Developing Effective Performance Measures that Make Waves at Local, State, and Federal Levels

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Health Equity is a process AND an outcome

“Health disparities — differences in health outcomes that are closely linked with social, economic, and environmental disadvantage — are often driven by the social conditions in which individuals live, learn, work and play.”
Welcome & Focus

- Explain how the three components needed for effective evidence-based programs (evidence base, an implementation process, and specific MCH focus) can be used in MCH, both for needs assessment and for program development.
- RBA to work backwards from desired results to strong, measurable ESMs
- Using Needs Assessment Focus on Health Equity
Agenda and Getting Ready

1. Evidence
   - Introduction to the MCH Evidence Center

2. Implementation Strategy
   - Population & Performance Accountability
   - Start with the 7 Questions
   - Turn the Curve Activity –
     1. How Are We Doing?
     2. Story Behind the Curve?
     3. Who Are the Partners?
     4. What Works to Turn the Curve?
     5. What Is Our Action Plan?
   - Measurement

3. MCH Lens
   - Hexagon Tool
How are we Incorporating Health Equity?

State Examples

Evidence-based/informed Strategy Measures (ESMs):
• SDoH: 5/760
• Health Equity: 7/760 (may from RI)

State Action Plans:
SDoH:
• 5 Priority Needs (NC is a good example)
• 1 Objective (NM)
• 0 State Performance Measures (SPMs)
• 7 Strategies (many from IL)
Health Equity:
• 17 Priority Needs (NY, WA good examples)
• 7 Objectives
• 1 SPM (IL)
• 34 Strategies (many from NY)

IL and RI have measures that address both
How are we Incorporating Health Equity?

Common Strategies from State Examples

- Getting data from organizations that focus on health equity (RI)
- Partnering with organizations that focus on health equity (CA)
- Establishment of direct Priority Needs (FL):
  - Focus on systems development (HI)
- Using specific tools/trainings (IL) – either health-equity focused or a resource that includes as a component
- Internal capacity-building: Including health equity/SDoH in activities (e.g., meetings)
- Including health equity/SDoH into programs (NPM activities) (e.g., safe sleep programs)
- Special shout-out to RI’s Health Equity Zone Initiative
How Does the MCH Evidence Center Work?

**Accelerate**

*Evidence Base*
Ensures that programs/interventions are **meaningful** and have the greatest potential to affect a desired change.

(Science-based interventions based on peer-reviewed findings, promising practices, and expert opinion)

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**Upstream**

*Implementation Process*
Ensures that programs/interventions are **measurable** in “turning the curve” on big issues that face MCH populations.

(Results-Based Accountability concepts of population & performance)

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**Together**

*MCH Title V Focus*
Ensures that programs/interventions are **achievable** within the realities of Title V programs and lead to health equity.

(MCH resources, learning tools, and Technical Assistance to drive health equity)

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This Model Aligns with MCHB’s Framework for Change:

- **Accelerate.** Using evidence-based/informed strategies accelerates the pace of change...
- **Upstream.** Focusing on the desired change allows programs to strategically address issues early...
- **Together.** Employing resources developed by MCH partners helps to ensure common goals such as health equity...

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*Effective Evidence-Based/Informed Programs*

- **Evidence Tools**
- **Technical Assistance**
- **Training Resources**
- **Team of Experts**

The MCH Evidence Center provides a scaffold of support to help states/jurisdictions incorporate evidence with proven implementation processes, all with a MCH Title V focus to develop, implement, and measure effective evidence-based/informed programs.
I. Evidence Base

Using the evidence base as the building block to show anticipated effect of programs and as a key element in assessing needs and developing new interventions to meet those needs.

The evidence base includes:
• Peer-reviewed findings
• Promising practices & expert opinion
• Effective state ESMs currently in use

Goal: Creating ESMs that are based on the evidence.
I. Evidence Base

How to learn more about evidence?

