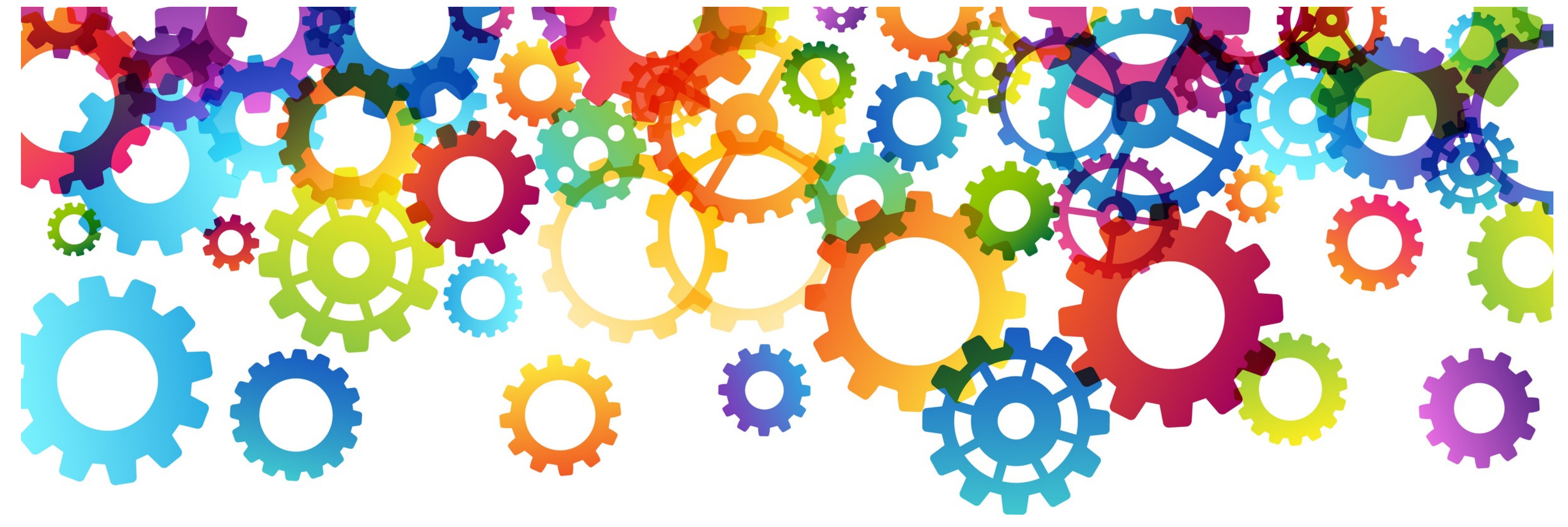
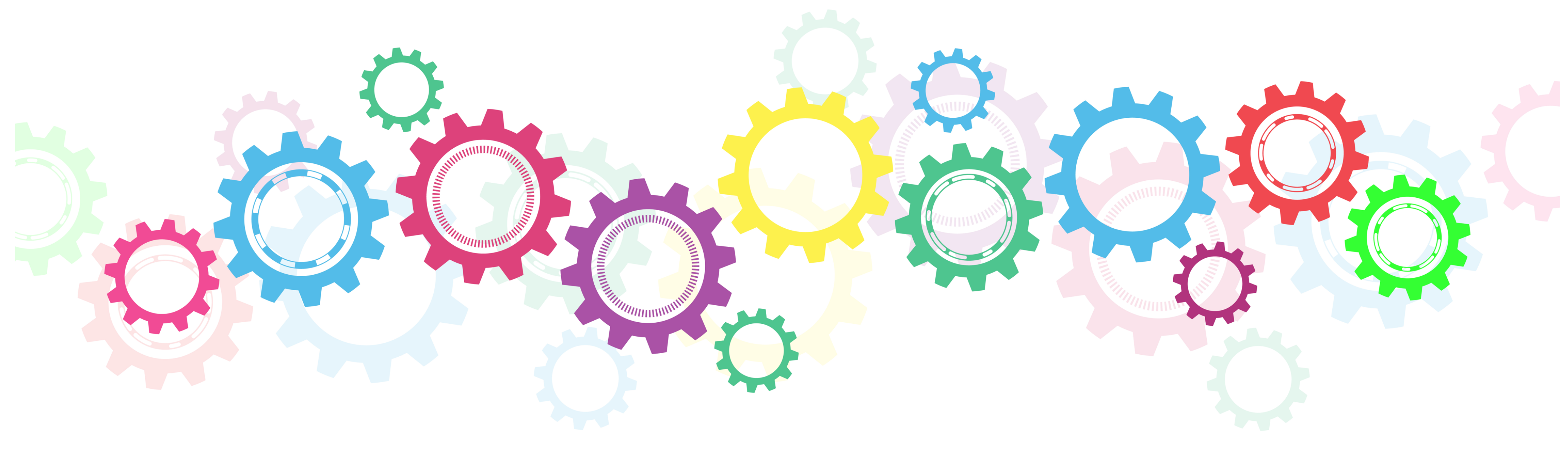


Understanding and Planning for the New Performance Measures:

Developing ESMs to Meet New Challenges



John Richards, Georgetown University

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC31613, MCH Advanced Education Policy, $3.5 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Learning Objectives

- Introduce the Evidence Accelerators and the RBA Planning Tool.
- Identify how MCH programs can utilize updated research and evidence to implement new programs that work in real life for real people.
- Increase a shared understanding of the technical assistance MCH programs will need to implement the strategies moving forward.

