HVCoIN
Home Visiting Collaborative Improvement and Innovation Network

Caregiver Depression

Electronic Playbook

HRSA Maternal & Child Health

EDC.ORG

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Caregiver Depression Key Driver Diagram and Change Package

Aim Statement	Primary Drivers	Change Ideas	Gold Standard PDSA cycles	Resources for teams
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		2) Establish screening periodicity (e.g., prenatally, postnatally, rescreening as needed)	1) CD.PD1.C2. Example 1 Prenatal Screening 2) CD.PD1.C2.Example 2 Protocol at Intake	
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		families and de-stigmatizing/ normalizing the experience of depression symptoms.	3) CD.PD1.C3.Example 3 Use of English and Spanish scripts	Depression Talking Points.docx Rappahannock Screening Guidelines NHVRC-Brief-081318_FINAL.pdf
		4) Guide and support HV response to screening results (e.g., decision trees including crisis, urgent and non-urgent results; caregiver education materials)	1) CD.PD1.C4.Example 1 EPDS, Guide for Elevated Depression, Suicide Assessment for a Positive EPDS Screen, PPD handouts, warmline information, Postpartum Support handout 2) CD.PD1.C4.Example 2 In House RN Support 3) CD.PD1.C4.Example 3 Resource List & Education Packets 4) CD.PD1.C4.Example 4 Protocol for Referral and Linkage to Services	Finding a Mental Health Provider for Children and Families in Your Early Head Start Program.pdf National Maternal Mental Health Hotline Materials | MCHB (hrsa.gov) Oakland Decision Tree.docx Guide for Elevated Depression.docx Depression Crisis Intervention Algorithm MD Measure 6 Case Study.pdf Planning Guide Maternal Depression
		5. Use a tracking system (e.g., calendar alerts, file stickers, data system alerts) for caregiver depression screening	1) CD.PD1.C5. Example 1. Guidelines for Follow up on Referrals	MD Registry Final Template_0.xls MD Registry Example 1.xlsx MD Registry Example 2.xlsx

		periodicity and results, referral, acceptance of referral, and follow-up to treatment	2) CD.PD1.C5.Example 2 Registry Approach to Measures	
	PD2. Competent, skilled, and supported workforce to address caregiver depression	1. Educate and support home visiting staff on caregiver depression prevalence, symptoms, impact, and treatment	1) CD.PD2.C1.Example 1 Perinatal Mood Training 2) CD.PD2.C1.Example 2 Free Training	https://www.postpartum.net/ https://institutefsp.org/modules/adult-mental-health-part-two-perinatal-depression Institute for the Advancement of Family Support Professionals free training
		2. Train and support home visiting staff to improve skills and capacity to support families experiencing caregiver depression (e.g., Motivational Interviewing, IECMH)	1) CD.PD2.C2.Example 1 Use of MI techniques 2) CD.PD2.C2.Example 2 Training and Education 3) CD.PD2.C2.Example 3 Enhance Skill Development 4) CD.PD2.C2.Example 4 MH Consultant	https://eclkc.ohs.acf.hhs.gov/mental-health/article/what-motivational-interviewing http://www.motivationalinterviewing.org/ http://www.centerforebp.case.edu/resources/tools/readiness-ruler Motivational Interviewing (MI) Reminder Card (case.edu) Motivational Interviewing Suite | ECLKC (hhs.gov)
		3. Train and support home visiting staff on evidence-based preventive support (e.g.,	1) CD.PD2.C3. Example 1. Reflecting M&B	https://www.mothersandbabiesprogram.org/providers/

		Mothers & Babies, model curricula)		
		4. Leverage / adapt reflective supervision to support home visitors connecting with families on caregiver depression	1) RS Sample PDSA v 5 Copy.pdf (edc.org) 2) CD.PD2.C4.Example 2 Reflective Supervision	Virtual-Reflective-Supervision-Tip-Sheets.pdf
		5. Support home visitors on protocol responses, including crisis response	1) CD.PD2.C5.Example 1 Database Creation	Sample MD Vignette v2 MD breakout measure 6 case study.pptx
	PD3. Effective referral, access to EB treatment and follow-up	1. Support home visitors to refer and link caregivers who screen positive to services (internal and/or external services)	1) CD.PD3.C1.Example 1 Social Media 2) CD.PD3.C1.Example 2 In House RN 3) CD.PD3.C1.Example 3 Motivational Interviewing	Postpartum Support International Referral Checklist.docx
		2. Implement in-house, evidence-based preventative support effectively (e.g., Mothers and Babies)	1) CD.PD3.C2.Example 1 Partnering with Behavioral Health Staff 2) CD.PD3.C2.Example 2 Mothers & Babies Session 1	Lead the Change: March AP | Maternal Depression - YouTube Begin 0:51:23 HV testimony for M & B