TA that we offer:

- Literature Searches of the Evidence
- RBA Basics
- Overall ESM Check-Ups
- Help adapting/creating ESMs

Process:
- Initial Call
- Follow-up Calls
I. Evidence Base

Evidence Tools & Resources

1. Evidence Tools
   - NPM Portal Pages
   - Evidence Reports
   - Evidence Databases
2. ESM Reviews
3. Learning Resources
4. Team of Experts
5. MCH Digital Library

www.mcchevidence.org
I. Evidence Base

Incorporating Evidence into Needs Assessment

“Many frameworks place needs assessment at the beginning of the process. But needs-based decision making processes tend to get mired in the simple fact that we can never meet all the needs. Incrementally meeting a greater percent of need misses the point. We meet needs for a reason and that reason is the improved well-being of children, adults, families, and communities. Results and indicators should come first…RBA challenges people to think more deeply about causes and to consider both service and non-service solutions that will make a difference.”

*Trying Hard Is Not Good Enough*
*Mark Friedman*
I. Evidence Base

Start Strategies with Effective Evidence

Harvard University’s Science-Based Intervention Framework/Frontiers of Innovation (FOI) IDEAS methodology.

- **Innovate** to solve unmet challenges (program development).
- **Develop** a usable program with a clear and precise theory of change (implementation).
- **Evaluate** the theory of change to determine what works for whom and why.
- **Adapt** in rapid-cycle iterations.
- **Scale** promising programs.
Achieving greater impact at scale requires rethinking the definition of an evidence-based/informed program.

Typical research methods study how programs work on average for those who receive interventions.
I. Evidence Base

Using the IDEAS Impact Framework allows us to look at an evidence-based/informed strategy to ask:

- *What* about it works?
- *How* does it work?
- *In what contexts* does it work?
- *For whom does it work*, and for whom does it *not* work?

Looking at Early Childhood Programs over 50 years.
Source: Center on the Developing Child, Harvard University
I. Evidence Base

How can we use Science-Based Intervention Framework and other Evidence Models to answer the key questions:

• *What* about it works?
• *How* does it work?
• *In what contexts* does it work?
• *For whom does it work*, and for whom does it *not* work?
I. Evidence Base

**What about it works?** If we understand the key ingredients, we can replicate and adapt them.

**Nerd level:** Three Stars – We need to look at health behavior theories for answers.
I. Evidence Base

*How does it work?* Being specific about the underlying mechanisms can help us increase the impact.

**Nerd level:** Four Stars – We need to look at Theories of Change/Logic Models (Harvard’s Components) or other implementation theories (e.g., PDSA).
I. Evidence Base

*In what contexts does it work?* By evaluating the context in which a program is implemented, we can adapt it for other settings.

**Nerd level:** Four Stars – We need to look at program life cycles/Harvard’s Guiding Principles.
I. Evidence Base

**For whom does it work, and for whom does it not work?** When we know who is and isn’t responding, we can make targeted adaptations to improve outcomes.

**Nerd level:** Five Stars – "One size does not fit all.” We need to look at this from ALL levels: Health behavior, logic models, program components (precision and co-creation), and **evaluation**.
I. Evidence Base

Racial Equity Impact Analysis (REIA)

1. Are all racial/ethnic groups who are affected by the strategy at the table?

2. How will the proposed strategy affect each group?

3. How will the proposed strategy be perceived by each group?

4. Does the strategy worsen or ignore existing disparities?

5. Based on the above responses, what revisions are needed for the strategy under discussion?
I. Evidence Base

Using REIA to Assess Health Equity
— Activity 1: Your Turn

Take a few minutes to work through the REIA tool on a specific program
II. Implementation Process

Using **Results-Based Accountability (RBA)** as tool to align:

Program Performance
(performance-based accountability: e.g., measurement of ESMs)

with

Population Goals
(population-based accountability: e.g. NPMs and NOMs)

and

Improve Measurement of Activities
II. Implementation Process

Results-Based Accountability: A Method of Linking Evidence to Measures that Address NPMs

- **What Is RBA?**
  - A tool to help you connect the dots and select measures and make sense of your activities across the MCH Block Grant
  - Intentional way of being sure your measurements are actually connected to your work and have impact to NPMs and NOMs
  - Tool to move from population health to program performance and activities
  - Plain language, stakeholder-friendly way to think about measurement.

