



CQI Journey on Maternal Depression: Illinois MIECHV

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The Content

- Why Maternal Depression?
- HV CoIN 2.0 – Background information
- Technical Assistance and Tools Provided
- PDSA cycles
- Outcomes
- Behind the Scenes
- **PANEL PRESENTATION**



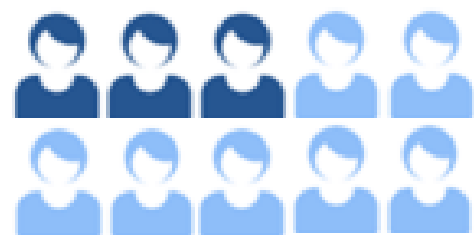
Why the HV CoIIN 2.0?

In Illinois, **1 in 5** new moms experience postpartum depression

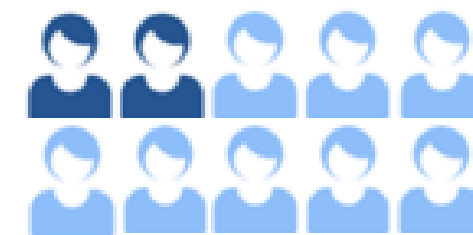


Why is it important?

- Without treatment, postpartum depression can last up to months or years
- There are long term consequences for mother's and baby's health
- It may interfere with the mother's ability to connect with and care for her baby
- It may cause the baby to have problems with sleeping, eating, and behavior
- There are effective treatment options, including counseling and medication



Only **3 in 10** women with postpartum depression are diagnosed and only **2 in 10** receive treatment



From: "Postpartum Depression in Illinois", Illinois Department of Public Health

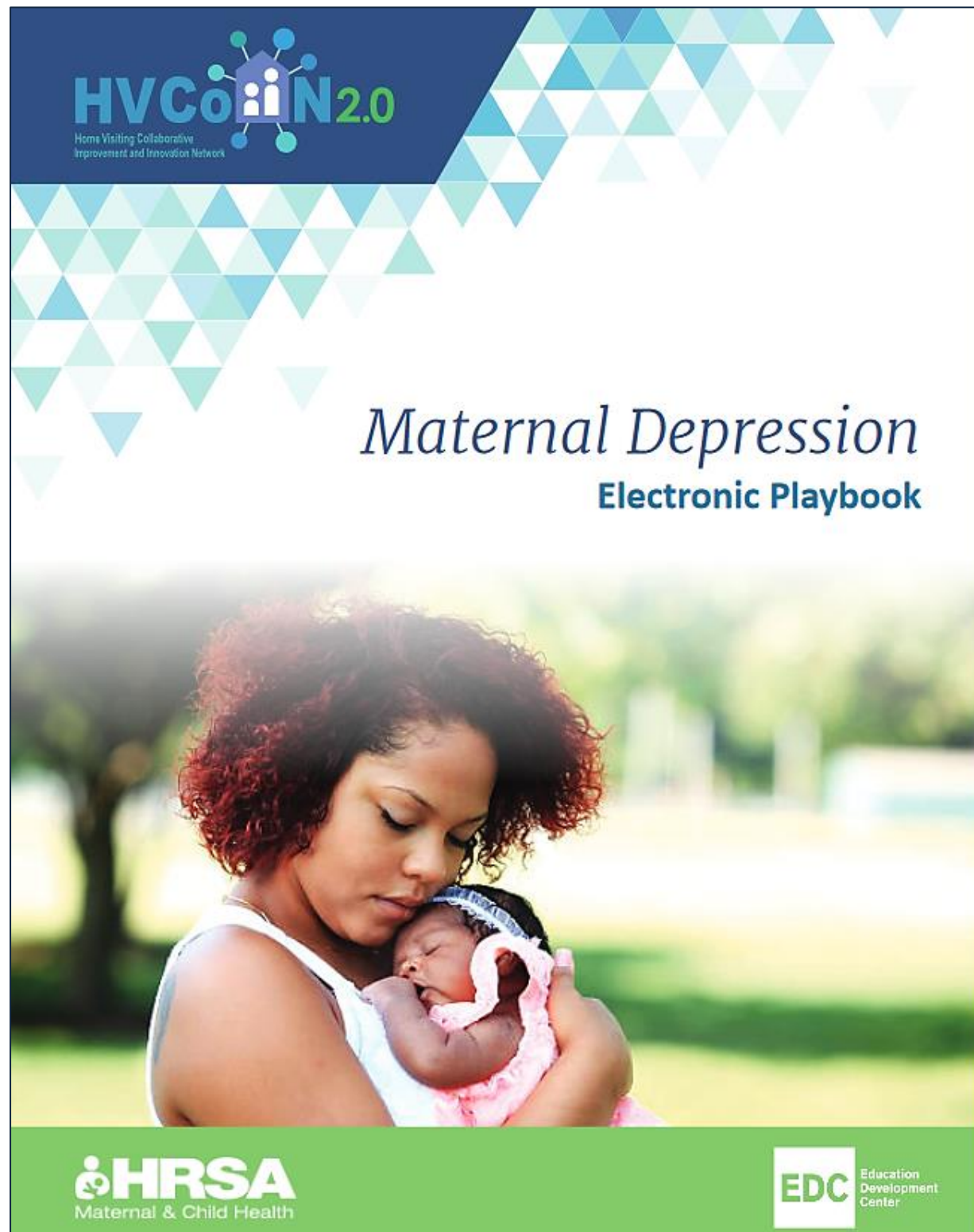
<https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/publicationsowhfsppostpartum-depression-factsheet-1.pdf>

