HV CoIIN Maternal Depression Charter

A. WHAT ARE WE TRYING TO ACCOMPLISH?

Call to Action: Studies show that 40-60% of families with young children enrolled in home visiting programs experience elevated depressive symptoms, and 10-15% have major depression.[i][ii] Left undetected and untreated, maternal depression can have long-lasting negative effects on the growth and development of infants and young children. Studies have shown that mothers with depression present as less positive, spontaneous, and responsive with infants, [iii] compromising the critical relationships a young child needs to develop. Young children with compromised responsive caregiving are at an increased risk of exhibiting challenging behavior, developmental difficulties, poor social relationships, and cognitive impairment.[iv][v]

Identification and linkage of women with depressive symptoms to effective, evidence-based interventions can make a difference, [vi][vii][viii] reducing by half the percent of women exhibiting major depression or developing depression. [ix,x] However, families challenged with maternal depression often struggle to access and engage with treatment: they have less frequent use of preventive health services and greater use of emergency departments and in-patient services for illness and injury.

HV CoIIN teams have made great strides in developing and refining policy and practices to improvement identification of mothers with maternal depression symptoms. Screening rates of all enrolled mothers in Phase I is at a mean of 88%. Furthermore, once identified, referral of mothers to treatment is high, averaging 88%. In the next steps of alleviating symptoms, parental acceptance of referrals and getting to treatment must be strengthened. For example, approximately 30% of mothers being referred to treatment in the HV CoIIN are receiving a minimum of one evidence-based contact. Overall, 50% of women screening positive for maternal depression, with receipt of evidence-based services are reporting an improvement of 25% > in symptoms.

Mission: Together, in Year 4 Scale-Up, we will dramatically reduce depressive symptoms among mothers of young children receiving home visiting services over five months by developing and refining policy and practices that lead to: 1) standardized and reliable processed for maternal depression screening and response, 2) competent and skilled workforce to address maternal depression, 3) standardized processes for referral, treatment, and follow-up, 4) active family involvement in maternal depression support, and 5) comprehensive data-tracking system for maternal depression.

This is important to home visiting because:

- Consistent delivery of evidence-based models and services improves maternal and infant well-being.
- Data tracking will lead to Continuous Quality Improvement (CQI).
- Communities will prosper with more focus on promotion of mental health, prevention of issues when feasible, and identification and treatment when necessary

Home visiting programs have a unique opportunity to reach families and to incorporate evidence-based and practice-informed strategies- what we know works, and what we do on the ground, to decrease rates of maternal depression.

SMART AIM: 85% of women who screen positive for depression and access services will report a 25% reduction in symptoms in 12 weeks (from first service contact)

PROCESS AIMS:
- 85% of women will be screened, using appropriate instruments at appropriate intervals: Within three months of enrollment (pre- or postnatal) and within three months postnatal.
- 85% of women with a positive screen for maternal depression who do not access evidence-based services will be rescreened within 30 days, (or sooner in cases of crises or worsening symptoms).
- 75% of all enrolled women who screen positive (and are not already in evidence-based services) will be referred to evidence based services [viiii] (offsite or in-house) within one month.
- 85% percent of women referred to an evidence-based service will have one service contact.

B. How will we know a change is an improvement?

To identify progress towards these shared aims, we will report a common group of measures monthly. Data will be graphed on run charts and shared with all HV CoIIN participants across the Collaborative to promote shared learning. The following measures were selected to reflect the processes necessary to achieve the SMART aim. They are listed in the order in which these processes occur in many sites, and are labeled with the Primary Driver they reflect.

