

MCH Evidence - Navigating the MCHbest database for evidence-based strategy and ESM selection

1. Open the Strategy Search Tool

Go to: <https://www.mchevidence.org/tools/strategies/search/index.php>.

This page allows you to look up evidence-based strategies connected to the national or state performance measures (NPM/SPM).

About the MCHbest Database

Welcome to the **MCHbest** database: the **Bank of Evidence-linked Strategies and Tools**.

The database aggregates over 500 sample evidence-based/informed ("evidence-linked") strategies that can be adopted as-is or adapted to develop Evidence-based or informed Strategy Measures (ESMs) for each of the MCH National Performance Measures (NPMs) or Standardized Measures (SMs). It's as easy as Ready, Set, Go. Read the following guidance and then access the strategies below.

2. Select the Appropriate NPM or SPM

On the main search page, locate the section titled *Population Domain*.

Choose the NPM or SPM that matches the measure listed in your Scope of Work (SOW) template or SOW strategy list.

After selecting the measure, click the Search Strategies button.

Search the MCHbest Database

There are two ways to find strategies; you can refine your search on the next page.

1. By Performance Measure

Choose which measure you want to find strategies for:

Select Measure

SEARCH STRATEGIES

3. Review the Strategy Results

The search results page will display a list of strategies associated with your selected measure.

These are potential strategies you can use in your SOW under Evidence-Based Strategy.

Results for Postpartum Visit

1. **Appointment Intervals:** Support flexibility in appointment scheduling that reduces the time interval between birth and postpartum follow-up care
2. **Community Health Workers:** Train Community Health Workers to serve as a liaison between patients and healthcare providers to improve access to postpartum care
3. **Cost Sharing Partnerships:** Support cost-sharing partnerships between payers, providers, and community support systems to defray expenses associated with postpartum visits
4. **Group Prenatal Care:** Promote the use of Group Prenatal Care models that encourage and facilitate postpartum visit attendance
5. **Guideline Adherence Protocol:** Develop or adopt a toolkit or note template for use by providers to help ensure they address all components of a comprehensive postpartum visit
6. **Home Visiting:** Collaborate with home visiting programs to support mothers in obtaining timely postpartum care
7. **Medicaid Expansion/Extension:** Support policy that expands and extends Medicaid coverage to pregnant women beyond 60 days postpartum
8. **Mobile Medical Clinics:** Promote the use of mobile health clinics to provide postpartum preventive care in under resourced communities
9. **Mother-Infant Dyad Programs:** Support primary- and pediatric-care partnerships that enable concurrent (co-located and co-timed) mother/infant preventive checkups
10. **Motivational Interviewing and Cognitive-Behavioral Therapy:** Support evidence-based behavioral/motivational therapy that encourages women to attend postpartum visits
11. **Patient Navigation:** Support patient navigation programs that include postpartum visit appointment scheduling and patient reminders
12. **Postpartum Care Plans:** Promote the use of individualized postpartum care plans, co developed by obstetric providers and their patients, that include postpartum visit scheduling
13. **Provider Training and Education:** Train perinatal nurses to education patients on potential postpartum complications that may require treatment after discharge
14. **Quality Improvement Initiatives:** Promote hospital quality improvement initiatives designed to increase the rate of postpartum visit attendance
15. **Remote Monitoring:** Incorporate telehealth options for postpartum checkups and remote monitoring of treatable conditions such as hypertension
16. **Workplace Support:** Promote workplace policies that support paid leave for new parents and facilitate postpartum visit attendance

4. Explore Each Strategy in Detail

Click on any strategy in the results list to open a detailed overview.

This page provides:

- A description of the **evidence-based strategy**
- A summary of the **evidence supporting the strategy**
- Potential **data sources** you can use
- Outcome components to help you create a **SMART goal**
- A list of **Evidence-Based Strategy Measures (ESMs)** organized into quadrants



Strategy. Patient Navigation

Approach. Support patient navigation programs that include postpartum visit appointment scheduling and patient reminders

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Overview. Patient navigation programs that include appointment scheduling and patient reminders—whether via telephone, text-messaging, or email (patient preference)—can increase postpartum visit attendance rates.[1,2] Trained patient navigators can also provide additional services as needed, including arranging transportation and access to language interpreters. This multi-pronged approach can help decrease system challenges and facilitate postpartum engagement, particularly among low-income women.[1,3] This strategy is a promising approach that is likely to be effective in increasing postpartum visit attendance rates.