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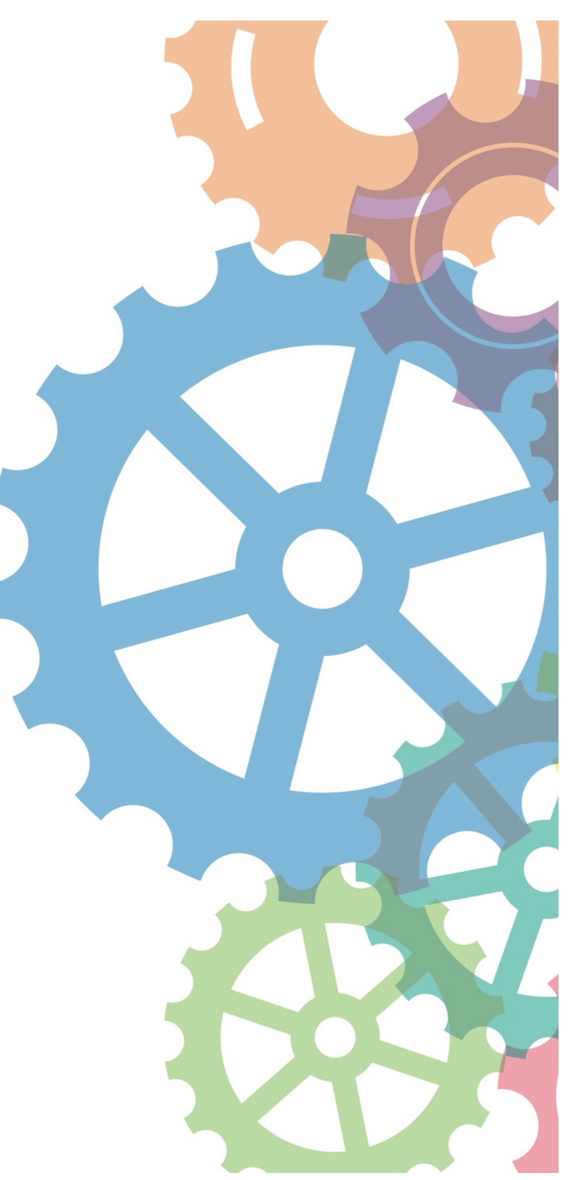
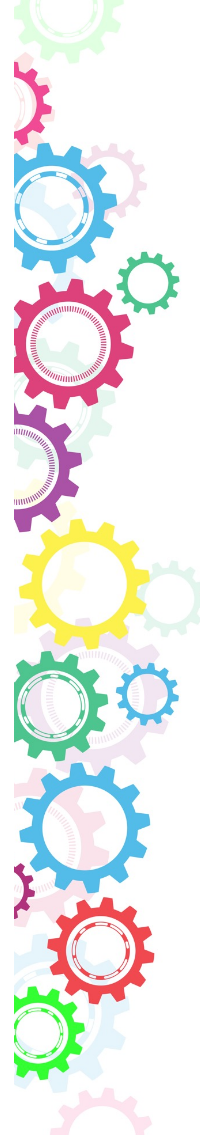
Agenda

- **Introduction: 25 minutes**
  - Welcome (5 minutes)
  - Overview (20 minutes)
    - NCEMCH Resources (1 minute)
    - New Measures and Evidence Accelerators (5 minutes)
    - RBA (10 minutes)
    - Questions about new measures and RBA (4 minutes)
- **Group Work: Digging into the Measures with the RBA Planning Tool: 50 minutes**
  - Goal and Graph: 10 minutes
  - RCA and Partners: 10 minutes
  - What Works: 10 minutes
  - Action Plan: 10 minutes
  - ESMs: 10 minutes
- **Group Discussion and Wrap Up: 15 minutes**
  - Questions and Discussion
  - Gallery Walk





National Center for Education in Maternal and Child Health
Georgetown University

mchevidence.org
mchlibrary.org
mchnavigator.org
mchneeds.net

MCH Evidence Center | MCH Navigator | National MCH Workforce Development Center | AMCHP | CityMatCH

MCH Needs Assessment Toolkit

HOME | FRAMEWORK AND TOOLS | STATE AND JURISDICTION LINKS

STEPS: 1 2 3 4 5 6 7 8 9

- Home
- Framework and Tools
- List of Tools by Step
- Step 1. Engage Partners
- Step 2. Assess Needs
- Step 3. Examine Strengths and Capacity
- Step 4. Select Priorities
- Step 5. Set Performance Objectives
- Step 6. Develop Action Plan
- Step 7. Seek and Allocate Resources
- Step 8. Monitor Progress for Impact on Outcomes
- Step 9. Report Back to Partners

MCH Needs Assessment Toolkit: MCHneeds.net

Five-Year Title V Needs Assessment. The challenges of the maternal and child health (MCH) system are complex. To create solutions to address these challenges it is important to understand the systems and the interrelated components of the system that shape health. The five-year needs assessment process allows state Title V programs to begin to understand the complexity of these challenges, identify needs, and select priority areas of focus.

To build upon the needs assessment process, the MCH Evidence Center and MCH Navigator, National MCH Workforce Development Center, the Association of Maternal and Child Health Programs, and CityMatCH developed this toolkit, **now in its second version**, to help Title V agencies use tools to dig deeper into the complex system surrounding the health of the MCH population.

MCH EVIDENCE | MCH NAVIGATOR | National MCH Workforce Development Center | AMCHP | citymatch

We Heard You

Title V Five-Year Needs Assessment Webinar Series. Please save the date!

MCHB's Division of State and Community Health (DSCH) along with our colleagues are hosting a **Title V Five-year Needs Assessment Webinar Series**. This series has been planned in response to feedback we received at the Title V Directors/Skills-building Session at the AMCHP 2024 Annual Conference. During that session attendees were asked status of their five-year needs assessment and what topics would be helpful to cover during a webinar series. The Title V Needs Assessment Webinar Series will follow the 9-Step Conceptual Framework and cover the topics shared by survey respondents.

Session I: Recording of *From Needs Assessment to State Action Plan: Translating Data to Action* (originally presented during the AMCHP 2024 Annual Conference). Viewing this recording will serve as Session I in this series and provides an overview of all 9 steps.

The New MCH Performance Measures

WOMEN/MATERNAL HEALTH	INFANT/PERINATAL HEALTH	CHILD HEALTH	ADOLESCENT HEALTH	CHILDREN WITH SPECIAL HEALTH CARE NEEDS

National Performance Measures (NPMs)

Women/Maternal Health

1 Postpartum Visit (Universal)

2 Preventive Dental Visit

3 Postpartum Mental Health Screening

4 Postpartum Contraception Use

5 Perinatal Care Discrimination

6 Housing Instability

Infant/Perinatal Health

7 Risk Appropriate Perinatal Care

8 Breastfeeding

9 Safe Sleep

Perinatal Care Discrimination

Housing Instability

Child Health

10 Medical Home (Universal)

- 11 Personal Doctor or Nurse
- 12 Usual Source of Sick Care
- 13 Family Centered Care
- 14 Referrals
- 15 Care Coordination

16 Childhood Vaccinations

17 Developmental Screening

Preventive Dental Visit

18 Physical Activity

19 Food Sufficiency

Housing Instability

Adolescent Health

20 Adolescent Well-Visit

21 Mental Health Treatment

22 Transition to Adult Health Care

23 Tobacco Use

24 Adult Mentor

25 Bullying

Children with Special Health Care Needs

Medical Home (Universal)

- Personal Doctor or Nurse
- Usual Source of Sick Care
- Family Centered Care
- Referrals
- Care Coordination

Transition to Adult Health Care

Bullying

KEY: DOMAINS OF ACTION

- CLINICAL HEALTH SYSTEMS
- HEALTH BEHAVIORS
- SOCIAL DETERMINANTS OF HEALTH

Standardized Measures (SMs)

26 Early Prenatal Care

27 Well-Woman Visit

28 Low-Risk Cesarean Delivery

29 Drinking During Pregnancy

30 Smoking: Pregnancy

MMR, Flu, HPV (Vaccinations)

