Introduction. This resource provides a summary of Evidence-based/informed Strategy Measures (ESMs) as part of the 2018/2020 MCH Block Grant submission as seen through the Results-Based Accountability (RBA) framework. It can be used to begin a process of quality improvement in strengthening ESMs, both across the nation and in each Title V agency.

Summarizing RBA. RBA can be used by Title V agencies as a planning process in two ways:

1. To ensure that ESMs measure activities that advance National Performance Measures (NPMs). A set of population and performance accountability questions (detailed on pp. 20–21) requires programs to consider:
   1. Desired impact on a targeted group.
   2. Relevant barriers and facilitators, relevant resources and potential partners.
   3. Identification of what works to produce measurable outcomes.
   4. Mechanisms to deliver programs effectively.

2. To strengthen measurement of ESMs. A four-quadrant measurement matrix assists programs to move from tracking effort (basic) to assessing effect (advanced). The quadrants (detailed on p. 22) are:
   1. Quantity of the effort (How much did we do?).
   2. Quality of the effort (How well did we do it?).
   3. Quantity of the effect (Is anyone better off?).
   4. Quality of the effect (How are they better off?).

Summarizing national progress. Title V programs have made significant progress in strengthening ESMs from the 2017/2019 to the 2018/2020 report and application. This progress can be summarized:

Overall, there has been a noteworthy shift from tracking the level to which activities were completed to a more meaningful assessment of how programs are impacting MCH populations and how those groups are better off.

Shift from Measuring Effort to Effect

| Quadrant 1: “Yes/no” activities dropped from 22% to 11% |
| Quadrant 2: High measure of reach & satisfaction |
| Quadrant 3: Increase from 0.5% to 5.8% |
| 64% of these measure system changes |
| Quadrant 4: Increase from 1.0% to 9.4% |
| 87% of these measure population benefits |
What’s Next. **There is still room for improvement!** Building on recent progress, this year can serve as an opportunity to use findings from the 5-Year Title V Needs Assessment along with MCH Evidence Center tools to further strengthen how you measure ESMs to address the needs of women, infants, children, adolescent, youth – including those with special health care needs – along with their families in your communities.

This tool provides resources aligned with the three essential components for developing effective evidence-based/informed programs: (1) the evidence base, (2) a structured planning process, and (3) Title V implementation tools. These three components align with HRSA’s Maternal and Child Health Bureau’s framework for change and can be visualized by the following figure. The report is organized by these components:

![Diagram of three components](image)

1. **Accelerate with the Evidence Base**
2. **Think Upstream with a Structured Planning Process**
3. **Work Together to Implement Title V Tools**

**Effective Evidence-Based/Informed Programs**

**How to Use This Report.** This resource is dense; do not let that discourage you. The work you do in setting priorities, choosing NPMs, and developing measures is complex and requires numerous tools to ensure the process is conducted strategically to advance MCH over the next five years (and beyond). This report contains the basics for everything you need during the process:

**Ready.** Start by reviewing your individualized ESM Review Agency Brief to gauge where your ESMs fit within the RBA continuum. If you don’t have your brief, please contact us at mchevidence@ncemch.org to receive a copy.

**Set.** Read through this report quickly to understand the state of the field and to gain a sense of the three components of the work. Throughout the document, there are many tools to download. You can go as lightly or as deeply with these tools, but remember that they are there to augment your agency’s own process. We are also available to help you work through specific tools, topics, or the entire process. See p. 25 for more on technical assistance (TA).

**Go.** Work through the three sections of the report to find example strategies from the evidence base, review the RBA planning processes for double checking your needs assessment and developing ESMs, and access tools to ensure your programs have the greatest potential to be effective for the families you serve.

1. **Accelerate with the Evidence Base.** Dive quickly into the MCH evidence base with the following tools:
   - Continuum of Evidence and Online Tools ................................................. 3
   - Questions to Ensure Health Equity and Tips for Strengthening ESMs.................. 4
   - Strategy Shortcuts for the 15 NPMs to Identify Model Strategies ................................ 5-19

2. **Think Upstream with a Structured Planning Process.** Walk through a summary of RBA process and tools:
   - RBA on a Population/Needs Assessment Level (the “Public Square Test”) .................. 20
   - RBA on a Performance/ESM Level, Turn the Curve Activity (the “SiLvE R Test”) ........ 21
   - Measuring and Reporting (the “Four Quadrants”) .............................................. 22

3. **Work Together to Implement Title V Tools.** Access and download tools to help you go further:
   - Field-Generated Online Resources from MCH Evidence and MCH Library .................. 23
   - Social Determinants of Health and Health Equity Tools ........................................... 23-24
   - Request Technical Assistance ............................................................................. 25
1. **Accelerate with the Evidence Base.** To ensure that programs are *meaningful* and have the greatest potential to affect desired change, it’s critical that they are unbiased, significant to public health, and rooted in science, experience, and policy. They should show results that are statistically significant and lead to decisions that bring about change. By understanding what has worked in the past, we can build programs on proven successes. The evidence base includes peer-reviewed findings, promising practices, and other state ESMs currently in use. Evidence-based/informed programs should be:

- *Agreed* upon by expert consensus.
- *Based* in science.
- *Clearly* reflect actual experience.
- *Developed* with the potential to influence policy.
- *Expressly* address the needs of your community.

1.1. **Start with the evidence.** In developing new or revising current ESMs, begin with the corresponding science that shows intervention effectiveness. The MCH Evidence Center has analyzed thousands of interventions to find strategies that have the potential to be effective in practice. These strategies can be mapped across a *continuum of evidence* that facilitates the most rigorous MCH science while also encouraging innovation:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scientifically Rigorous</td>
<td>Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.</td>
</tr>
<tr>
<td>Moderate Evidence</td>
<td>Strategies with this rating are likely to work. These strategies have been tested more than once and results trend positive overall; however, further research is needed to confirm effects.</td>
</tr>
<tr>
<td>Expert Opinion</td>
<td>Strategies with this rating are recommended by credible, impartial experts and are consistent with accepted theoretical frameworks. Further research is needed to confirm effects.</td>
</tr>
<tr>
<td>Emerging Evidence</td>
<td>Strategies with this rating typically “trend positive” and have good potential to work. They often have limited research documenting effects and need further research to confirm effects.</td>
</tr>
<tr>
<td>Mixed Evidence</td>
<td>Strategies with this rating have been tested more than once and results sometimes trend positive and sometimes show little effect; further research is needed to confirm effects.</td>
</tr>
<tr>
<td>Evidence Against</td>
<td>Strategies with this rating are not good investments. These strategies have been tested in many robust studies, are not effective, and sometimes produce harmful results.</td>
</tr>
</tbody>
</table>

**Jump to the Evidence.** How to quickly identify strategies based on evidence: use the STRATEGY SHORTCUTS on pp. 5 – 19 to find examples of evidence-based/informed strategies from the MCH Best database, promising practices from AMCHP’s Innovation Station and MCH Library, and current ESMs being used in the field. You can modify these strategies to address the specific needs of your populations.

1.2. **Consult MCH Evidence Center tools.** These can be used in conjunction with this report:

- **Evidence Toolkits.** Access comprehensive resources from basic summaries of the evidence base to detailed reports, sample ESMs, promising practices, additional learning, and supporting materials from the field.
- **MCH Best Database.** Use this “Bank of Evidence-linked Strategies and Resources” to find detailed strategies that are directly supported by the best evidence; model your ESMs on examples. Includes details on the role of Title V in implementing strategies.
- **State ESM Database.** Find ESMs that are currently in use by Title V programs as well as those that have been completed. You can search by key word (e.g., WIC, hospital), NPM, or state/jurisdiction.
- **Established Evidence Database.** Search the peer-reviewed research articles that were reviewed in developing the evidence reports. Links are provided to electronic access. Not all articles are available freely online.
- **Emerging Evidence Database.** Use these links to generate automated searches of the most current research literature using the same search parameters that the project uses to identify articles for evidence reports.
1.3. Double-check strategies through an equity lens. Not all strategies are effective for all population groups, and the evidence is often lacking in terms of using specific strategies to advance health equity. To help address this issue, we use the Science-Based Intervention approach to ensure that a program is effective for MCH populations by asking:

- **What about it works?** If we understand the key ingredients of a strategy, we can replicate and/or adapt them. Looking at a strategy through a **health behavior theory** identifies key ingredients. Here are several to consider:
  - **Intrapersonal.** Theory of Planned Behavior, Health Belief Model, Attribution Theory.
  - **Interpersonal.** Social Cognitive Theory.
  - **Community.** Diffusion of Innovation, Ecological Models.

- **How does it work?** Being specific about the underlying mechanisms can help us increase the impact. Developing a **logic model** with program actions, targets, outcomes, and moderators allows you track the process from action to consequence.

- **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. Harvard’s approach is to think strategically about the program life cycle:
  - **Precision.** Understand what a program entails so you can go beyond “does it work,” to “what about it works” – and eventually “for whom does it work.”
  - **Fast-cycle iteration.** Incorporate new ideas as you go – what is working and what is not working.
  - **Shared learning.** Create a platform to share learning about success and failures.
  - **Co-creation.** Bring together multiple parties to create a mutually valued outcome.