			3) CD.PD3.C2. Example 3. Check In for Home Visitor Accountability for Training Completion 4) CD.PD3.C2. Example 4. Recognizing Feelings	

Caregiver Depression SMART Aim, Process Aims, and Measures

Caregiver Depression Measures Cheat Sheet

SMART AIM:

80% of primary caregivers who screen positive for depression and access services will report a 25% reduction in symptoms within 3 months from first service contact.

PROCESS AIMS:

- 90% of primary caregivers are screened for depression within 3 months of enrollment
- 90% of primary caregivers are screened for depression within 3 months of their child's birth
- 90% of primary caregivers who screened positive for depression not in evidence-based services are **offered a referral** to evidence-based services.
- 85% of primary caregivers who screened positive for depression not in evidence-based services **verbally accept** a referral to evidence-based services
- 80% of primary caregivers who screened positive for depression and verbally accept a referral have at least **one evidence-based service contact**
- 85% of primary caregivers who screened positive for depression and did not access evidence-based services **receive a home visitor 'check in'** within 30 days

Measure #1 (SMART Aim) % of primary caregivers who screen positive for depression and access services with a 25% reduction in symptoms 3 months from first service contact. [Column V]

- Numerator: N of primary caregivers who screen positive for depression that had a first evidence-based service contact 3 months or more ago with a 25% reduction in symptoms. [Column U].
- Denominator: N of primary caregivers who screen positive for depression that had a first evidence-based service contact 3 months or more ago. [Column T].

The following measures were selected to reflect the processes necessary to achieve the SMART aim. They are labeled with the Primary Driver they reflect.

Measure #2 (Primary Driver 1): % of primary caregivers screened for depression within 3 months of enrollment *[column G]*

- Numerator: N of primary caregivers enrolled 3 months or more ago that were screened for depression within 3 months of enrollment *[column E]*
- Denominator: N of primary caregivers enrolled 3 months or more ago *[column C]*

Measure #3 (Primary Driver 1): % of primary caregivers screened for depression within 3 months of their child's birth *[column H]*

- Numerator: N of primary caregivers whose child's birth was 3 months or more ago that were screened for depression within 3 months of their child's birth *[column F]*
- Denominator: N of primary caregivers whose child's birth was 3 months or more ago *[column D]*

Measure #4 (Primary Driver 3): % of primary caregivers who screened positive for depression not in evidence-based services **offered a referral** to evidence-based services *[column L]*

- Numerator: N of primary caregivers who screened positive for depression not in evidence-based services offered a referral to evidence-based services *[column K]*
- Denominator: N of primary caregivers who screened positive for depression not in evidence-based services *[column J]*

Measure #5 (Primary Driver 3): % of primary caregivers who screened positive for depression not in evidence-based services that **verbally accept** a referral to evidence-based services *[column N]*

- Numerator: N of primary caregivers who screened positive for depression not in evidence-based services that verbally accept a referral to evidence-based services *[column M]*
- Denominator: N of primary caregivers who screened positive for depression not in evidence-based services offered a referral to evidence-based services *[column K]*

Measure #6 (Primary Driver 3): % of primary caregivers who screened positive for depression and verbally accept a referral that have at least **one evidence-based service contact** *[column S]*

- Numerator: Number of primary caregivers who screened positive for depression and verbally accept a referral to evidence-based services **that have least one evidence-based service contact** *[column R]*

- Denominator: N of primary caregivers who screened positive for depression not in evidence-based services that verbally accept a referral to evidence-based services *[column M]*

Measure #7 (Primary Driver 3): % of primary caregivers who screened positive for depression and did not access evidence-based services that **receive a home visitor 'check in'** within 30 days *[column Q]*

- Numerator: N of primary caregivers who screened positive for depression and did not access evidence-based services that receive a home visitor 'check in' within 30 days *[column P]*
- Denominator: N of primary caregivers who screened positive for depression 30 or more days ago that did not access evidence-based services within 30 days *[column O]*

HV CoIIN 3.0 Questions & Answers

Related to Measures, PDSA documentation, & Data

October 2022

Below you will find questions that were submitted by teams. The questions and answers (from our improvement advisors and faculty) are presented below by topic area.