- **How Does RBA Work?**
  - RBA starts with ends and works backward, step by step, to means:
    - For communities, the ends are conditions of well-being.
    - For programs, the ends are how “customers” are better off.
II. Implementation Process

Seven Population Accountability Questions

1. What are the quality of life conditions we want for the families who live in our community? (Population Results)
2. What would these conditions look like if we could see them? (NOMs)
3. How can we measure these conditions? (Population Indicators - NPMs)
4. How are we doing on the most important of these measures? (Baselines and Causes)
5. Who are the partners that have a role to plan in doing better? (Typical and New)
6. What works to do better, including no-cost and low-cost ideas? (Possible Actions)
7. What do we propose to do? (Action Plan; Use "Public Square")

“Public Square” RBA Indicator Criteria

1. Communication Power. Does the indicator communicate to a broad and diverse audience? (“public square test” — what 2 or 3 ideas would you shout out in the public square)
2. Proxy Power. Does the indicator say something of central importance about the result? Can this measure stand a proxy or representative for the plain language statement of well-being? (“data tend to run in herds” — if one indicator is going in the right direction, usually others are as well)
3. Data Power. Do we have quality, timely data? Is the data reliable and consistent?

Process

1. Rate High - Medium - Low (best pattern HHH)
2. Two messages: (1) start with the best of what you have and (2) get better.
3. Simple method: circle indicators with High Data. Then choose 1-3 indicators to shout in the public square. Others can be worked on once you figure out data source.
II. Implementation Process

Seven Performance Accountability Questions

1. Who are your customers?
2. How can we measure if our customers are better off? (Is anyone better off?)
3. How can we measure if we are serving our customers well? (How well did we do it?)
4. How are we doing on the most important of these? (Baselines and Causes)
5. Who are the partners that have a role to play in doing better? (Typical and New)
6. What works to do better, including no-cost and low-cost ideas? (Possible Actions)
7. What do we propose to do? (Action Plan; Use “SiLVeR”)

“SiLVeR” RBA Strategy Criteria

1. **Specificity.** Is the strategy specific enough to be implemented? Can it actually be done?
2. **Leverage.** How much difference will the proposed strategy make on results, indicator, outcomes — will it Turn the Curve?
3. **Values.** Will the strategy be adopted by the community they are targeting?
4. **Reach.** Is it feasible and affordable? Can it actually be done and when?

Process

1. Rate High - Medium - Low (best pattern HHHH)
2. Consider the strategies that rate highest in the first three and space them out over a multi-year period.
3. Strategies that rate highest on the first three criteria can be tried this year and next year.
4. Lower-rated strategies can be tried in the next 3 to 5 years.
The Basics of Turning the Curve

To figure out how to get from here to there we need to know 2 things:

1. What’s our starting point?
2. What’s our current trajectory?
Condensed Turn the Curve Process

1. How are we doing?
2. What is the story behind the curve?
3. Who are the partners who have a role to play in turning the curve?
4. What works to turn the curve?
5. What is our action plan to turn the curve?

Turn the Curve?

Adapted from the seven Population and Performance Accountability questions found in "Trying Hard Is Not Good Enough."
II. Implementation Process

Using RBA Measurement: Starting to Turn the Curve

1. How are we doing?

2. What is the story behind the curve?
   - Barriers
   - Competing factors

3. Who are the partners that have a role to play?
   - Families (caregivers and beyond), baby stores, beauty salons, WIC clinics, church groups, hospitals and providers
II. Implementation Process

Using RBA Measurement: Rounding the Curve

4. What works to turn the curve?
   • Needed resources
   • Process-level activities
   • Systems-level activities

5. What is our action plan to turn the curve?
How will we measure:
   • Needed resources
   • Process-level activities
   • Systems-level activities
II. Implementation Process

Using RBA Measurement To Strengthen Program Measures

Goals in measuring your ESMs:
- Move from measuring quantity to quality (lowest measurement is Category 1).
- Eventually move from measuring effort to effect (highest measurement is Category 4).
- Not everyone needs to be measuring Category 4 activities; the most effective measurement combines a mix of categories.
II. Implementation Process

