Interpreting Results

Once the data are collected and compiled, the next step is to determine what can be learned from the results. The guidelines below provide suggestions for interpreting results depending on the data source. The questions a system asks itself to interpret the findings will vary depending on whether the data are self-ratings by system stakeholders, for example, or are counts or proportions obtained from program/population-level data sources. For self-ratings, a certain degree of interpretation may be built into the measure through the process of ranking a system according to performance levels. For measures sourced to population-level or program data, there are rarely built-in interpretive cues. Examples are provided to offer an abbreviated snapshot of how a community might go about interpreting their data for a particular system performance measure.

Interpreting Measures Based on Population-Level or Program Data

1.1 Early Prenatal Care

1.2.1 Maternal Depression: Screening

1.2.2 Maternal Depression: Connection to Services

1.3.1 Child Development: Screening

1.3.2 Child Development: Connection to Services

1.3.3 Child Development: Early Identification

1.4 Early Care and Education

1.5 Home Visiting

To interpret the results, communities should look at three broad categories of analysis, when the results enable it:

Trend What does the trend say about overall system improvement or decline for this particular measure?

Subgroup What do the subgroup results say about equity? Where are there gaps or disparities in results across groups (for example, by race or ethnicity)? Are they widening or narrowing?

Comparison How does our community compare to the state and nation overall, both in aggregate and by subgroup? What are the major opportunities for improvement?

Within each of these three broad categories of analysis, communities may want to explore what might be contributing to the results observed. Some potential influencing factors include the following:

Service Factors What is it that our system does, or doesn't do, that could be a factor? Consider:

- Types, lengths, or frequency of services (e.g., What is supply relative to demand? Is there a long waiting list or lag time?),
- Where services are provided relative to client population (e.g., To what extent are they located in, or easily accessible from, the neighborhoods where families live? Which subgroups or neighborhoods have better access to services? Do people know about the service?),
- How services are provided or accessed (e.g., To what extent are the services provided, or outreach conducted, in culturally and linguistically appropriate ways?)
- The processes of engagement and referral (e.g., To what extent are services easy to find and navigate? To what extent are referrals followed up on?), and
- The content or quality of services (e.g., Is there something about the service itself that is unappealing to clients? To what extent are the hours, delivery methods, and staffing responsive to the needs of the community?)

Environmental Factors What are factors over which the system has little direct control nevertheless have a substantial impact on results? Consider time or money limitations, funder or partner policies, privacy laws, economic issues, or seasonal issues. Are there ways to mitigate the risk or effects of factors that we do not control?

Data Factors What do we not know or need more information about in order to understand the results? Consider the additional data or information needed to unpack the results, particularly when results are unexpected or surprising.

Example Results and Interpretation:

1.1 Early Prenatal Care

The chart belowdemonstrates early prenatal care results for a particular U.S. region, showing data by trend, subgroup and comparison to the state and nation (partial data). The results were interpreted as follows:

Trend

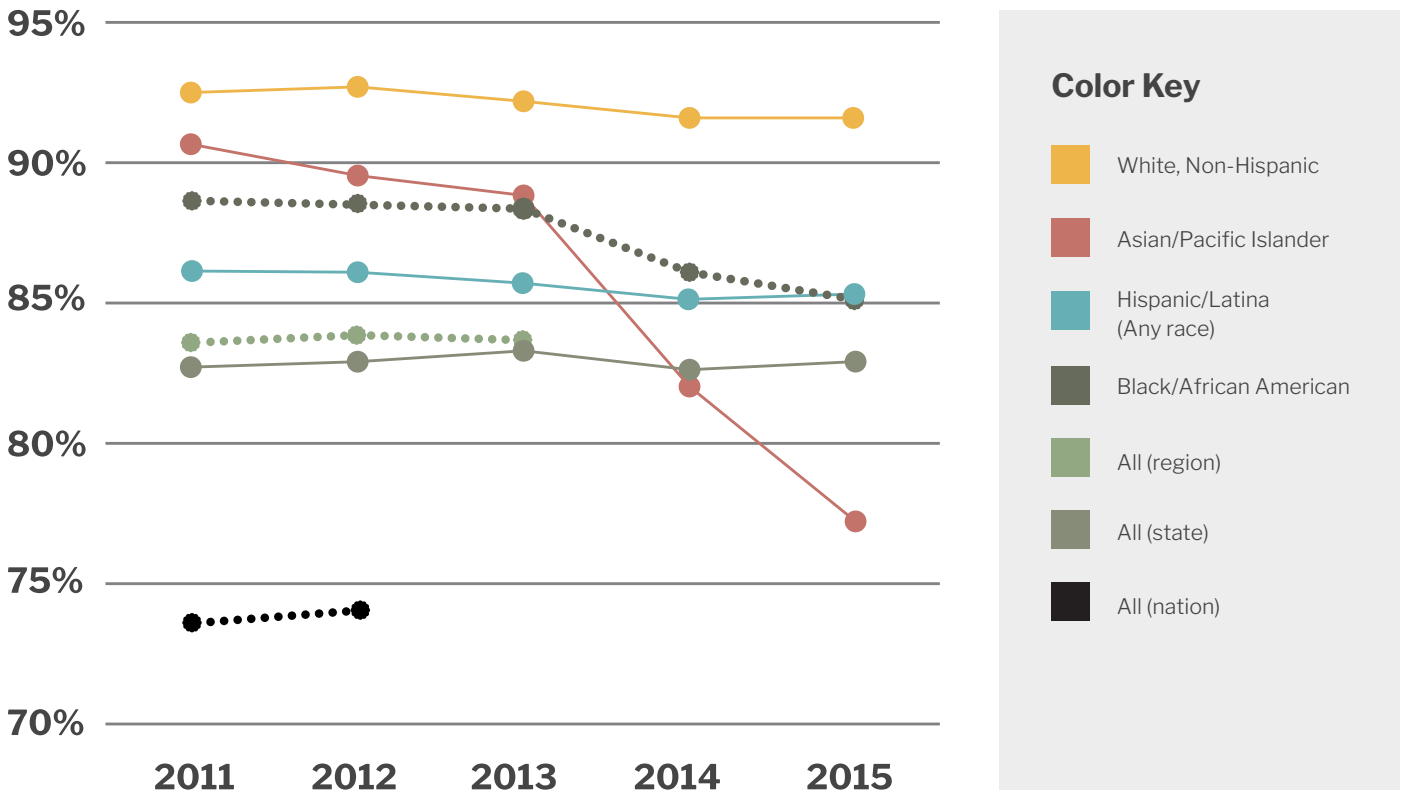
Overall trend is declining early prenatal care rates.

Subgroups

Fairly stable rates among White (Non-Hispanic), Hispanic/Latina, and Black/African American mothers; substantial decline among Asian/Pacific Islander mothers. Omitting the most recent Asian/Pacific Islander results, the gaps between subgroups are persistent. There is a notable nine-percentage point gap between White and Black/African American mothers and a six-percentage point gap between White mothers and Hispanic/Latina mothers.

Interpretation

A review of the data led the community to investigate service and environmental factors that contribute to the persistence of a race/ethnic gap. They looked at potential access barriers, including health insurance rates by race/ethnicity, availability of community clinics by neighborhood, and cultural and linguistic factors, including the race/ethnicity or gender of providers and languages spoken by providers or clinic staff. The community also sought to better understand cultural differences in attitudes toward pregnancy and health care and to assess the extent and appropriateness of education and outreach to underserved communities. The surprisingly rapid decline in prenatal care rates among Asian/Pacific Islander mothers led the community to take a deeper dive into the data. To attempt to find the salient variable, data were disaggregated in several different ways, including how the mother paid for the care (whether through private or public insurance or self-paid). The community also analyzed the access and cultural factors cited above to try to understand the rapid decline.



Interpreting Measures Based on System Self-Assessment Tools

2.1 Family Assessment
2.2 System Navigation
2.3 Working Together
2.4 Using Data
2.5 Capacity Building
3.1 Public Understanding
3.2 Leadership Engagement
3.3 Policy Change
4.1 Parent Engagement
4.2 Advancing Equity

Interpretation of self-assessments will vary depending on what is being assessed, but the following broad questions can apply to all self-assessments:

1. What is working well in our system? What can we learn from this self-assessment that we can replicate elsewhere?
2. Where are we not performing strongly? What might be contributing to that outcome?
3. How should we prioritize the results? What is the most important opportunity for improvement we have identified through the self-assessment? How will we go about pursuing this opportunity?
4. What would it take for our community to get to the next level rating? Are there system-level changes that could be made to progress?
5. If we achieved a level 3 or 4 rating, what led to that success? How can these successes be shared with other communities to support their improvement?
6. Were there any issues with the implementation of the self-assessment that may have impacted results? For example, are there important partners missing from the assessment, or did we get sufficient participation overall?
7. Do we need a unified plan or common agenda to improve our performance? If we already have a common agenda, is it effectively advancing our progress? Is it aligned with the changes we want to see?