I. Caregiver Depression FAQs

1. **How do we measure the caregivers who screen positive for CD that are already in evidence-based services?**
    a. This will vary from program to program.
        i. For many programs, when a caregiver screens positive for depression, within a client-centered conversation about the screening results, the home visitor can ask if they are already receiving any mental health support from anyone / anyplace outside of the home visiting program. If the client reports that they are receiving support of some kind, the home visitor (with support from supervisor) should classify the reported services clients are receiving as evidence-based or not using criteria provided by the faculty (see operational definition here or here)
        ii. In some cases, for example home visiting programs that enroll caregivers who are referred from mental health day treatment programs, information about evidence-based services is known at enrollment. The LIA needs to develop a way to keep track of it and report the information.
        iii. Other programs are affiliated with health facilities; these may have existing relationships with clinic-based or hospital-based programs and program staff. If these relationships are not well-established, they will need to develop relationships and processes to gather the information from mental health providers—as well as developing a way to track and report the information.
    b. *Remember:* In any situation when HV staff want to ask for client information from treatment providers (mental health providers, health facilities, etc.), they need to get informed consent from clients to ask for the information.

c. If you'd like to talk through what approach might be most appropriate for your site, please reach out and we can discuss this in more detail.

2. **How will we be measuring the symptom reduction? Can we use PHQ9?**
   a. The SMART aim 25% reduction in symptoms can be calculated using any one of the recommended screening tools; these include the PHQ9, Edinburgh Postnatal Depression Score, CES-D or PDSS. To calculate, compare the initial score with the score 3 months after the first evidence-based service contact. So, for example, on 6/15/22, a caregiver scored 12 on the PHQ9. The caregiver engaged in Mothers-and-Babies beginning on 6/22/22. 3 months later (9/20/22), the HV repeated the PHQ-9, and the caregiver scored 9. A reduction from a score of 12 to 9 is a 25% reduction. (12-9)/12x100= 25%

3. **What is a 25% reduction in screener score?**
   a. A 25% reduction in screener score refers to the difference between the initial positive screen score and the follow-up score. So, for example, a reduction from a score of 12 to 9 is a 25% reduction and is calculated as:

$$\left[\frac{\text{Initial score} - \text{follow-up score}}{\text{Initial score}}\right] \times 100$$

$$\left[\frac{12 - 9}{12}\right] \times 100 = \left[\frac{3}{12}\right] \times 100 = 25\%$$

Below we provide a table to make it easy for programs to check if the rescreen meets a 25% reduction or not, for reporting purposes. Any client with a rescreen that shows a 25% reduction in symptoms should be included in the numerator for the outcome measure.

Does my client's repeat depression screen score meet a 25% reduction in symptoms? * (*This table applies to PHQ9, Edinburg/EPDS and PDSS screeners)	
Initial Scores	**YES, if the 3-month repeat screener score is equal to or smaller than:**
9	6
10	7
11	8
12	9
13	9
14	10
15	11
16	12
17	12
18	13
19	14
20	15
21	15
22	16
23	16
24	18
25	18
26	19
27	20
28	21
29	22
30	23

NOTE: while clients who do NOT have a 25% reduction should not be included in the numerator of the outcome measure, in practice, it is important to discuss these scores in more nuanced ways. For example, any reduction in symptoms can be meaningful to a caregiver and dropping by a couple of points should be celebrated and provide an opportunity for a home visitor to encourage the caregiver in their activities and efforts to feel better. Recognizing and discussing reductions in symptoms that do not meet the 25% threshold could help the HV and caregiver to look at what barriers they are still experiencing and to develop small but achievable goals as a focus for their discussions, and to consider layering on additional types of support (for example, continuing Mothers and Babies curriculum and considering talking to their doctor about medication for depression symptoms that are persistently troubling despite active engagement in MB).