Maternal Depression Measures

Measure #1 (Primary Driver 1): % of women screened for MD within 3 months of enrollment

Measure #2 (Primary Driver 1): % of women screened for MD within 3 months of birth

Measure #3 (Primary Driver 3): % of women with a positive screen for maternal depression at any point who were not already in evidence-based services, & who were offered a referral to evidence-based services

Measure #4 (Primary Driver 3): % of women with a positive screen for maternal depression at any point who were not already in evidence-based services, & who were offered and verbally accepted a referral to evidence-based services

Measure #5 (Primary Driver 3): % of women with a positive screen for maternal depression this month that were not already in evidence-based services, & who were offered a referral to evidence-based services

Measure #6 (Primary Driver 3): % of women with a positive screen for maternal depression this month who were not already in evidence-based services, & who were offered and verbally accepted a referral to evidence-based services

Measure #7 (Primary Driver 1): % of women with a positive screen for depression and did not access services that received a home visitor 'check in' within 30 days of the positive screen

Measure #8 (Primary Driver 3): % of women who verbally accepted a referral to services after a

positive screen for maternal depression, & who have had 1 or more NON-evidence-based service contacts *This measure is optional.*

Measure #9 (Primary Driver 3): % of women who verbally accepted a referral to services after a positive screen for maternal depression, & who have had 1 or more evidence-based service contacts

Measure #10 (SMART Aim): % women who screened positive for maternal depression and accessed evidence-based services 90 or more days ago who had 25% improvement in depressive symptoms 3 months after accessing services

Measure #11: % of women who screened positive for maternal depression 90 or more days ago and did not access evidence-based services who have a 25% improvement in symptoms 3 months after their first positive screen

Measure #12 (Primary Driver 5): % Team Members Using CQI Data in Practice every month

C. WHAT CHANGES CAN WE MAKE THAT WILL LEAD TO IMPROVEMENT

The HV CoIIN maternal depression collaborative provides working technical documents that establish a common vision and mission, shared aims, theory, measures, and change ideas to guide its operation, in conjunction with participating partners. HV CoIIN staff, faculty, and frontline home visiting teams applied the latest evidence-based research and practice to develop a breastfeeding Key Driver Diagram (KDD). The KDD displays our aims and our shared theory of how that aim will be achieved, including the primary drivers (i.e., what needs to be in place to accomplish the aim,), secondary drivers (i.e., actions necessary to achieve primary drivers), and the change ideas (i.e., how those primary drivers might be put in place). Teams from participating local implementing agencies (LIAs) select which of these change ideas might work in their particular contexts, and design Plan-Do-Study-Act (PDSA) cycles to test those changes and drive improvement. The change package provides examples from seasoned LIA teams that tested specific change ideas and sample PDSA plans.

D. COLLABORATIVE EXPECTATIONS

Education Development Center, the Collaborative Chair and the HV CoIIN Planning Group will:
- Provide information on subject matter, application of that subject matter, and methods for process improvement during monthly calls.
- Offer coaching to state quality improvement teams to facilitate improvements in home visiting.
- Provide communication strategies to keep HV CoIIN participants connected to the Planning Group and colleagues during the Collaborative.
- Provide monthly report to state leaders, model developers, and LIAs.
- Provide regular coaching and teaching on quality improvement topics.

Participating grantees are expected to:
- Identify state quality improvement lead(s) to be part of the HV CoIIN project to provide support to local teams.
- Participate in every other month HV CoIIN management/quality improvement meetings.
- Develop a spread plan for the HV CoIIN work (e.g. aligned with MIECHV CQI plan and state strategic priorities).
- Meet regularly (e.g. monthly) with local quality improvement teams to review progress and provide coaching as needed (e.g. PDSA quality review, data progress and quality, etc.).
- Actively advise the HV CoIIN planning group through participation in a grantee advisory

committee which will meet on a quarterly basis.

Participating LIA s are expected to:
- Connect the goals of the Breakthrough Series work to a strategic initiative in the organization.
- Provide a senior leader to serve as sponsor for the team working on the Breakthrough Series.
- Set goals and work to achieve our AIMs.
- Perform tests of changes using PDSA rapid cycle methods.
- Make well-defined measurements related to the teams' aims at least monthly and plot the results over time for the duration of the Collaborative.
- Share information with the Collaborative including details and measurements of changes made.
- Participate in grantee-led quality improvement activities to review data, engage in learning, and problem-solve barriers.
- Work hard, implement change, and have fun.

E. OUR TEAM

Sponsor (State/Tribal Lead/Not-for-Profit Lead):

Agency Lead(s):

Day-to-Day Supervisor(s):

Home Visitor(s):

Family Member(s):

Others:

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