptors’ lack of time to conduct observations:

I also think at certain clinics that the WCS feels guilty for leaving her customer service representative duties to go and help the nutritionist because everyone is kind of like drowning in whatever’s going on. So you know she feels guilty leaving the front to go help in the back.

We’re getting pushed to finish, but we kept, you know, we kept getting interruptions. I’m trying to remember if anything else specific happened as far as somebody being out and us having to cover. Because it never fails when you have somebody on vacation and somebody gets sick, you don’t have coverage.

**External barriers.** External barriers consisted of situations beyond the clinic’s control. These include obstacles such as an audit, remodeling, and personal issues such as sick children and family deaths. Clinic directors reported having little power to address these barriers, but highlighted the importance of incorporating flexibility into plans and program design.

**Implementation best practices.** While the preceptors’ solutions to barriers were clinic contingent, several consistent themes emerged. These themes came to be understood as additional implementation best practices, and preceptors indicated they would employ them in future trainings. In total, five “during implementation” best practices surfaced: open communication, preceptor knowledge and availability, setting clear expectations and schedules, top-down buy-in (the clinic directors and supervisors have to want and support the training) and maintaining timetables:

To make it very clear to the candidates that they’re (preceptors) going to help them. They’re there as a resource. They’re going to answer their questions, but also to instill in them that we have to take the training timeline seriously. That we need to keep on track and just to communicate regularly.

You just have to make it work. There’s nothing hard about that. Just plan ahead. You really need to buy into it. The admin[istration] needs to buy into it. If you don’t buy into it or criticize
it before you put it to work then it’s not going to work for you, you know … Your director has to buy into it and support it and plan ahead of time with the clinic operations and supervisors and appointments. That’s it, that’s it.”

Overall, the interviewees were very positive when discussing the WCS Training Program’s implementation and impact. One, when talking about the implementation said, “as far as the implementation process I think it went real well because you all gave us the flexibility and let us fit it into whatever worked in our agency … and I know it’s different from agency to agency.”

**Phase 3: after implementation**

All interviewees considered the program to be worthwhile and provided evidence of workplace learning. They described a plethora of benefits and noted how they would improve future trainings. All interviewees stated they would continue to use the training program and hoped to train additional staff. Interviewees identified and described a wide range of benefits that positively impacted agencies, clinics, WCS candidates, WIC participants, and other staff members. Overall, two categories of benefits emerged: organizational and individual. All interviewees noted benefits in both categories, reflecting Kirkpatrick’s (1994) continuum of training, learning, behavior and organizational results.

**Organizational benefits.** Organizational benefits included improved clinic flow and efficiency, ability to better assist high-risk patients, improved staff morale, and ability to assist co-workers:

It [the WCS training] enables them to take on the lower risk clients and get them processed so the nutritionist has the time to deal with the higher risk clients. And the higher risk ones don’t seem to bog down the clinic quite as much as before. You know how it is, you get one of those high risk and they got a multitude of problems, taking twice or three times as long to take care of them and yet you’ve got five or six more clients waiting for you to see. Where now a WCS can circumvent that and start the process for the lower risk ones.

There are lots of positive changes at least for me anyway because again the clients aren’t waiting as long because I’m not short of a certifying staff that’s able to certify. With the WCS I have enough people available that I can make sure the clients are all going to be seen in a timely manner.

Attendance has improved. Two of the WCSs I was having problems with attendance with them before. Their attendance did improve. They’re not calling in near as much as they were before.

**Individual benefits.** Individual-level benefits included increased self-confidence, improved job attendance, increased personal and job-related knowledge (e.g. health and clinical skills), feeling like an essential part of the team (i.e. performing an essential function), improved status and, in one agency, increased pay:

They all seem very happy to come to work. It seems to me like they enjoy what they’re doing. They’re very willing to participate and being a team player and sometimes a leader in different things that we’re doing in the clinic.