4. **Are positive depression screenings only included for screenings done within 3 months of enrollment and 3 months of delivery (and then the subsequent re-screens) or should I include all positive screenings that are recorded at other intervals as well?**
    a. All positive screenings are important and should be included, whether they occur during the pre- or post-birth 3-month windows or not. Caveat: if a positive screen occurred long before the program began participating in HV CoIIN (for example, 6-12 months or more before HV CoIIN participation), we recommend conducting a rescreen with the client. If the current rescreen is elevated, that positive screen and that client should be included in the measures, no matter how old their child is currently.

5. **At what point do we stop screening a family? Should we continue to rescreen every 30 days until the score is below nine?**
    a. The 30-day check-in is for caregivers with positive screens that have not yet accessed EB services – either because they do not verbally accept the services OR because they verbally accept services but have not yet had a first contact (e.g., on a wait list). Do the first check-in by 30 days and then subsequent check-ins every 30-60 days until they access services or until the score is below 9.

6. **Does # caregivers who screened positive for depression not in EB services in any given month include ALL positive screens added together, or just new that month?**
    a. This number is NOT only the new positive screens in the reporting month.
    b. This number should include ALL caregivers who
        i. Were enrolled in services during part or all of the reporting month
        ii. Had a positive screen for caregiver depression since the beginning of your agency's participation in HV CoIIN and
        iii. Were not engaged in evidence-based services at the time of their positive screen.

7. **If we start with a list of current caregivers who had a positive screen and some of them rescreen negative, do we take them out of the group of positive screens?**
    a. When a program joins HV CoIIN, we recommend that they RESCREEN any caregiver who had a positive screen prior to the program joining HV CoIIN.
    b. If a caregiver who had a positive screen in the past has a **negative rescreen** at the time you are beginning your HV CoIIN work, they should not be included in the group of positive screens.

c. If a caregiver who had a positive screen in the past has a **positive rescreen** at the time you are beginning your HV CoIIN work, they should be included in the group of positive screens. As you continue to work with them, you will monitor their progress and report whether or not they were offered a referral, accepts it, accesses services and how their symptoms evolve (i.e., if their screener score decreases by 25% or more).

8. **When someone unenrolls from the program, do we stop tracking them as of that month? Do we leave them in the registry? Is there a suggested way to document this?**
    a. We leave all clients with positive screens in the registry indefinitely (that is, we don't delete clients once they've left the program). However, when a client leaves the program, they should be marked in the registry (in Column E, "Program End Date") so we know that we can stop tracking their progress. Stop including them in the program's measures **the month *after* they are closed out of the program**. For example, if a caregiver's case is closed in February, the caregiver should be included in February's reported data but not included thereafter (i.e., not in March, April, etc.).

9. **If "was referral verbally accepted" = no and/or "has client accessed EB services" = no Do we change the value if later it becomes yes? Do we need to track later check in dates?**
    a. Yes.
    b. If a caregiver initially declines a referral, they are counted as a "no" -- that is, they are counted in the denominator (column K, "N caregivers w +CD screen not in EB svcs that were offered a referral to EB svcs"), but NOT counted in the numerator (column M, "N caregivers with +CD screen not in EB svcs that verbally accepted a referral to EB svcs.") They should be counted in column O ("N of caregivers with +CD screen 30 or more days ago that did not access EB svcs within 30 days"), and if they receive a HV check-in within 30 days of their positive screen, they should be counted in column P ("N caregivers with a +CD screen and did not access EB svcs that received a home visitor 'check in' within 30 days").
    c. If they later verbally accept a referral, at that time, they should be changed to "yes," and they should be counted in the reporting template in both the denominator (column K) and the numerator (column M).

i. If they have not accessed evidence-based services yet, then they should be counted in column O ("N of caregivers with +CD screen 30 or more days ago that did not access EB svcs within 30 days"), and if they receive a HV check-in within 30 days of their positive screen, they should be counted in column P ("N caregivers with a +CD screen and did not access EB svcs that received a home visitor 'check in' within 30 days").
ii. Once they have a first evidence-based service contact, regardless of how long it is between the referral and the service contact, they should be counted in column R (N caregivers with +CD screen and verbally accepted referral that had 1+ EB svc contact), and the rescreen to check for symptom improvement should happen 3 months from the date they accessed evidence-based services.