- **In what contexts does it work?** By evaluating the context in which a program is implemented, we can adapt it for other settings. The best way to ensure that a strategy is effective is to conduct a robust evaluation. The **Kirkpatrick Model** asks four short questions to measure reaction, learning, behavior, and results.

**Tips for Strengthening ESMs.** Effective ESMs measure strategies that draw from the evidence, advance NPM topic areas, and include:

- **Strategies that are meaningful.** Consider if the ESM:
  - Is based on an evidence-based/informed strategy. Evidence can be based on peer-reviewed research or informed by emerging practices and expert opinion that there would be a positive, measurable, and expected result from the strategy.
  - Has a direct relationship to the NPM.
  - Is feasible relative to state priorities and funding.
  - Reflects the needs of your populations.
  - Has involved stakeholder input and/or buy-in.
  - Has potential for improvement over time.
  - Addresses disparities, gaps, or issues to improve health equity.

- **Activities that are measurable.** Consider if the ESM:
  - Is quantifiable (count, percentages, rate) and specific (defined indicator, numerator, denominator). Note: Quantitative measures are better than qualitative “yes/no” measures to show improvement over time.
  - Is well-defined, specific, and captures relevant data needed to demonstrate change.
  - Has data sources that are available to measure and track the ESM over time.

- **Improvements that are moveable.** Consider if the ESM:
  - Can show improvement over multiple assessments.
  - Is sensitive to change over time.
  - Is effective with multiple population groups, including vulnerable families and CYSHCN.
NPM 1 Strategy Shortcuts: Well-Woman Visit

These strategies have been proven effective in addressing **NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.** They can be adapted for your program needs.

### Evidence-Linked Strategies

#### Scientifically Rigorous Evidence
- **Patient Reminders:** Support providers in disseminating reminders (e.g., postcard, text, email, phone) to women about scheduling annual preventative visits.

#### Moderate Evidence
- **Community-Based Group Education:** Utilize community-based education groups to promote annual preventative visits.
- **Computerized Reminder System:** Support a cell phone texting program to send reminders to patients 48 hours before scheduled annual visit.
- **Designated Clinics/Extended Hours:** Increase access and visibility to clinics that offer extended hours of service within close proximity to MCH populations.
- **Expanded Insurance Coverage/Medicaid Eligibility:** Adopt a protocol to ensure that all persons in maternal, child, and adolescent health programs are referred for enrollment in health insurance.
- **Media Campaigns:** Utilize media outlets to promote preventive medical visits.
- **Patient Navigation:** Adopt protocols where clinic staff (e.g., WIC) assist with scheduling preventative visits.
- **Provider Education:** Host a webinar series for providers about annual preventive visits and strategies to address missed opportunities.

#### Promising Practices
- **Nurse Family Partnership** (National): Partnering nurses with low income mothers.
- **Pathways Community HUB** (OH): Network of community health workers.

#### Promising Practice
- **Body & Soul: A Faith Based Initiative** (FL): Health education and exercise program.
- **Healthy Women, Health Futures** (OK): Education, skills, and supports.
- **PowerMeA2Z** (TX): Folic acid education for women and providers.
- **Welcome Family** (MA): Nurse home visit and follow-up phone call to all mothers.

#### Emerging Practice
- **Perinatal Depression Screening/Referral** (CT): Developing a screening/referral system.
- **Superior Babies Program** (MN): Promotion of healthy prenatal & parenting behavior.

*>> Also see AMCHP’s [NPM 1 Implementation Toolkit](https://www.amchp.org/npm1) for field-based strategic approaches.*

### Field-Generated Measures

#### Examples of Current ESMs

**Quadrant 1: Quantity of Effort**
- **Number of women referred for an annual well-women visit by a perinatal program** (DC)

**Quadrant 3: Quantity of Effect**
- **The number of Title V programs that demonstrate incorporation of strategies to reinforce well-woman and preconception health care services** (NY)

**Quadrant 2: Quality of Effort**
- **Percent of Title V maternal health participants that received education on continuing their health care coverage** (IA)

**Quadrant 4: Quality of Effect**
- **Percent of annual preventive health visit appointments kept among women at ADH local health units** (AR)

### Additional Resources
- **Access ESMs** from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s [Well-Woman Visit Toolkit](https://www.amchp.org/npm1) for strategies and tools
NPM 2 Strategy Shortcuts: Low-Risk Cesarean Deliveries

These strategies have been proven effective in addressing NPM 2: Percent of cesarean deliveries among low-risk first births. They can be adapted for your program needs.

Evidence-Linked Strategies

Use MCH Best to find strategies based on high-level evidence

Note: Strategies with the most evidence are often more clinical. Check the MCH Best Database for newly-added, more public health strategies.

Emerging Evidence

- Childbirth Education Classes: Support the development of a community-based childbirth education class series.
- Elective Induction Policy: Support the development of an elective induction policy.
- Multicomponent: Active Management of Labor + Use of State/National Guidelines: Support the implementation of 2-pronged approach.
- Multicomponent: Chart Audit and Feedback + State/National Guidelines: Support the implementation of 3-pronged approach.
- Multicomponent: Childbirth Education Classes + Active Management of Labor: Support the implementation of 3-pronged approach.
- Supportive Care from Lay Doulas: Implement a statewide community-based doula program which contracts to local hospitals.

Mixed Evidence

- Programs to Promote Active Management of Labor: Promote the initiation by providers of oxytocin infusion when cervical dilation is less than 1 cm per hour.

Best Practice

- Healthy Babies are Worth the Wait (KY): Prevention of preterm births.

Promising Practice

- Healthy Babies are Worth the Wait Consumer Education Initiative (NY): Preventing elective preterm births.
- Health Equity Zones (RI): Seed funding to drive policies for healthier living.
- Women’s Health Education Navigation (WHEN) Program for justice-involved families (NY): Improvement of access to services through a strong referral network.

Emerging Practice

- The Ohio Pregnancy Associated Mortality Review: The Use of Simulation Training to Prepare for Obstetric Emergencies (OH): Simulation training for obstetric emergencies

Examples of Current ESMs

Quadrant 1: Quantity of Effort

- Number of hospitals participating in a quality improvement process to reduce low-risk cesarean deliveries (ME)

Quadrant 2: Quality of Effort

- Number of delivery hospitals that receive technical assistance on low-risk cesarean birth reduction (MD)

Quadrant 3: Quantity of Effect

- Number of Colorado birthing hospitals with NTSV c-section rates exceeding the HP 2020 and Colorado-specific target of 23.9% implementing at least one strategy from the CMQCC toolkit (CO)

Quadrant 4: Quality of Effect

- Percent of birthing hospitals implementing at least one strategy from the CMQCC toolkit (Sample)

Additional Resources

- Access ESMs from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Low-Risk Cesarean Deliveries Toolkit for strategies and tools
NPM 3 Strategy Shortcuts: Perinatal Regionalization

These strategies have been proven effective in addressing NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU). They can be adapted for your program needs.

Evidence-Linked Strategies

Moderate Evidence

- **Multicomponent: Continuing Education of Hospital Providers + State Policies/Guidelines**: Support establishment of intra-hospital transportation system and develop educational CME module.

Emerging Evidence

- **Continuing Education of Hospital Providers**: Develop module on transport guidelines.
- **State Policies/Guidelines**: Strengthen statewide intra-hospital transportation systems for transport of high-risk mothers and newborns.
- **Multicomponent: Access to Providers through Hotline + Continuing Education of Hospital Providers + State Policies/Guidelines**: Support a 3-pronged approach.

Summary of the Evidence

There are few evidence-linked strategies for NPM 6; as such, here is a summary of what we know works, including those strategies that “trend positive.”

- Interventions implemented at both the hospital and population-based systems levels appeared most effective in increasing risk-appropriate perinatal care.
- Population-based systems interventions alone appeared less effective.
- Adding a hospital component to population-based systems interventions appears to support the effectiveness of those interventions.
- The evidence of effectiveness for interventions with a patient component is less clear.

Promising Practices

- **Partners in Pregnancy** (VA): Home visits and case management for high-risk women.
- **PowerMeA2Z** (TX): Folic acid education for women and providers.
- **Prenatal Plus Program** (CO): Care coordination, nutrition, & mental health counseling.

Emerging Practice

- **The JJ Way Model of Maternity Care** (FL): Improve birth outcomes.
- **Mississippi Interpregnancy Care Project** (MS): Improving access to primary care.