Using RBA Measurement To Strengthen Program Measures

Using RBA Measurement To Strengthen Program Measures

Another Way of Looking at Measurement

<table>
<thead>
<tr>
<th>Effort</th>
<th>Quantity</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td># Customers served (by characteristics)</td>
<td>% Completion rates (%)</td>
<td>% Staff trained</td>
</tr>
<tr>
<td># Activities (by type of activity)</td>
<td>% Customer satisfaction (Did we treat you well?)</td>
<td>% Activities meeting standards (%)</td>
</tr>
</tbody>
</table>

Is anyone better off (#)?

Skills/Knowledge

# Attitude/Organization

Behavior

Circumstance

Is anyone better off (%)?

Skills/Knowledge

# Attitude/Organization

Behavior

Circumstance

NPM 4: Breastfeeding

Category 1: Measuring Quantity of Effort

- Number of Obstetric and pediatric providers who have completed breastfeeding education
- Number of birthing hospitals designated as Baby Friendly

Category 2: Measuring Quality of Effort

- Percent of births occurring in birthing hospitals designated as Baby Friendly
- Percent of Women, Infants, and Children (WIC) infants ever breastfed

Category 3: Measuring Quantity of Effect

- Number of hotline participants who, upon completion of call, indicate that they received appropriate advice from the hotline.
- Number of pregnant and post-partum WIC clients who report positive impact on breastfeeding practices based on breastfeeding peer counselors’ activities

Category 4: Measuring Quality of Effect

- Percent of pregnant women enrolled in group education programs through the hospital setting who are confident in their ability to engage in breastfeeding best practices
- Percent of MIECHV home visiting staff who received education about best-practices for supporting breastfeeding among new mothers who report an increase in knowledge and skill around breastfeeding best practices
II. Implementation Process

Using RBA Measurement
To Strengthen Program Measures
— Activity 2: Your Turn

Take a few minutes to organize your measures based on the 4-quadrant chart

It’s Your Turn
III. MCH Focus

Linking our work to MCH priorities & realities so that interventions developed are:

- Meaningful
- Measurable
- Achievable

While advancing health equity across all population groups.
Where do we fit in RBA Measurement?

### III. MCH Focus

#### Category 1: Measuring Quantity of Effort (Counts and “Yes/No” Activities)
- 59.9% of ESMs total (455/760)
- 76% of these are counts; 24% “yes/no” activities

#### Category 2: Measuring Quality of Effort (% of Reach; Satisfaction)
- 38.6% of ESMs total (293/760)
- 62% are client services; 38% are systems-building

#### Category 3: Measuring Quantity of Effect
- 0.5% of ESMs total (4/760)
- 50% measure increased knowledge/skills; 50% report systems changes

#### Category 4: Measuring Quality of Effect
- 1.0% of ESMs total (8/760)
- 50% are increased knowledge/skills; 50% are percent of people who benefited from programs
III. MCH Focus
Where do we fit in RBA Measurement?

Desire to “move on down” the MCH Pyramid
III. MCH Focus

The Hexagon Tool & Health Equity

Guides the selection of the appropriate, evidence-based/ informed practice through a detailed exploration process.
III. MCH Focus

The Hexagon Tool

Program Indicators:
- Evidence
- Supports
- Usability
III. MCH Focus

The Hexagon Tool

Implementing Site Indicators:
- Fit
- Need
- Capacity
III. MCH Focus

Learn More…

[Image of the National MCH Workforce Development Center website]

[Website link: https://www.mchnavigator.org/transformation/health-equity.php]
What’s Next
Continue the Conversation

Alexsandra Monge, alexapo@email.unc.edu
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Evaluation

Let Us Know How We Connected

Star Rating of Knowledge/Skills Gained:

- Understanding of how to use evidence
- Knowledge of RBA process
- Familiarity with MCH tools to use to make stronger ESMs

Print Evaluations Based on Kirkpatrick Model of Knowledge Acquisition

Thank You!