10. If a referral was given prior to the most recent documented PHQ-9 but not after the most recent positive PHQ-9 and the client has not accessed services, does that count as "referral to services was provided"

a. No. If a caregiver was offered a referral, did not access the referral, and screened positive again, we would want the HV to discuss a referral (the same one or to a different evidence-based service) again, and to document the caregiver was offered a referral again, whether they verbally accepted it or not, etc. This gets complicated when there are no available services for a caregiver – due to health insurance, language barriers and other obstacles. But regardless, this caregiver would need to be offered a referral after the most recent positive screen.

11. For Measure #6, if a caregiver does not get a 'check-in' within 30 days, should they stay in the denominator but not be included in the numerator?

a. Yes. If a caregiver screens positive for depression and does not access services, they should receive a home visitor 'check-in' within 30 days. If they do not, they will always be a 'no' on this measure for the duration of their time in the program.

12. For the SMART Aim, if someone has an elevated score months (or years) ago and no improvement within 3 months, will they stay in the denominator until they graduate but never be counted in the numerator?

a. No, not necessarily.

b. When a program joins HV CoIIN, we recommend that they RESCREEN any caregiver who had a positive screen prior to the program joining HV CoIIN. This will update all caregivers who have a positive screen during the program's participation in HV CoIIN and not count caregivers whose last screen was years ago.
c. For caregivers who screened positive and accessed EB services, when 3 months from that first EB service contact pass, the client should be rescreened.
    i. If they do **not** see a 25% reduction in symptoms on that screen, they should be counted in the denominator and NOT counted in the numerator.
    ii. They should be rescreened again every 30-60 day for as long as they do not see improvement in services— and are engaged in additional supports (layering services) if possible. If they do have a 25% reduction in symptoms at any point in time after the first 3 month rescreen, they should be counted in the numerator.

13. Should we only include data on biological caregivers?

a. No, you should collect and include data on primary caregivers, including foster parents/caregivers or non-biological caregivers. In these instances, you should screen for caregiver depression within 3 months of the child's arrival.

14. If a caregiver with a positive screen for caregiver depression is already receiving evidence-based services at the time of the positive screen, do we include them in any of the downstream measures: 'referral offered', 'referral verbally accepted,' 'accessed 1 or more EB service contact', and 'had a 25% reduction in symptoms 12 weeks from EB service contact.'

a. No, do not include caregivers who are already receiving evidence-based services at the time of the positive screen in any of the downstream measurements. We recommend that programs keep these caregivers in the list of positive screens and check in and provide support to them, but do not include them in their measurements for HV CoIIN.

15. We have a caregiver who screened positive for caregiver depression and was currently taking a medication. The caregiver stopped the medication and made an appointment with a psychiatrist in several months. It is 3months since the caregiver stopped taking

the medication, but the caregiver has an appointment to see a psychiatrist now. How should we handle this instance regarding the 3-month rescreen?

a. In this scenario, the caregiver should be rescreened 3 months from the medication initiation, but they should also be rescreened 3 months after the counseling initiation. "First service contact" should be independent for each kind of service they engage in when they are not synchronous and when the symptoms aren't resolved. The reasoning for this is that even with evidence-based services, what works for an individual often needs to be individualized through trial and error.
b. In reporting this instance, the agency should only count the most recent 3 month rescreen in their data for the month.

16. **Is it recommended by HV CoIIN for agencies to administer the PHQ-9 verbally to a caregiver or if the caregiver should fill out the PHQ-9 on paper form and submit to the staff member?**
    a. The PHQ-9 was meant to be read and filled out by a caregiver on their own, then scored by a service provider and discussed together. However, in cases where the caregiver has difficulty with reading or comprehension of the questionnaire it is appropriate for a home visitor who has been trained in the purpose and importance of the PHQ-9 to provide assistance by reading through it with the caregiver.