31 Smoking: Household

32 Adolescent Physical Activity

Smoking: Household

MULTIPLE POPULATION DOMAINS

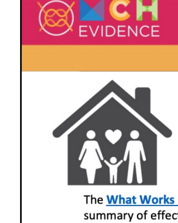
33 Uninsured

34 Adequate Insurance

35 Foregone Health Care

Accelerate with Evidence

MCH EVIDENCE | MEDICAL HOME | WHAT WORKS evidence accelerator



Medi
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States
childre
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The What Works Evidenc
summary of effective stra
sub-components: the per
a personal doctor or nurs
needed referrals; and rec

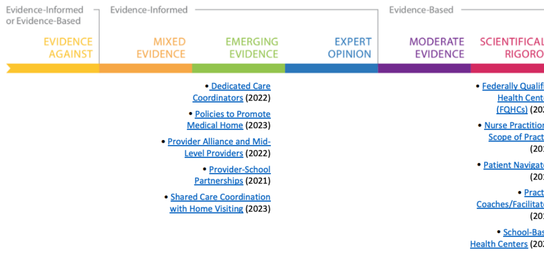
Overview. The America
(AAP) defines the medical
"approach to providing co
quality primary care."[1,2] S
children with and without
benefit from care consiste
pediatric medical home m
addressing preventive, ac
birth through transition to
facilitate an integrated he
interdisciplinary team of p
primary care physicians, s
health care facilities, and

The model helps connect
educational services, out-
support, and other public
services.[6] It recognizes the
child's life and emphasize
families and health care p
building or place, but an i
good care.[6] A medical hor
family-centered, continuo
coordinated, compassiona

Data. This NPM is measu
from the National Survey
In 2022, 39.5% of children
health care needs (CYSHC
46.7% of non-CYSHCN had
reported by their parent/
and non-CYSHCN, the rate
attainment was lowest an
Alaska Native, non-Hispan
37.1%), Hispanic children
non-Hispanic children (32

Medical Home Strategies. This page summarizes the latest strategies and practices that have emerged as potential approaches for increasing the percent of children with and without special health care needs, ages 0 through 17, who have a medical home. It provides a framework to identify, understand, and implement "what works" in creating new or strengthening current Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this NPM.

Evidence-Based/Informed Strategies. 10 strategies have emerged from studies in the scientific literature as being effective in advancing the NPM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center's MCHbest database.



Field-Based Practices. 22 practices from state-/community-based programs have emerged as potential approaches for advancing the NPM for specific communities or populations. They can be used as models to meet your program needs. More information can be found in the Association of Maternal and Child Health Program's (AMCHP's) Innovation Hub.

Cutting-Edge
- Cultural Brokering (Virginia)
- School Nurse Education (Missouri)
- Telehealth Lending Library (Utah)

Emerging
- Family-Centered Care Coordination (Virginia | Iowa)
- LEND Training (Tennessee)
- Medical Home for Foster Care (Florida)
- Primary Care Provider Training (Tennessee)
- Publicly Financed Palliative Care Model (Florida)
- Virtual Autism Diagnostic Clinic (Pennsylvania)

Promising
- Community-based Care Coordination (Oregon)
- County System Care Coordination (California)
- Integrated Mental Health Services (New York)
- Community Team (Pennsylvania)
- Statewide Leadership Initiative (Washington)
- Telehealth Autism Screening (Tennessee)
- Youth Advocacy (National | Wisconsin)

Best
- Culturally Competent Community Health Workers (South Carolina)
- Early Childhood Mental Health Care (Massachusetts)
- Family Connects Model (National)
- Family-Driven Systems Change (North Carolina)
- Teen Educator Program (Wisconsin)
- Telemedicine (New York)

Key Findings. The following are key findings emerging from the literature:

1. There is limited rigorous evidence about effective interventions to increase access to a medical home for children with and without special health care needs.[25]
2. The identified interventions for this NPM overall were focused on all children with no strategy specifically targeting CYSHCN.[25]
3. The studies identified partnerships and care coordination as mechanisms to improve access to care within the medical home model.[26]
4. Use of community collaborators, such as School-Based Health Centers (SBHCs) and outreach via community care coordinators, resulted in more children receiving care within the medical home model. More specifically, collaborations with SBHCs, home visiting programs, or use of enhanced care coordination in underserved, urban neighborhoods or with children in foster care led to positive outcomes. These impacts include increased contact with the medical home model for well-child visits, access to specialty care, better adherence with disease management, and dental care.[27]
5. A shift in policy was found to increase access to a medical home for children receiving Medicaid. Moving from a traditional fee-for-service model of health care financing and delivery to a primary care case management model by a Medicaid program resulted in more targeted identification and support for children and their families to enter into a medical home model of care.[28]

Discussion: Research, Practice, Partnership.

Research. Multiple strategies are emerging as potential approaches to advance this NPM, but they have not been studied with enough rigor to be included in the evidence-based continuum. Additional research is needed to verify outcomes, but initial studies have shown promise of these strategies in MCH settings:

- Developing robust, comprehensive telehealth coverage to expand the reach of the medical home, reduce inequities, and improve the health and well-being of children, particularly CYSHCN and children without access to high-quality care.[29]
- Offering innovative education and training, such as using a parent-led curriculum for interprofessional students to build the knowledge and skills necessary for establishing a medical home in the future.[30]

Practice. The following tools can be used to translate evidence to action to advance this NPM:

- Fostering Partnership and Teamwork in the Pediatric Medical Home (AAP). This video series shows pediatric practices how to build a stronger medical home through collaboration.
- The Medical Home Index: Pediatric (Center for Medical Home Improvement). This tool is designed to translate the broad indicators defining the medical home into observable, tangible behaviors and processes of care.

Partnership. The following organizations focus efforts on supporting the medical home model:

- AAP Medical Home Resources. Provides tools and resources to assist families, practices, and others with pediatric medical home implementation.
- Primary Care Collaborative. Focuses on advancing an effective health system built on a strong foundation of primary care and the medical home.

Frameworks and Tools for "What Works." Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- MCH Evidence Framework
- Blueprint for Change for CYSHCN
- Maternal Health Toolkit
- Life Course and Social Determinants Brief

Need More Help? Contact us for training and technical assistance customized to your needs.