Overall they’re happier because they still feel rewarded that they were able to become WCSs and have that opportunity to move up in the organization without having to go back to school, go back to college and take a lot of classes and things. It was an opportunity for them.
Suggested improvements

The interviewees noted areas to improve both the program and their implementation processes. They talked about the importance of program evaluation, how they can incorporate implementation best practices into future trainings, and, overall, the need to be reflective as well as innovative during future implementation processes. One preceptor discussed her plans for future trainings and the importance of adding a detailed program orientation for all staff.

5. Discussion

Inadequate program implementation has historically hampered initiative and program success (Nah et al., 2001; Russ-Eft, 2002; Fixsen et al., 2005; Hoeve and Nieuwenhuis, 2006). Deficient implementation can create a faulty foundation, which can obfuscate subsequent program aspects and workplace goals. This work considers several implementation criteria for successful workplace learning, such as appropriate leadership (i.e. role of the preceptor), the importance of accommodating workplace learning (i.e. planning), being conscious of workplace learning’s impact on all employees, and presenting clear expectations.

The findings point to the importance of creating and employing a flexible (Smith, 2003), yet chronologically bounded implementation process while incorporating best, albeit structurally determined, practices into the implementation process. The findings illustrate the benefits of presenting expectations, timetables and materials in a timely fashion and being sure they are clearly understood. In general, implementation processes must be dynamic, not stagnant, and continuously evaluated and adapted to reflect changing contexts.

While this research identifies several implementation best practices, it recognizes how social context (Brewer, 2000) can impact a workplace training intervention’s efficacy, the way a system and its levels deal with external factors, such as employee attendance, and ultimately how various levels consider and interpret the actions, decisions, and changes at other levels. However, one cannot guarantee how a system’s levels will act, because, regardless of the degree of structural coupling, these actions are inherently unpredictable. While organizational science and theories of organizational change (Heward et al., 2007) attempt to account, predict and control for unpredictability, it can never be fully eliminated (Bolman and Deal, 2008). Ideally, persons in charge of program implementation processes should be able to recognize and learn from unpredictable events. Moreover, the evaluation results suggest the importance of addressing the unpredictability inherent in complex organizational contexts, reinforcing the need for flexible implementation procedures.

In addition to identifying flexible implementation design as an important workplace learning component, this research identifies pre-planning, candidate selection, top-down managerial buy-in, open communication, preceptor knowledge and availability, establishment of clear expectations and timelines and the need to be cognizant of the impacts of decisions and policy changes at all relevant organizational levels. The WIC agencies in which these elements were apparent and consistent reported a more efficient and effective implementation experience. While this workplace learning was implemented in WIC clinics, it appears that these best practices would be transferable to other workplace settings, especially human service and public health organizations.
As workplace learning trends enter or reenter the professional domain (Abrams and Berg, 2010), they impact how stakeholders and organizations conceptualize and ultimately implement training programs. Future researchers should note how popular trends, regardless of whether they have been rigorously substantiated, constrain and broaden potential action, and how ultimately these trends can be thought of as another contextual level to consider when designing and implementing workplace training programs. The professional landscape is never stagnant and, to enhance program implementation success, implementers should endeavor to understand how shifting organizational and environmental trends could redefine “truths” about their workplace learning contexts. Future workplace learning program implementations cannot directly mirror previous implementations as an awareness of ever-changing attitudes and settings that constitute “the workplace” are needed. However, research such as this can act as a starting point as well as a reference guide to future implementation processes since the identified best practices have potential applicability to a variety of settings and situations. Future researchers and practitioners may apply the best practices most relevant to their implementation context, while being receptive to potential, yet undiscovered, complementary best practices. This will enhance implementation and ultimately workplace training program success.

Limitations
This research suffered from several limitations that impact the findings’ generalizability. The sample size was small ($N = 11$), even though all preceptors were interviewed. Further, the preceptors represented only one level of the organization, although they shared their perspectives regarding the experiences of individuals at other organizational levels. Considerable variation among local agencies was found within this small sample because WIC contracts with various non-profit and public agencies. The findings can most readily be generalized to the approximately 70 Texas WIC local agencies and 500 clinics. Future research should endeavor to address these issues.

References


Further reading

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