What is the HV CoIIN 2.0?

Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN)



The Goals of the HV CoIIN 2.0



- Create a **collaborative learning** experience
- Allow **rapid PDSA testing** for improvement
- **Share best practices** with other teams
- Allow for **scaling of tested interventions**
- **Build continuous quality improvement capacity**

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UF4MC26525, Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

<https://hv-coiin.edc.org/>

HV CoIIN: Health Equity Framework

Defining Health Equity for Home Visiting

All families served by MIECHV programs have fair and just opportunities to achieve the highest level of health and well-being. This requires that MIECHV advance and sustain family informed practices, policies and resources that value all home visiting participants and staff equally and engage in focused and ongoing programmatic and societal efforts that address historical and contemporary injustices. Health equity demands that MIECHV programs remove obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, transportation, safe environments, and health care with the goal of eliminating inequities in the key family outcomes that home visiting aims to improve.

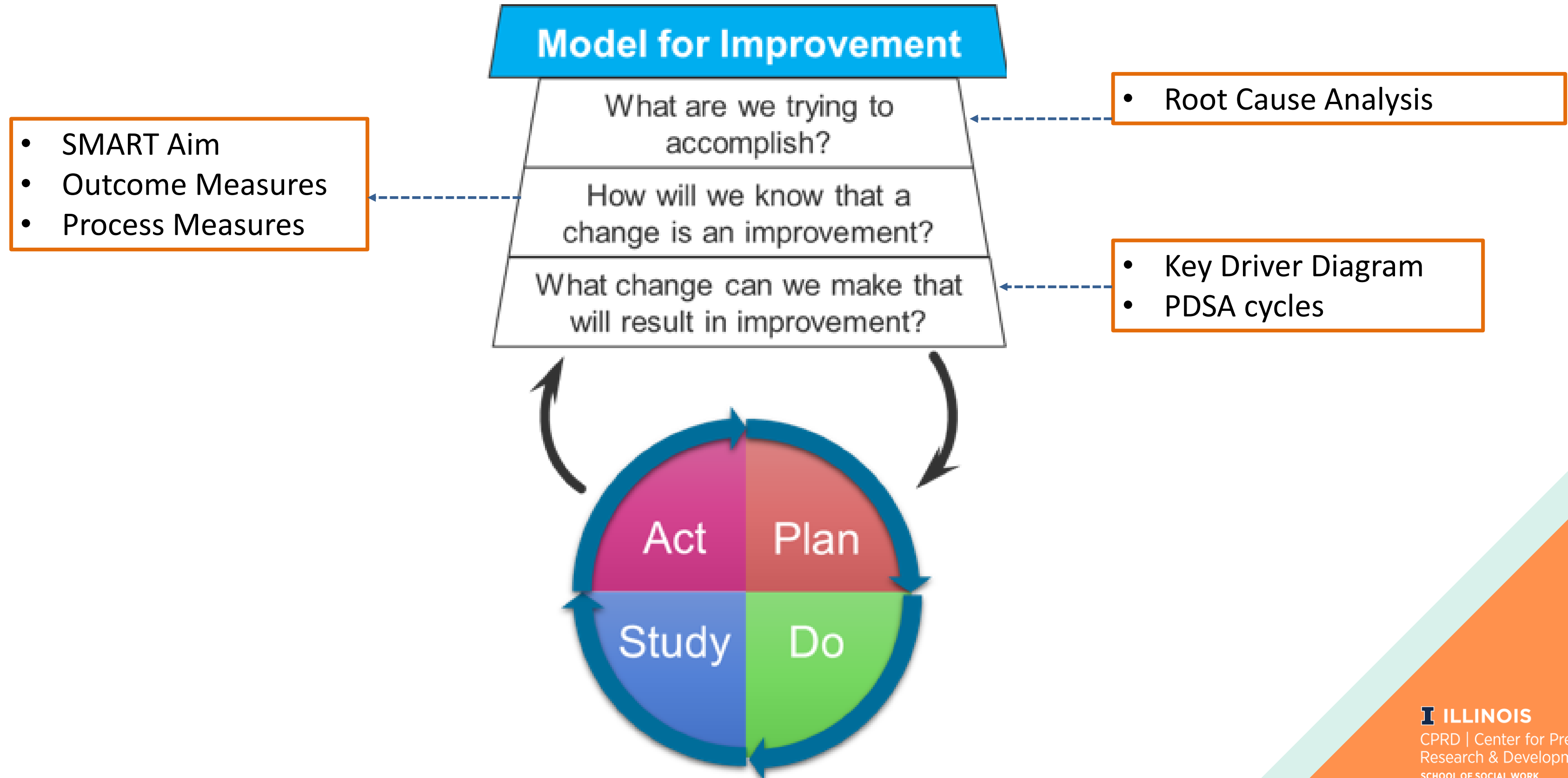
From: Home Visiting Collaborative Improvement and Innovation Network 2.0:
Advancing & Sustaining Health Equity In Home Visiting

https://hv-coiin.edc.org/sites/hv-coiin.edc.org/files/Health%20Equity%20Fact%20Sheet_OCT%202022.pdf



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Model of Improvement



The Benefits of the HV CoIIN 2.0

- Collaborative **SMART Aims**
- Collaborative **Data Measures**
- Collaborative **Key Driver Diagrams**
- Access to **Gold Medal Plan-Do-Study-Act** Cycles to test
- Access to Content and CQI Experts



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The Expectations: Participating Illinois CQI Teams

- Attend monthly HV CoIIN 2.0 Action Period Calls
- Attend HV CoIIN 2.0 Learning Sessions
- Attend Mothers and Babies training
- Test PDSA cycles each month and submit onto the HV CoIIN 2.0 dashboard
- Submit monthly data onto HV CoIIN 2.0 dashboard
- Complete Storyboards, 90-day plans, and other materials as assigned by the HV CoIIN 2.0
- Work hard, implement change and have fun!