Field-Generated Measures

Use the MCH Library to find ESMs being used by other Title V programs

Examples of Current ESMs

**Quadrant 1: Quantity of Effort**

- Number of perinatal regionalization educational fact sheet distributed to expectant mothers (AR)
- Number of communities participating in Every Woman Connecticut (CT)

**Quadrant 3: Quantity of Effect**

- Number of hospitals with a formal written plan for transport of complicated obstetric/maternal patients (MO)

**Quadrant 2: Quality of Effort**

- Percentage of birth facilities with documented level of care using the LOCATe tool (MS)

**Quadrant 4: Quality of Effect**

- Percent of very preterm infants born in a non-Level III hospital with a VPT review form submitted to IDPH (IL)
- Percent of facilities with a plan for transport out of complicated obstetric/maternal patients (CA)

Additional Resources

- **Access ESMs** from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Perinatal Regionalization Toolkit for more
NPM 4 Strategy Shortcuts: Breastfeeding

These strategies have been proven effective in addressing **NPM 4A: Percent of infants who are ever breastfed** and **NPM 4B: Percent of infants breastfed exclusively through 6 months**. They can be adapted for your program needs.

### Evidence-Linked Strategies

**Moderate Evidence**
- **Home Visits**: Provide training and coaching to MIECHV home visiting staff to promote breastfeeding best practices.
- **Lactation Consultants**: Maintain a 24-hour breastfeeding hotline staffed by a bilingual certified lactation consultant.
- **Peer Counselors**: Utilize breastfeeding peer counselors through WIC programs.

**Emerging Evidence**
- **Family Leave, Workplace Policies, State Laws**: Provide training on workplace Mother-Friendly breastfeeding support policies across the state/jurisdiction.
- **Provider Training**: Provide training to health care providers around breastfeeding best practices.

**Mixed Evidence**
- **Group Education**: Promote the use of group education for pregnant women around breastfeeding practices.
- **Hospital Policies**: Promote Baby Friendly policies for hospital systems.
- **WIC Food Package Change**: Enhance the number of families participating in the fully-breastfed WIC food package change.

**Evidence-Linked Strategies**

Use MCH Best to find strategies based on high-level evidence.

Note: Strategies with the most evidence are often more clinical. Check the MCH Best Database for newly-added, more public health strategies.

### Promising Practices

**Best Practice**
- **Every Child Succeeds** (OH): Building trusting relationships for those with children 0-3.

**Promising Practice**
- **First 5 California Kit for New Parents** (CA): Parenting and community resources.
- **Healthy Women, Health Futures** (OK): Provision of supports to change behaviors.
- **Partners in Pregnancy** (VA): Home visits and case management for high-risk women.
- **Prenatal Plus Program** (CO): Care coordination, nutrition, & mental health counseling.
- **Welcome Family** (MA): Nurse home visit and follow-up phone call to all mothers.

**Emerging Practice**
- **Baby Steps to Breastfeeding Success** (AZ): Training and TA on hospital practices.
- **Communities Supporting Breastfeeding** (KS): Multifaceted community approach.
- **Early Intervention Partnerships Program** (MA): Home visiting for high-need families.
- **Superior Babies Program** (MN): Promotion of healthy prenatal & parenting behavior.
- **Touching Hearts and Minds** (MA): Behavior change messaging to WIC families.

>> Also see AMCHP’s [NPM 4 Implementation Toolkit](https://www.amchp.org) for field-based strategic approaches.

### Field-Generated Measures

**Examples of Current ESMs**

**Quadrant 1: Quantity of Effort**
- Number of pregnant women provided with breastfeeding education and counseling (PW)

**Quadrant 2: Quality of Effort**
- Percentage of MIECHV home visiting staff who received education about best-practices for supporting breastfeeding among new mothers (ID)

**Quadrant 3: Quantity of Effect**
- Number of eligible WIC participants who receive counseling services from a breastfeeding Peer Counselor (Sample)

**Quadrant 4: Quality of Effect**
- Percent of Women, Infants, and Children (WIC) infants ever breastfed (HI)

### Additional Resources

- Access [ESMs](https://www.amchp.org) from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s [Breastfeeding Toolkit](https://www.amchp.org) for strategies and tools
NPM 5 Strategy Shortcuts: Safe Sleep

These strategies have been proven effective in addressing NPM 5A: Percent of infants placed to sleep on their backs, 5B: Percent of infants placed to sleep on a separate approved sleep surface, and 5C: Percent of infants placed to sleep without soft objects or loose bedding. They can be adapted for your program needs.

**Evidence-Linked Strategies**

**Moderate Evidence**
- **Mass Media: National Campaign**: Promote the national Safe to Sleep Campaign locally by providing professionals (e.g., first responders) with safe sleep kits.
- **Multicomponent: Caregiver Education + Health Care Provider Education + Hospital Safe Sleep Policy**: Implement a multicomponent strategy that targets caregivers, child care providers, health care providers, and hospital systems (not including quality improvement components).

**Emerging Evidence**
- **Caregiver/Parent Education (e.g., mothers, family members)**: Partner with WIC, home visiting, and other programs to provide safe sleep education and counseling to new caregivers.
- **Child Care Provider Education**: Enforce laws regarding mandatory training for childcare providers on infant safe sleep practices.
- **Health Care Provider Education**: Provide staff of birthing hospitals with training on infant safe sleep.

**Promising Practices**

**Best Practice**
- **Nurse Family Partnership** (National): Partnering nurses with low income mothers.

**Promising Practice**
- **Back to Sleep Nurse Training** (MO): Training for hospital nursing staff.
- **Safe Sleep Instructor Certification** (KS): State-wide infrastructure to share messages.
- **Welcome Family** (MA): Nurse home visit and follow-up phone call to all mothers.

**Emerging Practice**
- **Safe Infant Sleep** (GA): Education materials for professionals, parents, and caregivers.
- **Sisters United: Promoting Healthy Habits, Protecting Our Babies** (AR): Training on preventative measures to address infant mortality.
- **TN Safe Sleep Hospitals** (TN): Comprehensive hospital-based interventions.

**Cutting Edge Practice**
- **DOSE: Direct On Scene Education Program** (FL): Education for first responders on safe sleep.
- **Safe Sleep Sweep** (NY): Phone app for education on safe sleep practices.

**Field-Generated Measures**

**Examples of Current ESMs**

**Quadrant 1: Quantity of Effort**
- **Number of providers educated about Safe Sleep environments and resources provided at www.safesleepva.com** (VA)

**Quadrant 2: Quality of Effort**
- **Percent of new mothers who were told by a healthcare provider to place their baby on his/her back to sleep** (IL)

**Quadrant 3: Quantity of Effect**
- **Number of hospitals that have implemented safe infant sleep policies** (ND)

**Quadrant 4: Quality of Effect**
- **Percent of home visiting participants who report always placing their infant to sleep on their backs and in a crib, cradle, or bassinet** (MA)

**Additional Resources**
- Access ESMs from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Safe Sleep Toolkit for strategies and tools
NPM 6 Strategy Shortcuts: Developmental Screening

These strategies have been proven effective in addressing **NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.** They can be adapted for your program needs.

## Evidence-Linked Strategies

*Use MCH Best to find strategies based on high-level evidence*

**Note:** Strategies with the most evidence are often more clinical. Check the [MCH Best Database](#) for newly-added, more public health strategies.

### Moderate Evidence

- **Home Visiting Programs:** Utilize Home Visiting/MIECHV programs to provide the Ages and Stages Developmental Screening tool to clients.
- **Implementation of Quality Standards:** Support statewide learning collaborative for primary care practices + enhanced reimbursement + collaboration with local agencies.
- **Provider Training:** Train medical and childcare providers on developmental screening.
- **Quality Improvement Programs in Health Care Settings:** Support practice-based learning collaborative for primary care practices without enhanced reimbursement.

### Summary of the Evidence

There are few evidence-linked strategies for NPM 6; as such, here is a summary of what we know works, including those strategies that “trend positive:”

- QI in health care settings appears to be effective.
- Systems-level approaches with QI interventions appears to be effective.
- Health care provider training and home visiting programs may be effective; however, further evidence is needed to fully assess.

## Promising Practices

*Use AMCHP’s [Innovation Station](#) to find practices that can advance NPMs*

### Best Practice

- **Every Child Succeeds** (OH): Building trusting relationships for those with children 0-3.
- **Nurse Family Partnership** (National): Partnering nurses with low income mothers.

### Promising Practice

- **Boys’ Health Advocacy Program** (SD): Increase access to health care services for boys.
- **Family Voices of California Project Leadership** (CA): Advocacy training for families.
- **First 5 California Kit for New Parents** (CA): Parenting and community resources.

### Emerging Practice

- **Alaska Childhood Understanding Behaviors Survey (CUBS)** (AK): Data collection.
- **Community Systems Building Grants for CYSHCN** (NC): System changes for CYSHCN.
- **Parents as Detailers for Learn the Signs. Act Early.** (GA): Training for parents.
- **Tribal Court FASD Program** (MN): Screening and support for children with FASD.

### Cutting Edge Practice

- **Universal Autism Screening** (TN): Screening for Autism Spectrum Disorders.

>> Also see AMCHP’s [NPM 6 Implementation Toolkit](#) for field-based strategic approaches.