17. **For the N of caregivers whose child's birth was 3 months or more ago, should we exclude caregivers who enrolled in home visiting after 3 months of their child's birth?**
    a. Caregivers who enrolled in the home visiting program 3 months or more after their child's birth should be excluded from this measure.

18. **What is a "check-in"? What does this entail?**
    a. Home visitor 'check in'. Either a re-screen or a focused conversation that addresses depressive symptoms. The central point of this measure is to ensure that caregivers that are experiencing depressive symptoms and have not accessed support beyond the home visitor don't fall off the radar. Programs could test different approaches to 'check ins', as long as the conversation makes the depressive symptoms the focus – e.g., the NFP programs have all integrated MI, so they could test an MI-focused conversation on screening, acceptance of a referral or continuation of efforts to get support; others could institute a

monitoring and repeated check-in with caregivers who decline to be screened. Another approach is to revisit the specific symptoms a caregiver reported on their positive screen – for example, "a month ago, we discussed your mood and energy, and you had described challenges with sleep and feeling disinterested in things you normally enjoy doing. How is that going now?"

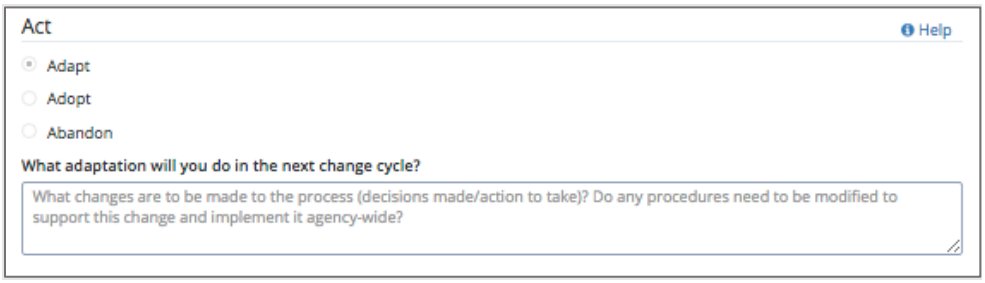
19. If a client leaves the program and then re-enters, how should we track them?

a. If a client leaves the program and then comes back, teams should track the most recent enrollment information and associated screening information with the most recent enrollment. Teams can think of it as a new enrollment and new tracking.

II. PDSA Q & A

1. **How many cycles do we need to do for each test?**
   a. As many cycles as it takes for the team and administrators at your local agency to decide that you have sufficient evidence to either adopt the idea and spread it or abandon the idea.

2. **Are you expecting teams to turn in a new cycle each month?**
   a. We are expecting teams to turn in as many cycles as they have realized each month. These cycles may be multiple PDSA cycles working to get a single change idea to work well. They may be multiple PDSA cycles working on a few different change ideas at once. If a team embarks on a new test (cycle) in August and gets through the Plan and Do phase, then in September, we expect you to submit an update with the Study-Act phases. If a team starts a new cycle, then the new cycle would be submitted as well. When teams are uploading PDSA information to the HV CoIIN website each month we ask:



If your PDSA is a continuation or new cycle for the same primary driver, the website will populate your prior month's submission for editing to relieve the burden of re-entering information.

3. **How many cycles do you expect a team to turn in each month?**
    a. Because every PDSA cycle is designed to help us learn, the more cycles you run, the more you learn. Like the gears in a car, running 1 cycle per month is like driving in 1st gear: you will advance, but your progress will be slow. Running 5 cycles per month is like driving in 5th gear: you'll go a lot further/make a lot more progress in the same amount of time. Keeping in mind the other demands teams have on their time, we recommend aiming to complete at least 2 PDSA cycles per month. This will allow you to see steady progress, and also provides enough practice designing and executing PDSA cycles for the process of doing PDSAs to become easier and more intuitive.

HV CoIIN 2.0
Caregiver Measure Specifications

Last Updated April 2024

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Aim	Outcome Measures
80% of primary caregivers who screen positive for depression and access services will report a 25% reduction in symptoms within 3 months from first service contact.	% of primary caregivers who screen positive for depression and access services with a 25% reduction in symptoms 3 months from first service contact.