Let's Talk Specifics…Medical Home: Overall

(10 strategies)

Level:

3 Individual/Family Focused

7 Community-Focused

- Dedicated Care Coordinators (2022)
- Policies to Promote Medical Home (2023)
- Provider Alliance and Mid-Level Providers (2022)
- Provider-School Partnerships (2021)
- Shared Care Coordination with Home Visiting (2023)

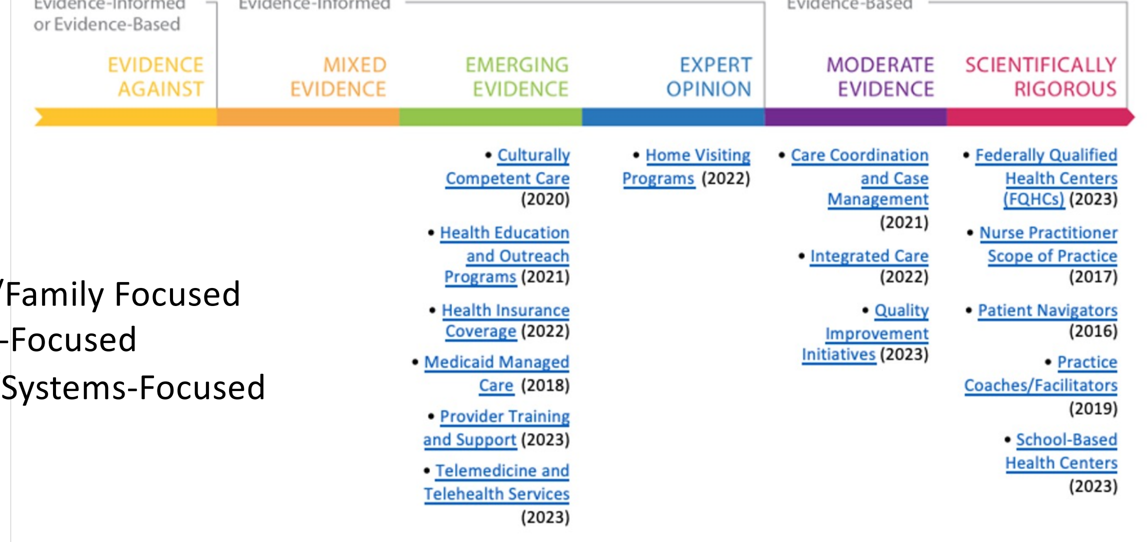
- Federally Qualified Health Centers (FQHCs) (2023)
- Nurse Practitioner Scope of Practice (2017)
- Patient Navigators (2016)
- Practice Coaches/Facilitators (2019)
- School-Based Health Centers (2023)

https://www.mchevidence.org/tools/accelerators/

https://www.mchevidence.org/tools/strategies/search/

Medical Home: Personal Doctor or Nurse

(15 strategies)

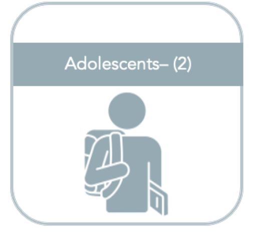


Level:

11 Individual/Family Focused

2 Community-Focused

2 Population/Systems-Focused



Plan Upstream:
Results-Based Accountability
Decision Making
Ends to Means
Accountability
Partnerships
Population & Performance
Impact
Common Language
Population Accountability: We SHARE responsibilty
Result
Children to live to their first birthday
Indicators
NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
NPM 5: Percent of infants placed to sleep on their backs
Performance Accountability: We OWN responsibility
Measures
1 – How much did we do?
# of hospitals that report having a safe sleep policy
2 – How well did we do it?
% of hospital systems partnered with Title V safe sleep initiatives
3 – Is anyone better off? (Quantity)
# of WIC and MIECHV clients who report an enhanced understanding of safe sleep practices following a structured counseling session
4 – Is anyone better off? (Quality)
% of staff in state Medical examiner's office who report an increased understanding in SIDS/SUIDS coding
% of infants placed to sleep on their back in Baby Friendly hospitals
Source: Equity & Results, Anti-Racist RBA Training, Spring 2023

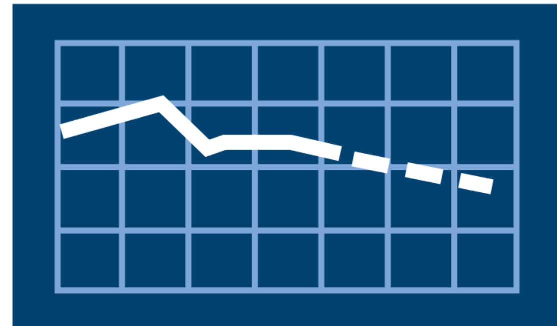
Results-Based Accountability

1 **What is the "end"?**

Choose either a result and indicator or a performance measure.

2 **How are we doing?**

Graph the historic baseline and forecast for the indicator or performance measure.



3 **What is the story behind the curve of the baseline?**

Briefly explain the story behind the baseline: the factors (positive and negative, internal and external) that are most strongly influencing the curve of the baseline.

4 **Who are partners who have a role to play in turning the curve?**

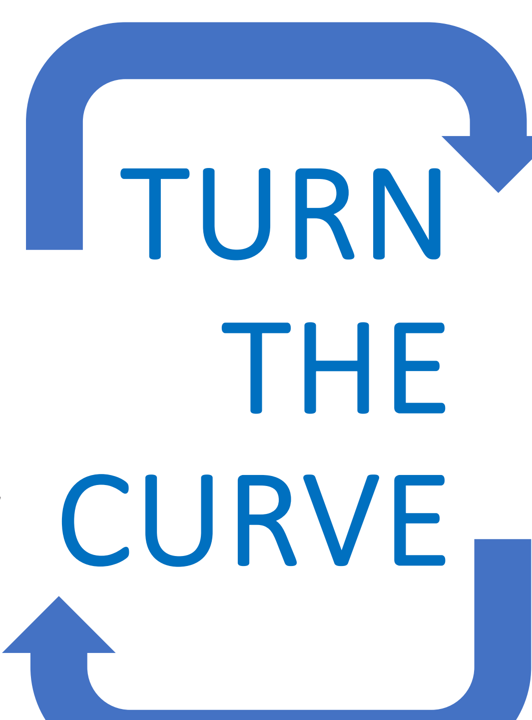
Identify partners who might have a role to play in turning the curve of the baseline.

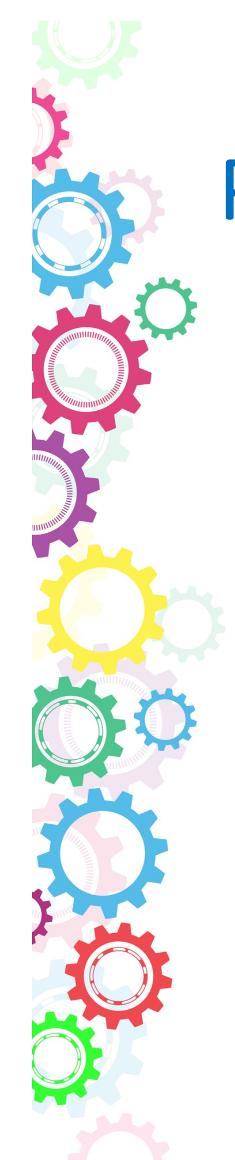
5 **What works to turn the curve?**

Determine what would work to turn the curve of the baseline.
Include no-cost/low-cost strategies.