## Field-Generated Measures

*Use the MCH Library to find ESMs being used by other Title V programs*

### Examples of Current ESMs

#### Quadrant 1: Quantity of Effort

- **Number of providers trained in developmental surveillance and screening** (VT)

#### Quadrant 2: Quality of Effort

- **Percent of clinical staff trained in the standing operating procedures for referrals to Early Intervention and other programs** (AS)

#### Quadrant 3: Quantity of Effect

- **No. of LHJs that implement at least two core components of the Help Me Grow System connecting at-risk-children with services they need** (CA)

#### Quadrant 4: Quality of Effect

- **Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to EPSDT guidelines** (IA)

### Additional Resources

- **Access ESMs** from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s [Developmental Screening Toolkit](#) for strategies and tools
NPM 7 Strategy Shortcuts: Child Safety/Injury

These strategies have been proven effective in addressing NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 and 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19. They can be adapted for your program needs.

**Evidence-Linked Strategies**

Use MCH Best to find strategies based on high-level evidence

Note: Strategies with the most evidence are often more clinical. Check the MCH Best Database for newly-added, more public health strategies.

**Moderate Evidence**

- **Education During Home Visiting Programs**: Provide injury prevention education for families participating in home visiting programs.
- **Oversight and Regulation of Innovative Programs**: Provide oversight and regulation of innovative programs such as comprehensive home safety assessments.
- **Person-to-Person Interventions Outside the Clinical Setting**: Adopt person-to-person interventions such as the drug disposal program, Count it! Drop it! Lock it!
- **School-Based Interventions**: Conduct outreach, education campaigns, and trainings in school-based settings.

**Summary of the Evidence**

- Children’s Safety Network has developed the resource Evidence-based and Evidence-informed Strategies for Child and Adolescent Injury Prevention. See p. 29 for a summary of strategies.

**Best Practice**

- **Every Child Succeeds** (OH): Building trusting relationships for those with children 0-3.
- **Nurse Family Partnership** (National): Partnering nurses with low income mothers.

**Promising Practice**

- **Adolescent Champion Model** (MI): PDSA cycles for youth-serving clinical providers.
- **Boys’ Health Advocacy Program** (SD): Increase access to health care services for boys.
- **Graduated License Education** (NE): Parent and teen education on GDL restrictions.
- **Safe Stars** (TN): Safety standards for youth sport programs.

**Examples of Current ESMs**

<table>
<thead>
<tr>
<th>Quadrant 1: Quantity of Effort</th>
<th>Quadrant 2: Quality of Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of parents and caregivers receiving car seat education (GU)</td>
<td>Percent of families participating in the evidence-based home visiting program who receive injury prevention education (GU)</td>
</tr>
<tr>
<td>Number of comprehensive home assessments completed (PA)</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Quadrant 3: Quantity of Effect</th>
<th>Quadrant 4: Quality of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of local communities that have implemented Child Passenger Safety Strategies (KY)</td>
<td>Percent of families served in home visiting programs who have reports of child maltreatment (AR)</td>
</tr>
<tr>
<td>Percentage of high school students who wear seatbelts (NH)</td>
<td></td>
</tr>
</tbody>
</table>

**Field-Generated Measures**

Use the MCH Library to find ESMs being used by other Title V programs

**Promising Practices**

Use AMCHP’s Innovation Station to find practices that can advance NPMs

**Cutting Edge Practice**

- **e-Submissions of Car Seat Inspections** (IN): Electronic submissions of safety checks.
- **Graduated License Education** (NE): Parent and teen education on GDL restrictions.
- **Safe Stars** (TN): Safety standards for youth sport programs.

**Additional Resources**

- Access ESMs from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Child Safety Toolkit for strategies and tools
NPM 8 Strategy Shortcuts: Physical Activity

These strategies have been proven effective in addressing NPM 8.1 Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day and NPM 8.2 Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day. They can be adapted for your program needs.

Evidence-Linked Strategies

Moderate Evidence
- **Individual Counseling by Health Professionals**: Promote physical activity counseling during well-child visits.
- **Infrastructure and Environmental Supports for Physical Activity**: Promote the development and use of infrastructure that facilitates physical activity (e.g., walking trails, sidewalks, playgrounds, parks).

Mixed Evidence
- **Mass Communication Strategies Combined with Other Efforts**: Use mass media strategies (e.g., posters, flyers, websites) in conjunction with other strategies to promote physical activity.
- **Policies Regarding the Use and Promotion of Local Locations and Resources**: Develop policies for the use of local locations and resources (e.g., sporting clubs, community centers, shopping malls, schools) and promote physical activity events at these locations.

Strategies from “What Works for Health”
- **Active (Semi-) Structured Recess**: Establish a break from the school day, typically before lunch, that involves planned, inclusive, actively supervised games or activities.
- **Community Weight Loss Challenges**: Support temporary programs to energize participants to lose weight via prizes, often combined with education and support.
- **Extracurricular Activities for Physical Activity**: Provide chances for children and adolescents to be active via before- and after-school activities.

Promising Practices

Best Practice
- **Empower Program** (AZ): Promotion of physical activity standards in child care.

Promising Practice
- **La Vida Sana, La Vida Feliz** (IL): Health, nutrition, and fitness promotion program.
- **Urban Lotus Project** (NV): trauma-informed yoga & coping skills for youth affected by adverse childhood experiences (ACEs).

Emerging Practice
- **Alaska Childhood Understanding Behaviors Survey (CUBS)** (AK): Data collection.
- **Georgia Shape** (GA): Increase physical activity and health for children.

Field-Generated Measures

Examples of Current ESMs

<table>
<thead>
<tr>
<th>Quadrant 1: Quantity of Effort</th>
<th>Quadrant 2: Quality of Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of programs/trainings implemented to increase and integrate physical activity into typical school activities (for children) (IN)</td>
<td>Percent of children participating in the WV Coordinated Approach to Child Health (CATCH) Program (for children) (WV)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant 3: Quantity of Effect</th>
<th>Quadrant 4: Quality of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of community environmental changes demonstrated as a result of enhanced collaborations (NY)</td>
<td>Percentage of children ages 6-11 enrolled in CFSS whose parent reports that the child gets at least one hour of physical exercise per day (NH)</td>
</tr>
</tbody>
</table>

Additional Resources
- Access ESMs from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Physical Activity Toolkit for strategies and tools
NPM 9 Strategy Shortcuts: Bullying
These strategies have been proven effective in addressing NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others. They can be adapted for your program needs.

Evidence-Linked Strategies
Use MCH Best to find strategies based on high-level evidence
Note: Strategies with the most evidence are often more clinical. Check the MCH Best Database for newly-added, more public health strategies.

Moderate Evidence
- Combining classroom and school level interventions appears to be more effective than implementing either alone (choose multiple strategies below).

Emerging Evidence
- Adult-Led Counseling, Mentoring, and Support: Increase youth participation in evidence-based mentoring, counseling, or adult supervision programs.
- Ongoing Outreach at Schools: Collaborate with School Based Health Centers to conduct ongoing meetings, conferences, and webinars to address bullying.
- Suicide Prevention In-Class Training: Provide learning opportunities and support to youth in the classroom regarding bullying and suicide prevention.
- Strengths-Based Classroom Training: Provide classroom training for students on positive youth development and non-violence intervention skills.
- Trauma Training: Provide education for school professionals and the community.

Mixed Evidence
- Peer-Led Counseling, Mentoring, and Support: Promote a peer-led, counseling support group to provide strengths-based skills in dealing with cyberbullying.

Evidence-Informed Practice
- Social Norms Intervention (National): Intervention using social norms.
- Social Support System (National): Intervention using a whole-school approach.
- Take the Lead (National): Curriculum-based bullying prevention program.

Promising Practice
- Bully-Proofing Your School (National): School safety program.
- Olweus Bullying Prevention Program (National): Bullying prevention resources.
- Positive Action (National): Curriculum to improve student behavior and motivation.
- Steps to Respect (National): Social-emotional learning resources.
- Success in Stages® (National): Program that involves victims, bystanders, and bullies.

Cutting Edge Practice
- Safe School Ambassadors (National): Student-centered bullying prevention program.

Examples of Current ESMs

Field-Generated Measures
Use the MCH Library to find ESMs being used by other Title V programs

Quadrant 1: Quantity of Effort
- The number of trainings provided by MCH to school staff on bullying prevention (OK)

Quadrant 2: Quality of Effort
- Percent of schools that have implemented evidence-based programs to address bullying (MP)

Quadrant 3: Quantity of Effect
- Number of schools and/or organizations in target communities that have implemented a comprehensive bullying program (WV)

Quadrant 4: Quality of Effect
- Percent of schools and/or organizations in target communities reporting fewer bullying incidents (Sample)

Additional Resources
- Access ESMs from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Bullying Toolkit for strategies and tools

>> From Assessing Prevention Capacity & Implementing Change: An Evidence-informed and Evidenced-based Bullying Prevention Capacity Assessment and Change Package
>> Also see AMCHP’s NPM 9 Implementation Toolkit for field-based strategic approaches.
NPM 10 Strategy Shortcuts: Adolescent Well-Visit

These strategies have been proven effective in addressing NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. They can be adapted for your program needs.

Evidence-Linked Strategies

Moderate Evidence
- **Expanded Insurance Coverage**: Ensure adolescents are enrolled in a health insurance program.

Emerging Evidence
- **Patient Reminders/Navigator Programs**: Support a patient reminder/navigator program that includes telephone and mailed reminders with transportation services.
- **School-Based Health Centers**: Partnership between a primary care clinic and local school-based health centers.