Primary Drivers	Process Measures
PD1. Caregiver depression screening and discussion of results	• % of primary caregivers screened for depression within 3 months of enrollment • % of primary caregivers screened for depression within 3 months of their child's birth
PD2. Competent, skilled, and supported workforce to address caregiver depression	
PD3. Effective referral, access to EB treatment and follow-up	• % of primary caregivers who screened positive for depression not in evidence-based services **offered a referral** to evidence-based services • % of primary caregivers who screened positive for depression not in evidence-based services that **verbally accept** a referral to evidence-based services • % of primary caregivers who screened positive for depression and verbally accept a referral that have at least **one evidence-based service contact** • % of primary caregivers who screened positive for depression and did not access evidence-based services that **receive a home visitor 'check in'** within 30 days

SMARTIE AIM

Measure #1 (SMARTIE Aim)
80% of primary caregivers who screen positive for depression and access services will report a 25% reduction in symptoms within 3 months from first service contact.

Data Elements

- *Numerator:* # of primary caregivers who screen positive for depression that had a first evidence-based service contact 3 months or more ago with a 25% reduction in symptoms.
- *Denominator:* # of primary caregivers who screen positive for depression that had a first evidence-based service contact 3 months or more ago

Frequency of Data Reporting
Monthly

Associated Driver
SMARTIE Aim

Primary caregiver: Many children have more than one caregiver. In some cases, it may be obvious to all involved that there is one primary caregiver, and who that is. In others, it may be difficult to deem one person the 'primary caregiver' and other(s) as secondary. HV CoIIN encourages home visitors and families to talk about this, and we encourage home visitors to screen multiple caregivers for depression and provide support to any caregiver(s) with positive screens. For reporting purposes, home visitors should choose one caregiver for each child to submit data from, for the duration of the project. If any caregiver has a positive screen, we encourage home visitors to report data from that individual. If more than one caregiver has a positive screen, submit data from only 1 caregiver per child.

Positive depression screen: Use of a validated depression screening instrument indicates a positive result for depression, using scoring criteria of the instrument used. HV CoIIN encourages home visitors to screen or re-screen all caregivers for depression at the beginning of the HV CoIIN project to identify caregivers with ongoing depression symptoms. This is important because depression symptoms evolve, and because if all caregivers are not rescreened at the beginning of HV CoIIN, some clients' most recent screen may be a positive screen from the peripartum period, when their child is now two years old. Report caregivers with positive screens at the time HV CoIIN begins, or caregivers with positive screens who enrolled after the LIA began participating in HV CoIIN.

Primary Driver 1

Measure #2
% of primary caregivers screened for depression within 3 months of enrollment

Data Elements

- *Numerator:* # of primary caregivers enrolled 3 months or more ago that were screened for depression within 3 months of enrollment
- *Denominator:* # of primary caregivers enrolled 3 months or more ago

Frequency of Data Reporting
Monthly

Associated Driver
Primary Driver 1

Measure #3
% of primary caregivers screened for depression within 3 months of their child's birth

Evidence-based services: Specific approaches and intervention models that have shown to have positive effects on depression outcomes through rigorous evaluations. For example, Cognitive-behavioral therapy (CBT), Interpersonal Therapy (IPT), Moving Beyond Depression™, Mothers and Babies Course and medication. Delivery of these approaches and models may happen through external referral to outside community-based services or internally within the HV program. For example, an Infant and Early Childhood Mental Health Consultation approach for home visiting (with a credentialed therapist) may integrate a short-term therapeutic CBT approach, IPT or Mothers and Babies group session to the service continuum to specifically and directly address depression symptoms with families and support (e.g., reflective supervision) home visitors as the home visitor implements an EB prevention approach or model directly with families, such as the 1:1 Mothers and Babies course.

Non-evidence-based services: Supports or interventions that have not been shown in rigorous research evaluations to have positive impacts on depression symptoms, but that families and individuals may access for support and may result in symptom relief, for example, home visiting benefits, pastoral counseling, cultural practices, yoga or meditation, socialization, etc.