6 **What do we propose to do to turn the curve?**

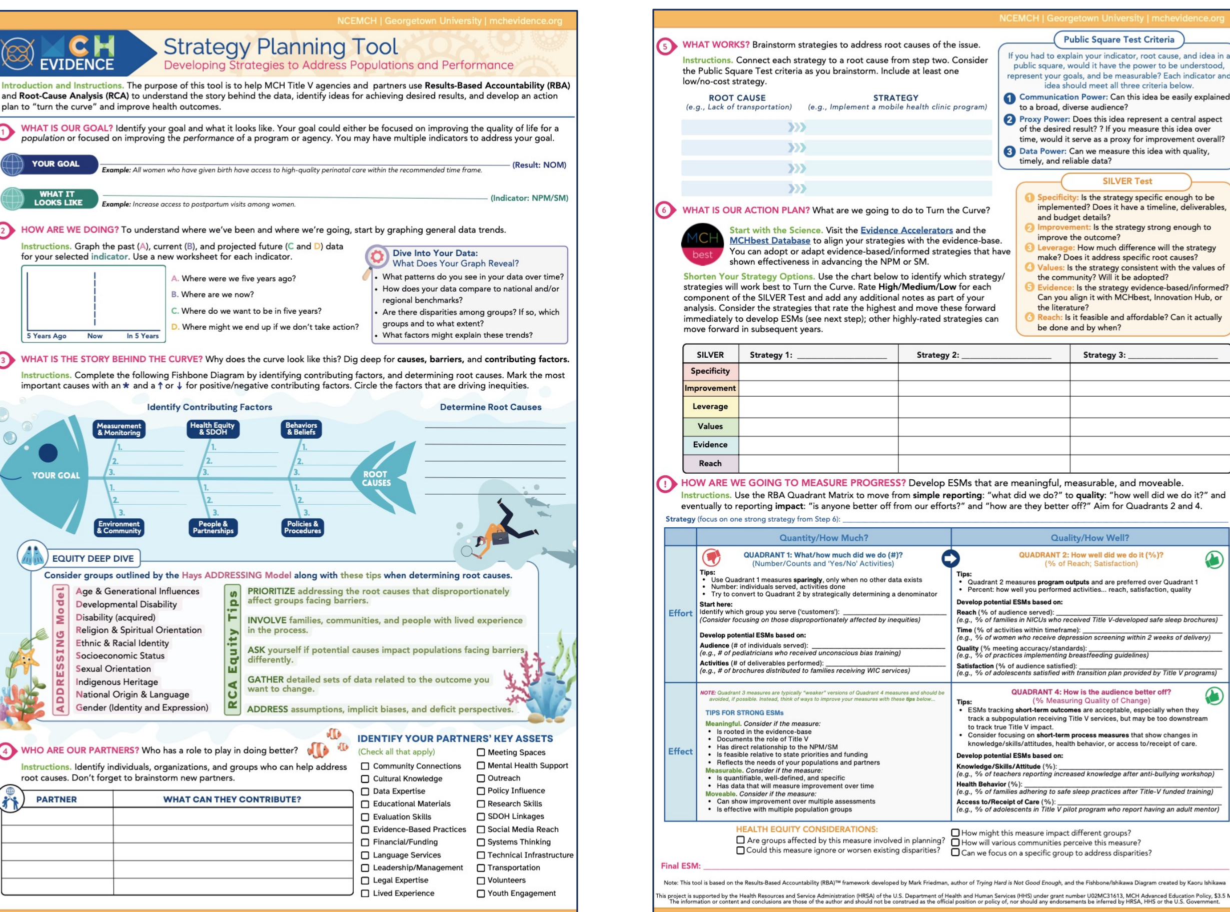
Determine what you and your partners propose to do to turn the curve of the baseline.





Pause, Breathe, and Questions

Group Work: Strategy Planning Tool



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MCH EVIDENCE

Strategy Planning Tool

Developing Strategies to Address Populations and Performance

Introduction and Instructions. The purpose of this tool is to help MCH Title V agencies and partners use **Results-Based Accountability (RBA)** and **Root-Cause Analysis (RCA)** to understand the story behind the data, identify ideas for achieving desired results, and develop an action plan to "turn the curve" and improve health outcomes.

1 WHAT IS OUR GOAL? Identify your goal and what it looks like. Your goal could either be focused on improving the quality of life for a *population* or focused on improving the *performance* of a program or agency. You may have multiple indicators to address your goal.

YOUR GOAL (Result: NOM)

Example: All women who have given birth have access to high-quality perinatal care within the recommended time frame.

WHAT IT LOOKS LIKE (Indicator: NPM/SM)

Example: Increase access to postpartum visits among women.

2 HOW ARE WE DOING? To understand where we've been and where we're going, start by graphing general data trends.

Instructions. Graph the past (A), current (B), and projected future (C and D) data for your selected indicator. Use a new worksheet for each indicator.

5 Years Ago | Now | In 5 Years

- A. Where were we five years ago?
- B. Where are we now?
- C. Where do we want to be in five years?
- D. Where might we end up if we don't take action?

Dive Into Your Data: What Does Your Graph Reveal?

- What patterns do you see in your data over time?
- How does your data compare to national and/or regional benchmarks?
- Are there disparities among groups? If so, which groups and to what extent?
- What factors might explain these trends?

3 WHAT IS THE STORY BEHIND THE CURVE? Why does the curve look like this? Dig deep for **causes, barriers,** and **contributing factors.**

Instructions. Complete the following Fishbone Diagram by identifying contributing factors, and determining root causes. Mark the most important causes with an ★ and a ↑ or ↓ for positive/negative contributing factors. Circle the factors that are driving inequities.

Identify Contributing Factors — Determine Root Causes

Measurement & Monitoring; Health Equity & SDOH; Behaviors & Beliefs; Environment & Community; People & Partnerships; Policies & Procedures; YOUR GOAL; ROOT CAUSES

EQUITY DEEP DIVE

Consider groups outlined by the Hays ADDRESSING Model along with these tips when determining root causes.

ADDRESSING Model: Age & Generational Influences; Developmental Disability; Disability (acquired); Religion & Spiritual Orientation; Ethnic & Racial Identity; Socioeconomic Status; Sexual Orientation; Indigenous Heritage; National Origin & Language; Gender (Identity and Expression)

RCA Equity Tips:
- PRIORITIZE addressing the root causes that disproportionately affect groups facing barriers.
- INVOLVE families, communities, and people with lived experience in the process.
- ASK yourself if potential causes impact populations facing barriers differently.
- GATHER detailed sets of data related to the outcome you want to change.
- ADDRESS assumptions, implicit biases, and deficit perspectives.