Evidence-Linked Strategies

Use MCH Best to find strategies based on high-level evidence

Note: Strategies with the most evidence are often more clinical. Check the MCH Best Database for newly-added, more public health strategies.

Strategies from the National Adolescent & Young Adult Health National Resource Center Improving Young Adult Health: State and Local Strategies for Success. This guide outlines five real-life strategies that Title V programs can adopt to improve young adult (YA) health:

- **Collect data and adopt a YA measure**: Develop surveys or adapt existing survey tools.
- **Build collaborative networks**: Bring stakeholders with diverse experience together.
- **Provide training on YA health**: Engage and increase young adult health knowledge.
- **Create targeted programs**: Kickstart programming through incentives and feedback.
- **Use innovative outreach**: Use social media with partners to provide outreach.

Promising Practices

Use AMCHP’s Innovation Station to find practices that can advance NPMs

Best Practice
- **Hospital Transition Planning Tool** (TX): EMR-based tool to improve readiness.

Promising Practice
- **Adolescent Champion Model** (MI): Improve services for adolescents at clinics.
- **Boys’ Health Advocacy Program** (SD): Increase access to health care services for boys.
- **Health Equity Zones** (RI): Community-led infrastructure to drive policies and systems.
- **Pono Choices** (HI): Respond to teen pregnancy and STIs through 10-hour curriculum.
- **Providers & Teens (PATCH) Program** (WI): Improve transition/overall health care experiences.
- **Youth Health Improvement Initiative** (VT): Health promotion initiative for teens.

Emerging Practice
- **Adolescent-Centered Environment Assessment** (MI): Self-assessment and process.
- **Youth Advisory Council** (RI): Leadership development through council participation.

>> Also see AMCHP’s NPM 10 Implementation Toolkit for field-based strategic approaches.

Field-Generated Measures

Use the MCH Library to find ESMs being used by other Title V programs

Examples of Current ESMs

**Quadrant 1: Quantity of Effort**
- **Number of adolescent well-visits provided by school-based health centers (SBHCs)** (IL)

**Quadrant 2: Quality of Effort**
- **Percentage of school-based health centers (SBHCs) able to bill for services rendered** (WA)

**Quadrant 3: Quantity of Effect**
- **Number of adolescents receiving a preventive medical visit in the past year at a local health department** (NC)

**Quadrant 4: Quality of Effect**
- **Percentage of adolescents at health centers who have at least one comprehensive well-care visit during the measurement year** (NH)

Additional Resources
- **Access ESMs** from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Adolescent Well-Visit Toolkit for strategies and tools
NPM 11 Strategy Shortcuts: Medical Home

These strategies have been proven effective in addressing NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. They can be adapted for your program needs.

Evidence-Linked Strategies

Emerging Evidence
- **Dedicated Care Coordinators**: Use dedicated care coordinators to develop relationships with families to increase timely attendance of well-child visits and respond to the needs of families.
- **Provider Alliance and Mid-Level Providers**: Use a provider alliance and mid-level providers to create a “one-stop” medical home model to provide community outreach and coordination of services.
- **Provider-School Partnerships**: Develop partnerships between primary care providers (PCPs) and school-based health centers (SBHC) to create an expanded medical home model based on care coordination.
- **Shared Care Coordination with Home Visiting**: Develop early connections to a medical home through care coordination and collaboration with home visiting.

Best Practice
- **Health-e-Access Telemedicine Program** (NY): Diagnosis/treatment using technology.
- **Hospital Transition Planning Tool** (TX): EMR-based tool to improve readiness.

Promising Practices
- **Family Voices of California Project Leadership** (CA): Advocacy training for families.
- **Oregon Care Coordination Program** (OR): Support and resources for CYSHCN.
- **Pediatric Practice Enhancement** (RI): Improve medical home infrastructure.

Promising Practice
- **Care Connection for Children** (VA): Care coordination for CYSHCN.
- **CMS-CYSHCN Youth Transitions** (FL): Improving transitions services for CYSHCN.
- **Medical Preparedness Pediatrics** (AK): Disaster preparedness around CYSHCN.
- **Partners in Care: Together for Kids** (FL): Pediatric palliative care model.
- **Utah Clicks: Universal Application System** (UT): Centralized application process.

Emerging Practice
- **National Resource Center for Patient/Family-Centered Medical Home Promising Practices**: Access practices selected by an expert workgroup as innovative and promising. Categories include practices for FQHCs, pediatric practices, local/community organizations, academic institutions, state-based groups, and family organizations.

Examples of Current ESMs

<table>
<thead>
<tr>
<th>Quadrant 1: Quantity of Effort</th>
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</thead>
<tbody>
<tr>
<td><strong>Number of providers trained and provided information on medical home implementation</strong> (TN)</td>
<td><strong>Percent of medical homes with trained staff</strong> (RI)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant 3: Quantity of Effect</th>
<th>Quadrant 4: Quality of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The number of Primary Care Provider practices who have adopted a Transition Policy</strong> (NH)</td>
<td><strong>Percent of family members, health care providers, and community professionals trained on medical home concepts who report a change in knowledge following the training</strong> (WI)</td>
</tr>
</tbody>
</table>

Additional Resources
- **Access ESMs** from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s **Medical Home Toolkit** for strategies and tools
NPM 12 Strategy Shortcuts: Health Care Transition

These strategies have been proven effective in addressing **NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.** They can be adapted for your program needs.

**Evidence-Linked Strategies**

**Moderate Evidence**

- **Six Core Elements Adaptation with Quality Improvement (QI):** Incorporate the Six Core Elements in a learning collaborative or medical center/hospital system with built-in QI activities.
- **Training/Educating Youth:** Provide training including communication and social media for adolescents with and without special health care needs who are ready for transition to adult health care.

**Emerging Evidence**

- **Medical Home Integration:** Incorporate transition strategies and billing codes into medical home systems.
- **Peer Support and Mentorship:** Create a peer support and mentorship program or adolescent advisory council to discuss issues around health care transition.
- **Professional Training/Workforce Development:** Provide transition training modules to health care professionals.
- **Transition Care Coordination Services:** Use care coordinators at clinics to help with appointments, scheduling, education, and other health care transition services.

**Promising Practices**

**Best Practice**

- **Community Systems Building Grants for CYSHCN (NC):** Capacity-building to launch innovative strategies and county-level and service delivery system change.
- **Hospital Transition Planning Tool (TX):** EMR-based tool to improve readiness.
- **Oregon Youth Transition (OR):** Comprehensive transition program.

**Promising Practice**

- **PATCH Program (WI):** Improve transition and overall health care experiences.
- **Pediatric Practice Enhancement (RI):** Improve medical home infrastructure.
- **Using the 6 Core Elements in Medicaid (DC):** Set of core elements for transition.

**Emerging Practice**

- **Care Connection for Children (VA):** Care coordination for CYSHCN.
- **CMS Kids: Medical Foster Care (FL):** Family-based care for medically complex foster kids.
- **CMS-CYSHCN Youth Transitions (FL):** Improving transitions services for CYSHCN.
- **Youth Advisory Council (RI):** Use of youth as advisors to the Department of Health.
- **Youth Leadership Development Initiative (RI):** Promoting youth leadership.

>> Also see AMCHP’s **NPM 12 Implementation Toolkit** for field-based practices & resources.

**Field-Generated Strategies**

**Examples of Current ESMs**

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<th>Quadrant 1: Quantity of Effort</th>
<th>Quadrant 2: Quality of Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of providers who have a health care transition policy within their practice (GA)</strong></td>
<td><strong>Percent of school-based health centers with a protocol for transitioning from youth to adult health care (IL)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant 3: Quantity of Effect</th>
<th>Quadrant 4: Quality of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of county CCS programs with family members providing input into transition policies (CA)</strong></td>
<td><strong>Percent of CYSHCN ages 12-17 years with at least one transition to adulthood service (NJ)</strong></td>
</tr>
</tbody>
</table>

**Additional Resources**

- **Access ESMs** from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s **Transition Toolkit** for strategies and tools
NPM 13 Strategy Shortcuts: Oral Health

These strategies have been proven effective in addressing NPM 13: 13.1 Percent of women who had a dental visit during pregnancy and 13.2 Percent of children, ages 1 through 17, who had a preventive dental visit in the past year. They can be adapted for your program needs.

**Evidence-Linked Strategies**

**Moderate Evidence**
- Medicaid Reforms (13.2): Increase the number of dental providers who accept Medicaid through activities such as provider training, increased reimbursements, and other incentives.
- Public Insurance Coverage (13.2): Collaborate with Medicaid to increase the number of children and youth who have had a preventive dental visit in the past year.
- School/Preschool Interventions (13.2): School-Based Dental Services/Head Start Participation: Increase oral health referrals among children and youth through School Based Health Centers (SBHCs).

**Expert Opinion**
- Provider Education (13.1): Collaborate with Early Head Start programs, home visiting programs, and/or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to train staff to provide preventive oral health care to pregnant women and referrals to oral health professionals for dental visits.