Evidence. *Moderate Evidence.* Strategies based on moderate evidence show a clear trend toward positive results. While these approaches are likely to be effective, further research is needed to confirm their impact. Implement with evaluation to better understand specific local effects.

[Access the peer-reviewed evidence](#) through the MCH Digital Library or related evidence source.

Potential Data Sources. Data to support this strategy can be accessed through:

- > Patient navigator caseload and activity logs
- > Client-reported challenges to care
- > Client service utilization data
- > Client satisfaction and perceived support surveys
- > Healthcare provider feedback on navigator impact

5. Select an ESM

You may choose an ESM from any quadrant; however, Quadrants 3 and 4 are preferred because they best reflect measurable change.

Quadrant 1: Measuring Quantity of Effort ("What/how much did we do?") > Number of healthcare systems, clinics, and practices that implement patient navigation programs for postpartum visit appointment scheduling and reminders. (Measures the adoption and spread of the strategy) > Number of patient navigators trained and deployed to provide appropriate support for postpartum visit scheduling, reminders, and care coordination. (Assesses the workforce capacity and readiness for the strategy)	Quadrant 2: Measuring Quality of Effort ("How well did we do it?") > Percent of healthcare systems, clinics, and practices that implement patient navigation programs for postpartum visit appointment scheduling and reminders. (Measures the adoption and spread of the strategy) > Percent of patient navigators trained and deployed to provide appropriate support for postpartum visit scheduling, reminders, and care coordination. (Assesses the workforce capacity and readiness for the strategy)
Quadrant 3: Measuring Quantity of Effect ("Is anyone better off?") > Number of partnerships and referral pathways established between patient navigation programs, healthcare providers, payers, and community-based organizations to support seamless postpartum care coordination. (Measures the multi-sector collaboration and integration approach of the strategy) > Number of policies, reimbursement models, and sustainability plans developed to support the long-term implementation and funding of patient navigation programs for postpartum care. (Measures the enabling environment and systems change efforts for the strategy) > Number of healthcare systems and payers that demonstrate improved postpartum care quality, outcomes, and patient experience through the integration of patient navigation programs. (Measures the healthcare value and return on investment of the strategy) > Number of patient navigators who become recognized as trusted champions, supporters, and leaders for advancing postpartum health and well-being in their communities. (Assesses the workforce support and leadership development outcomes of the strategy)	Quadrant 4: Measuring Quality of Effect ("How are they better off?") > Percent of partnerships and referral pathways established between patient navigation programs, healthcare providers, payers, and community-based organizations to support seamless postpartum care coordination. (Measures the multi-sector collaboration and integration approach of the strategy) > Percent of policies, reimbursement models, and sustainability plans developed to support the long-term implementation and funding of patient navigation programs for postpartum care. (Measures the enabling environment and systems change efforts for the strategy) > Percent of healthcare systems and payers that demonstrate improved postpartum care quality, outcomes, and patient experience through the integration of patient navigation programs. (Measures the healthcare value and return on investment of the strategy) > Percent of patient navigators who become recognized as trusted champions, supporters, and leaders for advancing postpartum health and well-being in their communities. (Assesses the workforce support and leadership development outcomes of the strategy)

Other Helpful Tips for Completing SOW Data Components

ESM Indicator

The ESM indicator should be a *measurable* datapoint that reflects how well your selected strategy is being implemented. This should always be linked to **your agency's existing data systems** and the **needs of the community you serve**. If one of the MCHbest indicators does not directly fit your strategy, feel free to alter it to fit, but it should still fulfill all other requirements as outlined below.

Choose an indicator that:

- Represents meaningful change for the population (mothers, children, families).
- Can be reliably measured using your agency's data sources.
- Directly aligns with the evidence-based strategy chosen through the MCHbest tool.

Examples include: completion rates, access measures, participation numbers, or quality improvement metrics — as long as these are realistic and relevant to your service population.

Baseline

The baseline represents the *starting point* for your ESM indicator. This value must come from **agency-level data**, not national trends or assumptions.

For programs without current data, describe how the baseline will be established — for example:

- Collecting initial program data,
- Pulling existing administrative or service records,
- Partnering with community organizations to gather local information.

The baseline should accurately reflect the conditions affecting your community at the beginning of the project period.

Annual Target

The annual target should reflect the **expected improvement** based on what is realistic for your agency's capacity and for the population served.

Targets must be:

- Achievable using the resources and data systems your agency has,
- Meaningful for the population (not just a number),
- Clearly connected to the selected evidence-based strategy and community needs.

Remember: Your target is not just a performance requirement — it's a commitment to improving outcomes for the real families and individuals your agency supports.