4 WHO ARE OUR PARTNERS? Who has a role to play in doing better?

Instructions. Identify individuals, organizations, and groups who can help address root causes. Don't forget to brainstorm new partners.

PARTNER	WHAT CAN THEY CONTRIBUTE?

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5 WHAT WORKS? Brainstorm strategies to address root causes of the issue.

Instructions. Connect each strategy to a root cause from step two. Consider the Public Square Test criteria as you brainstorm. Include at least one low/no-cost strategy.

ROOT CAUSE (e.g., Lack of transportation) — STRATEGY (e.g., Implement a mobile health clinic program)

Public Square Test Criteria

If you had to explain your indicator, root cause, and idea in a public square, would it have the power to be understood, represent your goals, and be measurable? Each indicator and idea should meet all three criteria below.

1. Communication Power: Can this idea be easily explained to a broad, diverse audience?
2. Proxy Power: Does this idea represent a central aspect of the desired result? If you measure this idea over time, would it serve as a proxy for improvement overall?
3. Data Power: Can we measure this idea with quality, timely, and reliable data?

6 WHAT IS OUR ACTION PLAN? What are we going to do to Turn the Curve?

Start with the Science. Visit the Evidence Accelerators and the MCHbest Database to align your strategies with the evidence-base. You can adopt or adapt evidence-based/informed strategies that have shown effectiveness in advancing the NPM or SM.

Shorten Your Strategy Options. Use the chart below to identify which strategy/strategies will work best to Turn the Curve. Rate High/Medium/Low for each component of the SILVER Test and add any additional notes as part of your analysis. Consider the strategies that rate the highest and move these forward immediately to develop ESMs (see next step); other highly-rated strategies can move forward in subsequent years.

SILVER Test

- Specificity: Is the strategy specific enough to be implemented? Does it have a timeline, deliverables, and budget details?
- Improvement: Is the strategy strong enough to improve the outcome?
- Leverage: How much difference will the strategy make? Does it address specific root causes?
- Values: Is the strategy consistent with the values of the community? Will it be adopted?
- Evidence: Is the strategy evidence-based/informed? Can you align it with MCHbest, Innovation Hub, or the literature?
- Reach: Is it feasible and affordable? Can it actually be done and by when?

SILVER	Strategy 1:	Strategy 2:	Strategy 3:
Specificity			
Improvement			
Leverage			
Values			
Evidence			
Reach			

7 HOW ARE WE GOING TO MEASURE PROGRESS? Develop ESMs that are meaningful, measurable, and moveable.

Instructions. Use the RBA Quadrant Matrix to move from **simple reporting**: "what did we do?" to **quality**: "how well did we do it?" and eventually to reporting **impact**: "is anyone better off from our efforts?" and "how are they better off?" Aim for Quadrants 2 and 4.

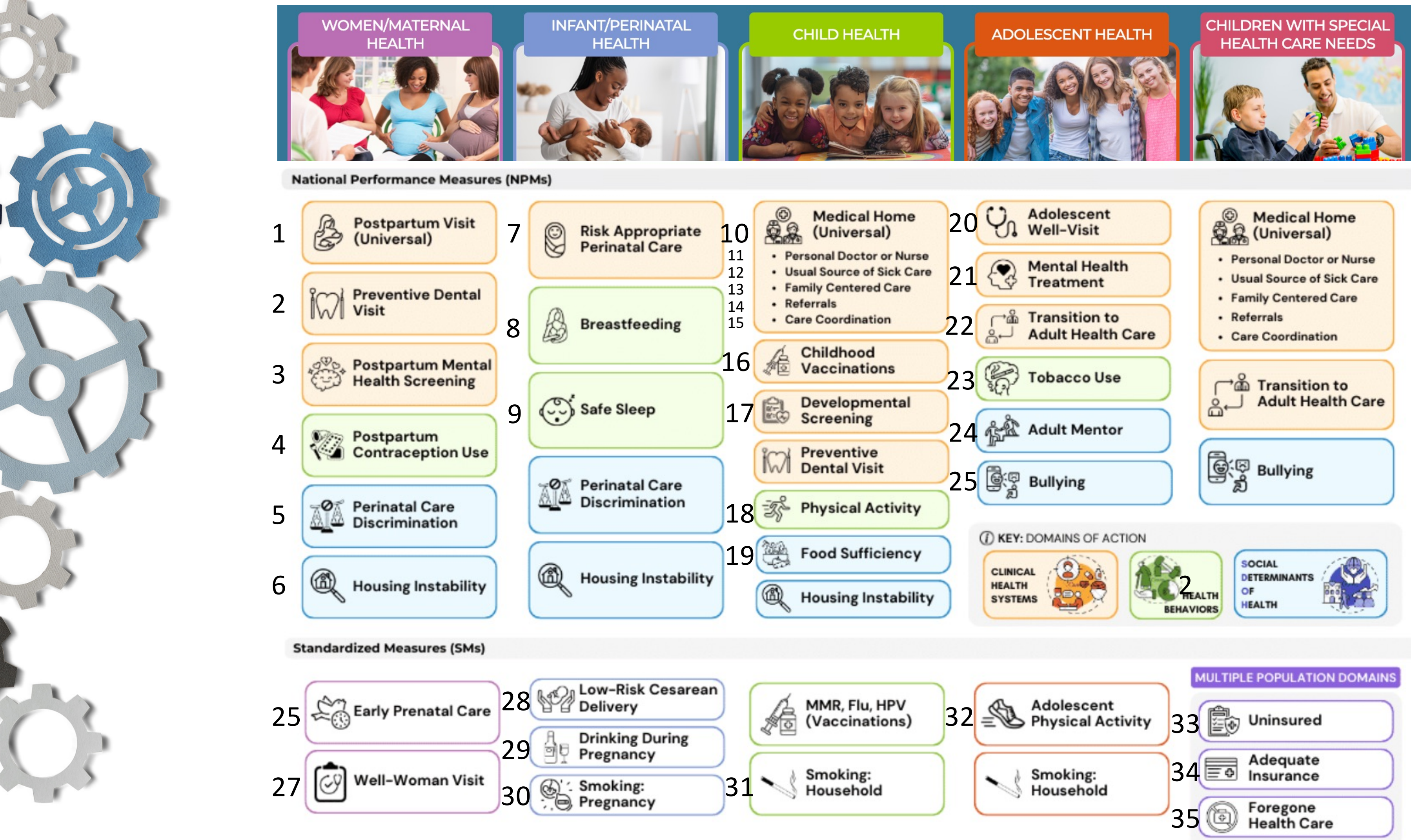
Strategy (focus on one strong strategy from Step 6):

	Quantity/How Much?	Quality/How Well?
Effort	QUADRANT 1: What/how much did we do (#)? (Number/Counts and 'Yes/No' Activities)	QUADRANT 2: How well did we do it (%)? (% of Reach; Satisfaction)
Effect	TIPS FOR STRONG ESMs	QUADRANT 4: How is the audience better off? (% Measuring Quality of Change)