**Emerging Evidence**
- Medicaid Reforms (13.2): Increase the number of dental providers who accept Medicaid through activities such as provider training, increased reimbursements, and other incentives.
- Public Insurance Coverage (13.2): Collaborate with Medicaid to increase the number of children and youth who have had a preventive dental visit in the past year.
- School/Preschool Interventions (13.2): School-Based Dental Services/Head Start Participation: Increase oral health referrals among children and youth through School Based Health Centers (SBHCs).

**Use MCH Best to find strategies based on high-level evidence**
*Note: Strategies with the most evidence are often more clinical. Check the MCH Best Database for newly-added, more public health strategies.*

**Promising Practices**

**Promising Practice**
- Virtual Dental Home (HI): Community-based dental services.

**Emerging Practice**
- Children’s Dental Services (MN): Safety net services for underserved populations.
- Educating Home Visitors (VA): Oral health training and supports to home visitors.
- Home by One Program (CT): Trainings for parents, case managers, and providers.
- Understanding Behaviors Survey (AK): Survey about early childhood experiences.

**Examples of Current ESMs**

**Quadrant 1: Quantity of Effort**
- Number of expectant mothers and those post-partum women who received oral health education (MS)

**Quadrant 2: Quality of Effort**
- Percent of dental or other health care workers providing information on how to care for teeth and gums during pregnancy (CT)

**Quadrant 3: Quantity of Effect**
- Number of pregnant women who saw the dentist post referral (MS)

**Quadrant 4: Quality of Effect**
- Percent of high-risk children, ages 1 through 17, who had a preventive dental visit in the past year (CT)

**Promising Practices from “What Works for Health”**
- Allied Dental Professional Scope of Practice: Expand the role of allied professionals.
- Community Water Fluoridation: Retain optimal fluoride concentrations.
- Early Head Start: Provide dental services for families with low income.
- Federally Qualified Health Centers (FQHCs): Increase support and access to FQHCs.
- School Dental Programs: Provide preventive care on school grounds.
- Text Message-Based Health Interventions: Provide reminder and education.

**Additional Resources**
- Access ESMs from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Oral Health Toolkit for strategies and tools

**Field-Generated Measures**

**Use the MCH Library to find ESMs being used by other Title V programs**
NPM 14 Strategy Shortcuts: Smoking

These strategies have been proven effective in addressing NPM 14: 14.1 Percent of women who smoke during pregnancy and 14.2 Percent of children, ages 0 through 17, who live in households where someone smokes. They can be adapted for your program needs.

Evidence-Linked Strategies

Moderate Evidence

- **Telephone Counseling + Education Materials**: Provide telephone counseling + educational materials to reduce children’s exposure to secondhand smoke in the home.
- **Home Visits + Education Materials + Telephone Counseling**: Provide in-person counseling via home visits + educational materials + telephone counseling to reduce child exposure to secondhand smoke in the home.
- **Incentives**: Incentives to reduce smoking during pregnancy.
- **Health Education**: Provide health education to reduce smoking during pregnancy.

Emerging Evidence

- **Counseling**: Provide counseling to reduce smoking during pregnancy.
- **School-based Counseling + Education Materials**: Provide in-person counseling in a school setting + educational materials to reduce child exposure to secondhand smoke in the home.
- **Clinic-based Counseling + Education Materials**: Provide in-person counseling + educational materials during visits with a health care provider to reduce child exposure to secondhand smoke in the home.
- **Feedback**: Provide feedback to support reduction or smoking cessation behaviors.

Promising Practices

- **Baby and Me Tobacco Free** (National): Tobacco cessation counseling & management.
- **Healthy Babies are Worth the Wait** (KY): Prevention of preterm births.
- **Nurse Family Partnership** (National): Partnering nurses with low income mothers.
- **One Tiny Reason to Quit** (VA): Social marketing directed to African-Americans.

Promising Practice

- **Internatal Care Program** (AZ): Care coordination and health education.
- **MotherWoman** (MA): Community resources to support mothers.

Emerging Practice

- **Superior Babies Program** (MN): Promotion of healthy prenatal & parenting behavior.
- **The Missouri Model for Brief Smoking Cessation Training** (MO): Provider training.
- **Women Together for Health** (AZ): Program to address modifiable lifestyle behaviors.
- **Tampa Bay Doula Program** (FL): Program providing free perinatal services.

Field-Generated Measures

Examples of Current ESMs

- **Quadrant 1: Quantity of Effort**
  - Number of women who receive tobacco cessation counseling by care managers and/or home visitors (NC)

- **Quadrant 2: Quality of Effort**
  - Percent of pregnant women who smoke referred to an evidence-based program enrolled/accepted services (KS)

- **Quadrant 3: Quantity of Effect**
  - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months (NV)

- **Quadrant 4: Quality of Effect**
  - Percent of clients enrolled prenatally in home visitation program who reported reduction or stoppage of smoking by time of delivery (GU)

Additional Resources

- Access ESMs from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s Smoking Toolkit for strategies and tools
**NPM 15 Strategy Shortcuts: Adequate Insurance Coverage**

These strategies have been proven effective in addressing **NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured**. They can be adapted for your program needs.

### Evidence-Linked Strategies

**Moderate Evidence**
- **Insurance Utilization Support**: Insurance enrollment helpline.
- **Expansion of Coverage Eligibility**: Medicaid buy-in program.

**Emerging Evidence**
- **Healthcare Delivery Quality Improvement (QI initiatives)**: On-site medical practice care coordination services.

**Strategies from the Catalyst Center**
- **Strategies** states are using to improve and finance care for CYSHCN: behavioral health, benefits counseling, care coordination, CHIP, EPSDT, family supports, foster care, inequities, managed care, mandated benefits, Medicaid buy-ins, Medicaid waivers, premium assistance, relief funds, TEFRA, telemedicine, and transition services.

**Strategies from “What Works for Health”**
- **Health Insurance Enrollment Outreach and Support**: For un-/under-insured families.
- **Mental Health Benefits Legislation**: Regulate insurance to increase access.
- **Patient Navigators**: Provide care coordination to guide patients through supports.
- **Public Reporting of Health Care Quality Performance**: Use report cards and sites.
- **School-Based Health Centers**: Provide services on school premises.
- **Unemployment Insurance (UI)**: Extend or raise compensation for UI.
- **Value-Based Insurance Design**: Create incentives to affect consumer choices.

### Promising Practices

**Best Practice**
- **Health-e-Access Telemedicine Program** (NY): Diagnosis/treatment using technology.
- **Parent Child Assistance Program (PCAP)** (WA): Advocacy/case management for mothers.

**Promising Practice**
- **Boys’ Health Advocacy Program** (SD): Increase access to health care services for boys.
- **First 5 California Kit for New Parents** (CA): Parenting and community resources.

**Emerging Practice**
- **MN Care Coordination Systems Assessment and Action Planning** (MN): Care Coordination assessment.
- **Tampa Bay Doula Program** (FL): Program providing free perinatal services.
- **Utah Clicks: Universal Application System** (UT): Centralized application process.

**Cutting Edge Practice**
- **Universal Adoption of Bright Futures** (GA): Program covering various services.

### Examples of Current ESMs

**Quadrant 1: Quantity of Effort**
- Number of families who received education in navigating health insurance financing options (MN)

**Quadrant 2: Quality of Effort**
- Percent of families who received insurance education through the home visiting program (Sample)

**Quadrant 3: Quantity of Effect**
- Number of primary caregivers and children with health insurance at one year post enrollment among Home Visiting participants (Sample)

**Quadrant 4: Quality of Effect**
- Percent of primary caregivers and children with health insurance at one year post enrollment among Home Visiting participants (MO)

### Additional Resources
- **Access ESMs** from other Title V programs that can serve as examples and models
- Access the MCH Evidence Center’s **Adequate Insurance Coverage Toolkit** for strategies and tools
2. Think *Upstream with a Structured Planning Process*. To ensure that programs address issues early, are *measurable*, and “turn the curve” on issues that face MCH populations, a system of translating the evidence into practice is needed. *Results-Based Accountability (RBA)* identifies root causes of population-based issues, develops responsive programs to bring about change, and establishes measures that can be quantified, brought to scale, and replicated across population groups.

**What is RBA?** RBA – also called “moving from talk to action” – is a tool that:

- Connects your programs to desired results and supports the development of robust and feasible action plans.
- Ensures your programs are connected to your work and advance your goals.

RBA can be used at a *population level* to identify and choose National Outcome and Performance Measures (NOMs and NPMs) and at a *performance level* to set State Performance and Evidence-based/informed Strategy Measures (SPMs and ESMs) and track measurement.\(^\text{12}\)

**RBA on a Population/Needs Assessment Level.** RBA starts with the ends and works backward, step-by-step, to means. This process can serve as a *way to double-check and reinforce your needs assessment process*.