Data Elements

Numerator: # of primary caregivers whose child's birth was 3 months or more ago that were screened for depression within 3 months of their child's birth

Denominator: # of primary caregivers whose child's birth was 3 months or more ago

Example

For example, for Feb 2023 data, the denominator for this measure would be caregivers who were enrolled or whose child was born before December 1, 2022. We have provided the dates associated with the numerator and denominator for this measure for each of the reporting months below (Table 1) and in the calculations tab in the HV CoIIN CD Data Reporting Template. We encourage you to print this table and have it handy to facilitate data reporting each month.

Reporting Month	Caregivers enrolled / whose child was born before
	Offered referral between
Feb-23	12/1/2022
Mar-23	1/1/23
Apr-23	2/1/23
May-23	3/1/23
Jun-23	4/1/23
Jul-23	5/1/23
Aug-23	6/1/23
Sept-23	7/1/23
Oct-23	8/1/23
Nov-23	9/1/23
Dec-23	10/1/23

Screened positive for depression: Scored above the established cutoff on one of the evidence-based screening tools

- Edinburgh – 10 or greater
- PHQ -– 10 or greater
- PDSS – 60 or greater
- CESD – 16 or greater

Primary Driver 3

Measure #4
% of primary caregivers who screened positive for depression not in evidence-based services **offered a referral** to evidence-based services

Data Elements

- *Numerator:* # of primary caregivers who screened positive for depression not in evidence-based services offered a referral to evidence-based services
- *Denominator:* # of primary caregivers who screened positive for depression not in evidence-based services

Frequency of Data Reporting
Monthly

Associated Driver
Primary Driver 3

Offered a referral to evidence-based services:
The home visitor offered to refer the primary caregiver with a positive screen to treatment for depression and explained why they were making this offer (e.g., psychoeducation about depression to explain that a positive screen means they are experiencing symptoms of depression; services can help them to feel better and will help the baby too). Offer of a referral includes a discussion of the types of assistance the home visitor can offer such as talking about the services that are available, what to expect, and providing the caregiver with a list of resources; offering to make a telephone call together or offer of other efforts to connect the caregiver with a mental health service provider. This may include a referral to the medical home services that are available, what to expect, and providing the caregiver with a list of resources; offering to make a telephone call together or offer of other efforts to connect the caregiver with a mental health service provider. This may include a referral to the medical home for psychopharmacology support. This offer should include a confirmation of what action(s) the caregiver would like the home visitor to take.

Measure #5
% of primary caregivers who screened positive for depression not in evidence-based services that verbally accept a referral to evidence-based services

Data Elements

- *Numerator: # of primary caregivers who screened positive for depression not in evidence- based services that verbally accept a referral to evidence-based services*
- *Denominator: # of primary caregivers who screened positive for depression not in evidence- based services offered a referral to evidence-based services*

Frequency of Data Reporting
Monthly

Associated Driver
Primary Driver 3

Measure #6
% of primary caregivers who screened positive for depression and verbally accept a referral that had at least one **evidence-based service contact**

Verbally accepted a referral: When the home visitor offered a referral to mental health services, the caregiver stated that they were willing or interested in pursuing the referral.

Had at least one evidence-based service contact: The caregiver had at least one contact with an evidence-based service provider. An initial appointment for evaluation counts as contact.

Frequency of Data Reporting
Monthly

Associated Driver
Primary Driver 3

Example
For example, for Feb 2023 data, the denominator for this measure would be caregivers whose positive screen was before January 1, 2023 and did not access services before the end of February 2023. We have provided the dates associated with the numerator and denominator for this measure for each of the reporting months below (Table 2) and in the calendar calculations tab in the HV CoIIN CD Data Reporting Template. We encourage you to print this table and have it handy to facilitate data reporting each month.

Reporting Month	Caregivers who have not accessed EB services whose positive screen was before
Feb-23	1/31/2022
Mar-23	2/28/23
Apr-23	3/31/23
May-23	4/30/23
Jun-23	5/31/23
Jul-23	6/30/23
Aug-23	7/31/23
Sept-23	8/1/23
Oct-23	9/1/23
Nov-23	10/1/23
Dec-23	11/1/23

HVCoIIN
Home Visiting Collaborative Improvement and Innovation Network

HRSA Maternal & Child Health

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Early Childhood Investment Corporation

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IMPROVEMENT LAB

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