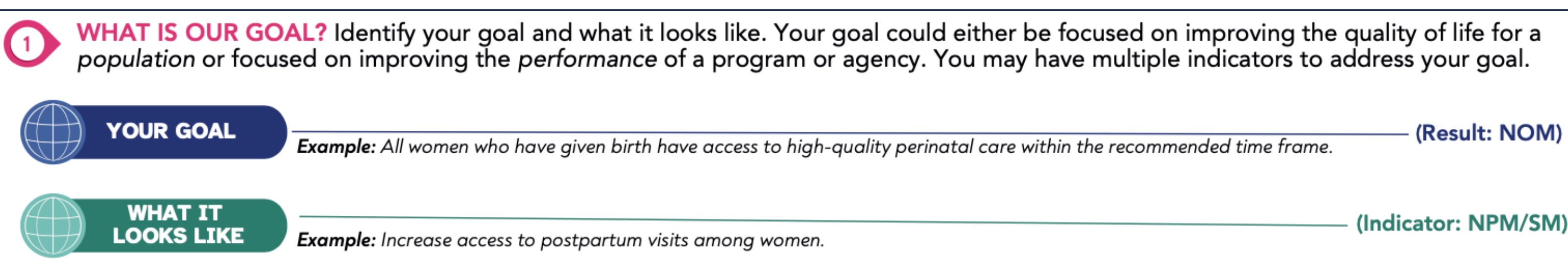
HEALTH EQUITY CONSIDERATIONS:
- Are groups affected by this measure involved in planning?
- Could this measure ignore or worsen existing disparities?
- How might this measure impact different groups?
- How will various communities perceive this measure?
- Can we focus on a specific group to address disparities?

Final ESM:

Remember These?!?



Steps 1 and 2: Goals and Data



2 **HOW ARE WE DOING?** To understand where we've been and where we're going, start by graphing general data trends.

Instructions. Graph the past (A), current (B), and projected future (C and D) data for your selected **indicator**. Use a new worksheet for each indicator.

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Dive Into Your Data:
What Does Your Graph Reveal?

- What patterns do you see in your data over time?
- How does your data compare to national and/or regional benchmarks?
- Are there disparities among groups? If so, which groups and to what extent?
- What factors might explain these trends?

Steps 3 and 4: Root Causes and Partners

3 **WHAT IS THE STORY BEHIND THE CURVE?** Why does the curve look like this? Dig deep for **causes, barriers,** and **contributing factors.**

Instructions. Complete the following Fishbone Diagram by identifying contributing factors, and determining root causes. Mark the most important causes with an * and a ↑ or ↓ for positive/negative contributing factors. Circle the factors that are driving inequities.

Identify Contributing Factors

Determine Root Causes

YOUR GOAL

Measurement & Monitoring
1.
2.
3.

Health Equity & SDOH
1.
2.
3.

Behaviors & Beliefs
1.
2.
3.

Environment & Community
1.
2.
3.

People & Partnerships
1.
2.
3.

Policies & Procedures
1.
2.
3.

ROOT CAUSES

EQUITY DEEP DIVE

Consider

ADDRESSING Model

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4 **WHO ARE OUR PARTNERS?** Who has a role to play in doing better?

Instructions. Identify individuals, organizations, and groups who can help address root causes. Don't forget to brainstorm new partners.

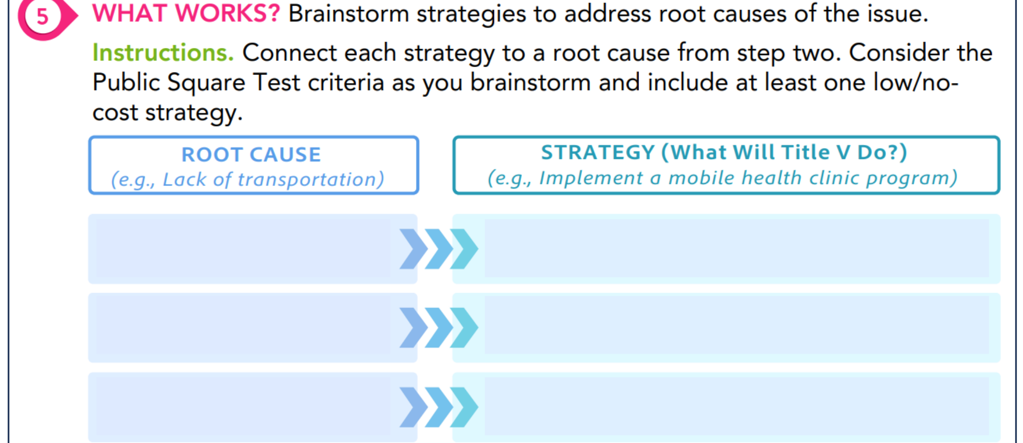
PARTNER	WHAT CAN THEY CONTRIBUTE?

IDENTIFY YOUR PARTNERS' KEY ASSETS

(Check all that apply)

- ☐ Community Connections
- ☐ Cultural Knowledge
- ☐ Data Expertise
- ☐ Educational Materials
- ☐ Evaluation Skills
- ☐ Evidence-Based Practices
- ☐ Financial/Funding
- ☐ Language Services
- ☐ Leadership/Management
- ☐ Legal Expertise
- ☐ Lived Experience
- ☐ Meeting Spaces
- ☐ Mental Health Support
- ☐ Outreach
- ☐ Policy Influence
- ☐ Research Skills
- ☐ SDOH Linkages
- ☐ Social Media Reach
- ☐ Systems Thinking
- ☐ Technical Infrastructure
- ☐ Transportation
- ☐ Volunteers
- ☐ Youth Engagement

Step 5: Brainstorming What Works



Public Square Test Criteria

If you had to explain your indicator, root cause, and idea in a public square, would it have the power to be understood, represent your goals, and be measurable? Each indicator and idea should meet all three criteria below.

1. **Communication Power:** Can this idea be easily explained to a broad, diverse audience?
2. **Proxy Power:** Does this idea represent a central aspect of the desired result? ? If you measure this idea over time, would it serve as a proxy for improvement overall?
3. **Data Power:** Can we measure this idea with quality, timely, and reliable data?

Step 6: Evidence-Based Strategies

WHAT IS OUR ACTION PLAN? What are we going to do to Turn the Curve?