Gather your staff, partners, and members of the community and ask these seven questions to make sure you have captured the necessary information from your stakeholders and are aligning your goals with NOMs, NPMs, and SPMs:

1. **RESULTS:** *What are the quality of life conditions we want for the families who live in our community?* These are the population results we want (e.g., children living to their first birthday, children are safe on the road).
2. **EXPERIENCE:** *What would these conditions look like if we could see them?* Ask how you would recognize these results in your everyday lives, without worrying about identifying programs or data (e.g., children not dying in their cribs while sleeping, children wearing bike helmets).
3. **INDICATORS:** *How can we measure these conditions?* How would you see these experiences in measurable terms? What data do you already have? What new data could you collect? (e.g., percent of child care facilities that are trained in safe sleep, number of bike helmets distributed). For each indicator, ask yourself how you are doing – are the numbers improving, staying the same, or getting worse?
4. **BASELINE and STORY BEHIND THE CURVE:** *How are we doing on the most important of these measures?* Map out your data over time and develop a baseline that includes 5 years ago to now and a projection 5 years into the future (ask yourself what would the data look like if you did nothing different). Write down the root causes of why the data looks the way it does – include health disparities, behavior change, and social determinants of health. Then map out how you would like the data to look into the future.
5. **PARTNERS:** *Who are the partners that have a role to play in doing better?* For every “cause” in step 4, think of a partner who you can work with to address the need. Include typical and new partners. Then list partners who can work to address disparities. Are they at the table? How can you engage them?
6. **WHAT WORKS:** *What works to do better, including no-cost and low-cost ideas?* Brainstorm possible actions that Title V can work directly to address identified root causes, engage partners, and leverage other programs already in place. Ask yourself “what would it take to make the numbers better?” Use MCH Evidence Center tools to see if your ideas align with the established or emerging evidence for “what works.”
7. **ACTION PLAN:** *What do we propose to do?* The next step is to create an action plan. Start by setting priorities and a timeline: “Now,” “Next 12 Months,” and “2 to 5 years.” No-cost/low-cost actions are natural places to start. Don’t wait for the perfect plan to be developed and approved. Get started right away.

**Public Square Test.** Will your stakeholders understand the priorities and actions that you have decided on based on your needs assessment? Could you stand in a community public square and explain what you want to do? Do your activities have the “power” to be understood? Are they representative? Are they data driven?

1. **Communication Power.** Does your proposed activity communicate to a broad and diverse audience?
2. **Proxy Power.** Does your activity address a root cause and carry potential to bring about the desired result? Can the activity stand as a proxy or representative for a number of strategies needed to affect change?
3. **Data Power.** Do you have quality, timely data? Is the data reliable and consistent?

To prioritize, choose the activities with the best data power, then rank those activities that have the best chance to “make a difference” and be adopted by the community and your partners.\(^\text{13}\)
RBA on a Performance/ESM Level. RBA can also serve as a way to choose and strengthen your ESMs and SPMs. Similar to the population-level process, you could consider seven performance accountability questions once you have set your priorities, identified your NPMs, and are focused on ESMs. Note some key differences in approach:

1. **CUSTOMERS: Who are our customers?** Develop a complete list of who these groups are. Remember, your “customers” are the direct recipients of your strategy – they might be providers, an organization, or the MCH population group you are targeting (the customer might not be the mother/infant/child/youth/family).
2. **EFFECT: How can we measure if our customers are better off?** Come up with the most meaningful measures, even if you don’t have data or don’t control every aspect of the activity. These might eventually be Quadrant 4 measures (highest measurement).
3. **EFFORT: How can we measure if we’re delivering services well?** Your answers will usually measure what staff do and how well your programs perform. These will be Quadrant 1 and 2 measures.
4. **BASELINE and STORY BEHIND THE CURVE: How are we doing on the most important of these measures?** Two parts: (1) From strategies in steps 2 and 3, what are the 3 to 5 “headline measures?” Try to get a mix of Category 2 and 4. (2) Graph out your efforts and create a baseline (history and forecast). Tell the story behind the data. Why are things getting better or worse? What are the causes at work?
5. **PARTNERS: Who are the partners?** Consider partners inside and outside your organization. Consider active, non-active, and outside-the-box partners. What can they do to help turn the curve?
6. **WHAT WORKS: What works to do better?** There are two natural pointers to answer this question: (1) each part of the story behind the curve (the “cause;” e.g., poor lighting is a cause of increased fear of crime) and (2) actions that come from the partners list. Each partner has something important to turning the curve. Evidence is important here. Look at the research for what has worked in other places, both from the MCH Evidence Center’s online toolkits and from best and promising practices. List these strategies.
7. **ACTION PLAN: What do we propose to do?** Choose the most powerful actions from the possibilities identified in #6. You can use the criteria list (SilVeR — specificity, leverage, values, and reach). Organize these actions into a plan that specifies the person responsible for each task, timelines, and necessary resources.

**Turn the Curve (TTC) Activity.** You can answer each of these questions individually or work through Turn the Curve (TTC) process. TTC is a quick method to strategically think about your needs assessment data and develop strong measures to assess progress we make in changing the trajectory of your work. There are five basic steps to the TTC activity that can be adapted to meet your team’s needs:

1. Graph or describe the trend of data associated with your outcome.
2. Analyze and describe the story behind the curve to give your outcome some background and context.
3. Identify existing and new partners who have a role to play in improving the data.
4. Brainstorm what works to address the contributing factors and turn the curve.
5. Develop and implement a comprehensive action plan that includes strong measures.

**SiLVeR Test.** When looking at your ESMs, SPMs, or other strategies, ask yourself if they are SiLVeR? Do they have:

1. **Specificity.** Are the strategies focused enough to be implemented? Do they align with the evidence? With a theory of change? With the goal of the NPM?
2. **Leverage.** How much difference will the strategies make – will they address a root cause and turn the curve?
3. **Values.** Will the strategies be adopted by the community they are targeting? Do they work to address health disparities and social determinants of health?
4. **Reach.** Are the strategies feasible and affordable? Can they actually be done and when? Do you have the resources to ensure that the level of activity will be enough to make a change?

Begin with activities that rate highest in the first three areas. Build up to strategies where “reach” is a question. 

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**Measuring and Reporting ESMs and SPMs.** RBA provides an intuitive framework to help you move from reporting “what did we do?” (simplest form of measurement) to “how well did we do it?” and eventually to “is anyone better off from our efforts?” and “how are they better off?” (reporting impact). RBA provides four quadrants of measurement when you look at **effort and effect** across **quantity and quality**.

### Four Quadrants of Measurement

**Effort**

**1. Measuring Quantity of Effort**
- **What did we do (#)?**
  - Quantity of effort; lowest measurement
  - How much service did we deliver?
  - Examples: # individuals served; # of activities

**Quality**

**2. Measuring Quality of Effort**
- **How well did we do it (%)?**
  - Quality of effort; better measurement than #1
  - How well did we deliver service?
  - We try to measure reach & satisfaction/quality of services
  - Examples: % individuals trained, % hospitals compliant, % referrals, % respondents satisfied with services

**Effect**

**3. Measuring Quantity of Effect**
- **How much change for the better did we produce?**
  - Explanation: # individuals who show improvements in skills/knowledge, attitude, behavior, or circumstance
  - Examples: # individuals who received treatment after referral, # individuals trained who showed increase in knowledge

**4. Measuring Quality of Effect**
- **What quality change for the better did we produce?**
  - Explanation: % individuals who show improvements in skills/knowledge, attitude, behavior, or circumstance
  - Example: % individuals who received treatment after referral, % individuals trained who showed increase in knowledge

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Once you have identified strategies to use as your ESMs and SPMs, map them across these four quadrants. Think of how you might strengthen your strategies by moving from quadrant 1 to 2 and from 3 to 4, knowing that it’s not always feasible to move up based on data and resources available. However, measurement is important! **Spend some time strategizing how to report stronger measures in your MCH Block Grant report and application.** Tell the Title V story as having a quantifiable and qualifiable effect on your MCH populations.

**Summarizing ESMs Nationwide.** Across the country, we are advancing our understanding of measurement. The following table summarizes where the 2018/2020 ESMs fell across the four quadrants.

<table>
<thead>
<tr>
<th>Quadrant 1: Measuring Quantity of Effort (Counts and “Yes/No” Activities)</th>
<th>Quadrant 2: Measuring Quality of Effort (% of Reach; Satisfaction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 48.6% of ESMs total (367/756)</td>
<td>• 36.2% of ESMs total (274/756)</td>
</tr>
<tr>
<td>• 89% of these are counts; 11% “yes/no” activities</td>
<td>• 63% are client services; 37% are systems-building</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant 3: Measuring Quantity of Effect</th>
<th>Quadrant 4: Measuring Quality of Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 5.8% of ESMs total (44/756)</td>
<td>• 9.4% of ESMs total (71/756)</td>
</tr>
<tr>
<td>• 64% report system changes; 36% measure number of people who benefited from programs</td>
<td>• 13% are increased knowledge/skills; 87% are percent of people who benefited from programs</td>
</tr>
</tbody>
</table>

**Goals in Strengthening Your Measures.** When looking at your ESMs, SPMs, or other strategies:

- Move from measuring quantity to quality.
- Eventually move from measuring effort to effect.
- Quadrant 1 strategies should be used sparingly, when no other data exists. Challenge yourself to find ways to report more meaningful accomplishments.
- The most effective measurement combines strategies in all levels, with most in quadrants 2 and 4.
- Use all the tools at your fingertips to double-check your strategies: ESM tip sheet (p. 4), strategy shortcuts (pp. 5 – 19), Public Square Test (p. 20), SilVeR Test (p. 21), and the tools in the next section.
3. Work Together to Implement Title V Tools. To ensure that programs are moveable within the realities of Title V programs and lead to health equity for all people, a strengths-based MCH approach draws on numerous Title V tools:

- **Field-Generated, Online Resources.** The MCH Library serves as a gateway to electronic resources across all topic areas addressed by Title V programs.
- **Social Determinants of Health and Health Equity Tools.** To address health disparities, including racism and social determinants of health, staff have highlighted short, practical resources to include in your process for identifying strategies and setting up programs.
- **Evidence-Based, RBA Technical Assistance (TA).** MCH Evidence Center staff are available for ongoing TA opportunities that address how to develop strong measures that are based in evidence and are effective with your population groups and within your Title V program.