Provided on the next pages are examples of streamlined results and interpretation for two hypothetical implementations of measures. The first is the implementation of *2.2 System Navigation* and *2.3 Working Together,* and the second is the implementation of the policy agenda setting and tracking part of *3.3 Policy Change*. It is important to note that few of the system performance measures based on self-assessment tools will have highly quantitative results; they may produce some summary data if an online survey was conducted, or the consensus result of a convenings may be summed up on a scale from 1-4. However, the real learning and progress comes from the dialogue generated by these assessments, the subsequent interpretation, and the planning to improve performance.

Example Results and Interpretation:

2.2 System Navigation / Working Together

This hypothetical community fielded a survey to front-line staff in several sectors, including home visiting, Early Head Start, early intervention, and child welfare. The sector leaders then convened to review the survey results and assign a level to their performance on measures 2.2 and 2.3. In looking at the results, they determined that providers know the referral organizations well, including having names for specific providers to refer to; however, they were less confident about knowing who to turn to if there is a problem with a referral. Most providers contact the referral provider and provide a warm hand-off, but this is not a consistent practice system-wide. Knowledge about a family's services at other agencies was low. Participants surmised that this was largely due to the lack of data sharing or protocols in place to provide information to each other. In the sector-specific survey results (not pictured), respondents cited the most positive experiences referring to the medical homes/health system, home visitation, and child care sectors, and the most negative experiences referring to child welfare, housing, and food/nutrition support sectors. Overall, the community rated itself a Level 3 for system navigation and a Level 2 for working together. They identified several goals and completed an action plan for each goal; they will meet quarterly to monitor progress.

	Very Likely	Somewhat Likely	Not Likely	Very Unlikeyly
I know the other organizations in the system that provide the kind of service the family needs.	83%	17%	0%	0%
I will help the family decide where to go to get the help they need.	72%	28%	0%	0%
I will give the family the name of a specific person to contact	83%	17%	0%	0%
I will contact the organization to let them know I have recommended the family to come to them	68%	17%	17%	0%
I will conduct a "warm hand-off" by getting new provider and family on the phone together, or accompanying family to new provider.	68%	17%	0%	17%
If there is a problem with a referral, I will know whom to contact at the new provider to try to solve the problem	50%	33%	17%	0%
I know that a family is receiving multiple services	17%	68%	0%	17%
I will know about the nature of the other provider's work and they will know about mine.	33%	50%	0%	17%
When I update or review a service plan, I will have up-to-date information from the other provider.	33%	50%	0%	17%
I believe that the other provider will work with the family in a way that helps my work more effective.	67%	33%	0%	0%

Example Results and Interpretation:

3.3 Policy Change

This hypothetical example of results for 3.3 Policy Change demonstrates how a community may select policies that most reflect their values for supporting children and track progress on those policies.

Trend

State-funded universal transitional kindergarten (T-K—modified kindergarten for 4-year old children who will turn five by December—was gradually expanded to full funding in 2019. A ballot measure passed in 2018 guaranteeing paid parental leave for 3 months for employees in companies with more than 50 employees. Wage equity for care providers has not improved over the period studied.

Subroups

Average hourly pay for BA-holders working with infants and toddlers is 29% below that of educators working with preschool age children and 268% below that of elementary school educators.

Interpretation

These results can be illuminated by identifying what advocacy activities were undertaken by the community or others over this period (e.g. without advocacy, progress is not to be expected; however, if the community has been actively advocating, lack of movement may suggest the need to find more effective strategies, messaging, or policy proposals).

Target Objective		Baseline 2016	2017	2018	2019
100% of Any County hospitals are **Baby-Friendly Hospitals** by 2020	Level of Achievement	partial	partial	full	full
	Status	1 of 4 are BFH	2 of 4 are BFH	4 of 4 are BFH	4 of 4 are BFH
State-funded universal **Transitional K** has been signed into law by 2020	Level of Achievement	none	none	partial	full
	Status	No official bill under construtction	SB 123 fails	AB 456 passes partial funding	AB 789 passes providing full funding
State law requires employers with 10 or more employees to offer **paid parental leave** for a minimum of 6 months following the birth or adoption of a child by 2020.	Level of Achievement	none	none	partial	partial
	Status	Some private companies offer it, but no state mandate	AB 246 proposed 6 months minimum, but failed legislature	Ballot measure A passed (3 months; opt for biz with under 50 employees)	Advocates working on bill for extension/ expansion
Wage gap between early childhood educators and K-12 educators has been reduced by 20% in Any County by 2020	Level of Achievement	none	none		
	Average pay 0-2 (with BA)	$13.83	$14.01	$13.88	$14.10
	Average pay 3-5 (with BA)	$17.86	$17.99	$17.85	$18.02
	Average pay K-6 (with BA + credential)	$50.94	$51.05	$51.98	$52.50
	Status	no bill under consideration	no bill under consideration	no bill under consideration	no bill under consideration