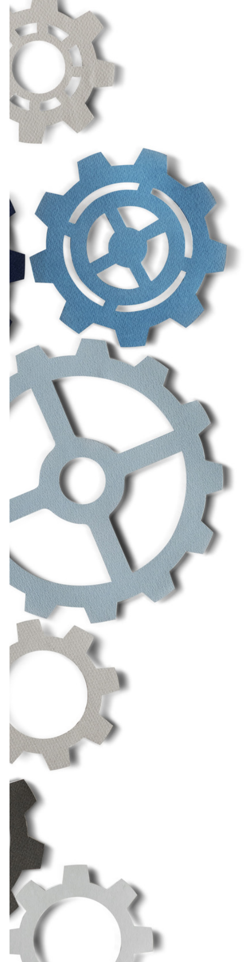
Start with the Science. Visit the Evidence Accelerators and the MCHbest Database to align your strategies with the evidence-base. You can adopt or adapt evidence-based/informed strategies that have shown effectiveness in advancing the NPM or SM.

Shorten Your Strategy Options. Use the chart below to identify which strategy/ strategies will work best to Turn the Curve. Rate **High/Medium/Low** for each component of the SILVER Test and add any additional notes as part of your analysis. Consider the strategies that rate the highest and move these forward immediately to develop ESMs (see next step); other highly-rated strategies can move forward in subsequent years.

SILVER Test

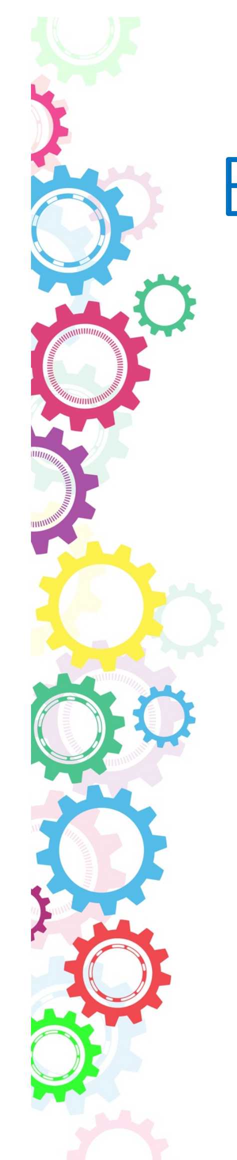
1. **Specificity:** Is the strategy specific enough to be implemented? Does it have a timeline, deliverables, and budget details?
2. **Improvement:** Is the strategy strong enough to improve the outcome?
3. **Leverage:** How much difference will the strategy make? Does it address specific root causes?
4. **Values:** Is the strategy consistent with the values of the community? Will it be adopted?
5. **Evidence:** Is the strategy evidence-based/informed? Can you align it with MCHbest, Innovation Hub, or the literature?
6. **Reach:** Is it feasible and affordable? Can it actually be done and by when?

SILVER	Strategy 1: ____________________	Strategy 2: ____________________	Strategy 3: ____________________
Specificity			
Improvement			
Leverage			
Values			
Evidence			
Reach			

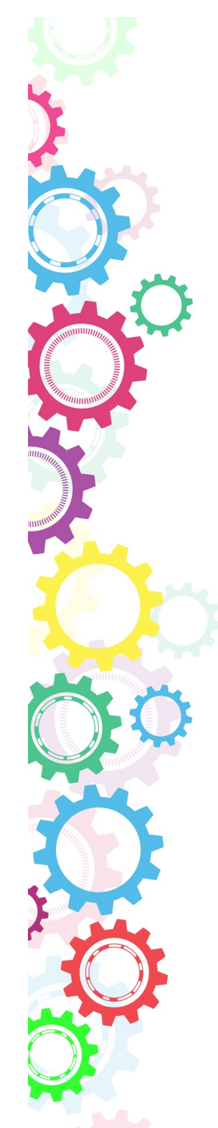


Measurement and Strong ESMs

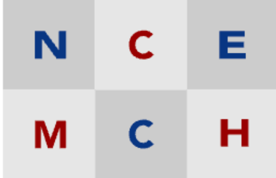
	Quantity/How Much?	Quality/How Well?
Effort	**QUADRANT 1: What/how much did we do (#)?** (Number/Counts and 'Yes/No' Activities) **Tips:** • Use Quadrant 1 measures **sparingly**, only when no other data exists • Number: individuals served, activities done • Try to convert to Quadrant 2 by strategically determining a denominator **Start here:** Identify which group you serve ('customers'): ___ *(Consider focusing on those disproportionately affected by inequities)* **Develop potential ESMs based on:** **Audience** (# of individuals served): ___ *(e.g., # of pediatricians who received unconscious bias training)* **Activities** (# of deliverables performed): ___ *(e.g., # of brochures distributed to families receiving WIC services)*	**QUADRANT 2: How well did we do it (%)?** (% of Reach; Satisfaction) **Tips:** • Quadrant 2 measures **program outputs** and are preferred over • Quadrant 1 Percent: how well you performed activities… reach, satisfaction, quality **Develop potential ESMs based on:** **Reach** (% of audience served): ___ *(e.g., % of families in NICUs who received Title V-developed safe sleep brochures)* **Timeliness** (% of activities within timeframe): ___ *(e.g., % of nursing staff who received training on infant safe sleep within 1 month of being hired.)* **Quality** (% meeting accuracy/standards): ___ *(e.g., % of practices implementing breastfeeding guidelines)* **Satisfaction** (% of audience satisfied): ___ *(e.g., % of adolescents satisfied with transition plan provided by Title V programs)*
Effect	***NOTE:*** *Quadrant 3 measures are typically "weaker" versions of Quadrant 4 measures and should be avoided, if possible. Instead, think of ways to improve your measures with these* ***tips*** *below…* **TIPS FOR STRONG ESMs** **Meaningful.** *Consider if the measure:* • Is rooted in the evidence-base • Documents the role of Title V • Has direct relationship to the NPM/SM • Is feasible relative to state priorities and funding • Reflects the needs of your population and partners **Measurable.** *Consider if the measure:* • Is quantifiable, well-defined, and specific • Has data that will measure improvement over time **Moveable.** *Consider if the measure:* • Can show improvement over multiple assessments • Is effective with multiple population groups	**QUADRANT 4: How is the audience better off?** (% Measuring Quality of Change) **Tips:** • ESMs tracking **short-term outcomes** are acceptable, especially when they track a subpopulation receiving Title V services, but too downstream to track true Title V impact. • Consider focusing on **short-term process measures** that show changes in knowledge, skills, attitudes, health behavior, or access to/receipt of care. **Develop potential ESMs based on:** **Knowledge/Skills/Attitude** (%): ___ *(e.g., % of teachers reporting increased knowledge after anti-bullying workshop)* **Health Behavior** (%): ___ *(e.g., % of families adhering to safe sleep practices after Title-V funded training)* **Access to/Receipt of Care** (%): ___ *(e.g., % of adolescents in Title V pilot program who report having an adult mentor)*



Breathe and Stretch; Let's Get Those Tools!



Questions, Gallery Walk, and Contacts



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MCH EVIDENCE

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