**Field-Generated, Online Resources.** The MCH Evidence website is your one-stop shop for resources to assist in finding, implementing, and measuring evidence-based/informed programs.

**Start Here:**
- **MCH Best Database.** Use this “Bank of Evidence-linked Strategies and Resources” to find detailed strategies that are directly supported by the best evidence; model your ESMs on examples.

**Dig Deeper:**
- **Evidence Toolkits.** Access comprehensive resources from basic summaries of the evidence base to detailed reports, sample ESMs, promising practices, additional learning, and supporting materials from the field.
- **Request TA.** See p. 26 for multiple paths to assistance.

The MCH Library website provides resources on:

1. **Evidence Finders.** Search our databases on your own to find resources that can be used as models for adjusting current or developing new ESMs:
   - **Established Evidence Database.** Access articles that highlight programs that have been proven effective in studies to advance NPM topic areas.
   - **Emerging Evidence Database.** Find new studies that have not yet been vetted, but provide research on the most current interventions.
   - **State ESM Database.** Search state ESMs to learn about promising practices.

2. **Resource Guides.** Access over 100 guides on topics critical to MCH. These guides include resources for public health professionals, families, and schools.
3. **Search the Catalog.** Use these search tools to access selected MCH resources from the founding of the Children’s Bureau to the present.
4. **Special Collections.** Browse the rich history of Title V and MCH with special collections ranging from Bright Futures, to Healthy Start, to historic MCHB-funded final reports.

**Social Determinants of Health and Health Equity Tools.** The MCH Navigator, in collaboration with the National MCH Workforce Development Center, houses extensive resources on strategies to reduce health disparities and address social determinants of health (SDOH) through its Diversity and Health Equity Training Spotlight. Key tools of importance to ensure that your programs address these concerns include:

- **At-A-Glance: Ten Essential Public Health Services and How they Can Include Addressing SDOH.** This brief document is intended to help public health agencies embed SDOH efforts as part of their portfolio in protecting the health of communities that they serve. A simple 2-column table helps illustrate the relationship between addressing SDOH inequities and the 10 essential public health services.
- **Collaborating for Equity and Justice Toolkit**: This toolkit includes case studies, resources, and tools related to the 6 core equity principles. The Community Tool Box has also created a [Data Collection for Implementation Equity assessment form](#) that asks 5 questions to consider when deploying new strategies. Do your strategies, outcomes, and determinants:
  - Explicitly address issues of social and economic injustice and structural racism?
  - Employ a community development approach in which residents have equal power in determining the coalition or collaborative’s agenda and resource allocation?
  - Employ community organizing as an intentional strategy and as part of the process?
  - Build on community-engaged scholarship and research that shows what works, acknowledges its complexity, and evaluates it appropriately?
  - Build core functions for the collaborative base on equity and justice that provide basic facilitating structures and build member ownership and leadership?
  - The process is outlined in this presentation: [Using Data to Promote Equitable Implementation: Decision-Making, Data, and Uncertainty in Complex Systems](#).

- **Race Equity Impact Assessment (REIA) Tool**. A systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities. Race Forward summarizes the [REIA process](#) that includes five questions:
  - Are all racial/ethnic groups who are affected by the strategy at the table?
  - How will the proposed strategy affect each group?
  - How will the proposed strategy be perceived by each group?
  - Think about how the strategy affects existing disparities. Does the strategy ignore existing disparities? Could it possibly worsen existing disparities?
  - Based on the above responses, what revisions are needed in the strategy under discussion? Don’t be afraid to re-think the strategy in light of addressing disparities – it’s worth it!

- **Hexagon Tool**. This is an extremely easy and useful planning and evaluation tool that guides the selection of the appropriate, evidence-based/informed strategies through a six-step exploration process. It can be used in collaboration with your partners to better understand how a new or existing program fits into your existing work and context. Use this tool as a double-check on strategies that you have chosen. It is designed to be used by a team to ensure diverse perspectives are represented in a discussion of the six contextual fit and feasibility factors:
  
  **Program Indicators**:
  1. **Evidence**. How strong is the evidence? What are the specific outcomes expected? Will it be cost-effective?
  2. **Usability**. Is the program well defined? Are components well operationalized? Are there successful models to observe?
  3. **Supports**. Are there resources (experts, training, evaluation templates) to borrow from? Are there financial resources?

  **Implementing Site Indicators**:
  4. **Need**. How well does the strategy align with the local context? Related questions leverage the community needs assessment and active feedback from parents, staff and stakeholders
  5. **Fit**. Is there a clear target audience? Are there data indicating population need? Will the strategy be accepted by the audience? What would change in the audience if the strategy were implemented?
  6. **Capacity**. Are there internal resources necessary to implement this strategy? Are we able to sustain staffing, training, data collection, performance assessment, and administration?
Request Technical Assistance (TA). We are eager to talk with you further about your ESMs. We provide TA that is customized to your needs and the time you have.

Addressing complex, systems-based issues is strengthened by a team approach. We collaborate with Evidence-Based Decision Making team of the National MCH Workforce Development Center to identify, develop, measure, and improve your ESMs.

We also collaborate with the Association of Maternal and Child Health Programs (AMCHP) to ensure that you have access to promising practices and tools from other Title V programs across the country. Finally, we coordinate with a wide array of MCHB-funded topical TA centers to make sure you have access to cutting-edge knowledge and resources from the experts. Read more about our TA here.

Specifically, we provide SMART TA that leads to:

- **Sharp, Specific, and Systems-based ESMs.** We help sharpen ESM goals to more fully advance NPM topics and utilize systems to sustain these strategies.
- **Measurable and Meaningful ESMs.** We ensure that your ESMs are measurable and in line with related projects in other states and jurisdictions.
- **Actionable, Achievable, and Aligned ESMs.** We ensure that your ESMs inform your actions, are aligned with your needs assessment, and flow from your State Action Plan.
- **Relevant and Research-based ESMs.** We connect your ESMs with the published evidence, emerging promising practices, and what other states are currently doing.
- **Translatable, Targeted, and Time-phased ESMs.** We engage your team in developing sustained approaches to address specific needs of your populations, including Children and Youth with Special Health Care Needs (CYSHCN).

Examples of TA that we provide:

- A Title V agency requests feedback on how to develop meaningful measures for its full list of ESMs before final submission of the annual block grant application.
- A Title V agency asks us to engage in a year-long process to help improve their ESMs for the next block grant application and upcoming needs assessment.
- A Title V agency wants to develop a safe sleep campaign (NPM 5) but isn’t sure whether to base it in the hospital or during prenatal visits and wants to know what the evidence says is the most effective intervention.
- A Title V agency (MCH, CYSHCN, or both) needs guidance on the RBA process specific to certain NPMs.
- A new project requires research on “what works” from the evidence and the field.
- A group of states/jurisdictions who have chosen NPM 9 (Bullying) want to compare pilot programs to find the most effective behavior-change programs.
- A region is interested in the MCH Evidence team presenting the RBA process to a group of states/jurisdictions.

How to request TA. It’s easy to connect with us. We work closely with regional project officers to provide the most appropriate assistance. You can:

- Email us at mchevidence@ncemch.org with specific questions or to set up a time to talk. We’ll get right back with you to get the process started.
- Use our online form to choose from several different types of TA.
- Talk with your regional project officer who will contact us to arrange for TA, either for your group individually or as part of a group Title V programs.
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Prepared by Strengthen the Evidence Base for MCH Programs

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3 Hagan JF. Making Bright Futures Work! How Evidence, the Periodicity Schedule, and the Bright Futures Guidelines Impact Practice. Presentation for Pediatric Care Online.
4 Adapted from Robert Wood Johnson Foundation. What Works for Health.
5,7,8 Adapted from IDEAS Impact Framework, Center on the Developing Child, Harvard University.

Summary. We are here to support you. We’ll continue to review the evidence and present it to you in meaningful ways.

• Keep checking out our websites for new tools and training opportunities.
• Let us know your needs and feedback on our ESM analysis.
• Talk to us about expanded, personalized TA that we can provide.