The Illinois Participants

21 Illinois MIECHV Teams



500+ Mothers of Babies (MOBs) enrolled in Illinois MIECHV



Average of **69** Illinois MIECHV home visiting staff each month



The Learning (Technical Assistance): Over 300 Hours

HV CoIN 2.0 Learning Sessions



HV Collaborative Improvement and Innovation Network 2.0

Lead The Change: Learning Session 2, Day 2
Maternal Depression
June 15, 2021



CPRD CQI Specialist: Office hours & individual team coaching sessions



HV CoIN 2.0: Lead the Change Action Period Call

Maternal Depression



THE INSTITUTES AT NORTHWESTERN MEDICINE
INSTITUTE FOR PUBLIC HEALTH AND MEDICINE
CENTER FOR COMMUNITY HEALTH
THE MOTHERS AND BABIES PROGRAM
A Postpartum Depression Prevention Intervention



Training – 64 Participants

The HV CoIIN 2.0: The Process Aims

85% of women will be screened, using appropriate instruments **at appropriate intervals:** Within 3 months of enrollment (pre- or postnatal) and within 3 months postnatal.

85% of women with a positive screen for maternal depression **who do not access EB services will receive a home visitor check-in 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** (offsite or in-house) **within 30 days.**

85% of women referred to an evidence-based service will have **one service contact.**



Key Driver Diagram – A Brief Explanation

SMART Aim (also called Goal or Project Aim)	Key Drivers	Change Ideas (also called Secondary Drivers)
<p>S = Specific</p> <p>M = Measurable</p> <p>A = Achievable</p> <p>R = Realistic</p> <p>T = Time-Bound</p>	<p>➤ The aspects that drive or contribute to the achievement of the project Aim”</p>	<p>➤ The strategies that will help address the key drivers.</p>

For More Information about creating a key driver diagram, go to:
<https://www.med.unc.edu/ihqi/wp-content/uploads/sites/463/2020/09/Job-Aid.-Key-Driver-Diagram-002.pdf>



HV CoIIN 2.0 SMART Aim / Key Drivers

SMART Aim	Primary Drivers	Change Ideas
85% of women who screen positive for depression & access services will report a 25% reduction in symptoms 12 weeks (from 1 st service contact)	PD1: Standardized and reliable processes for maternal depression and screening and response	1. Policy and protocol for screening to include use of reliable and valid tools
		2. Policy and protocol for screening to include periodicity (e.g., prenatally, postnatally, and rescreening as needed).
		3. Policy and protocol along with talking points for explaining depression screening process to families
		4. Policy and protocol for home visitor response to screening results and referral
		5. Reminder system for rescreens
	PD2: Competent and skilled workforce to address maternal depression	1. Training/Education of home visitors on maternal depression symptoms, impact, and treatment
		2. Training/Education to enhance the skill development of home visitors for connecting with families on maternal depression
		3. Reflective supervision that encourages home visitors to discuss maternal depression
		4. Support for home visitors on protocol responses
	PD3: Standardized processes for referral, treatment, and follow-up	1. Crisis response protocol
		2. Protocol for referral and linkage to service for mothers who screen positive (internal or external services)
		3. In-house, evidence-based, preventative support (e.g., Mothers and Babies)
	PD4: Comprehensive data tracking system for maternal depression	1. Tracking system for maternal depression screening periodicity and results, referral, acceptance of referral, and follow-up to treatment
		2. Tracking system for team meetings (i.e., weekly) to review improvement data and its use for guiding program effectiveness



HV CoIIN 2.0: Measures

Measure 1:

(Primary Driver 1)

Percentage (%) of women screened for maternal depression (MD) **within 3 months of enrollment**

Measure 2:

(Primary Driver 1)

% of women screened for MD **within 3 months of giving birth**

Measure 3:

(Primary Driver 3)

% of women who screened positive (+) for MD not in “evidence-based” (EB) services, that were **offered a referral** to EB services.

Measure 4:

(Primary Driver 3)

% of women who screened + for MD, not in EB services that **verbally accepted** a referral to EB services

Measure 5:

(Primary Driver 3)

% of women who screened + for MD and verbally accepted a referral that had at least one **EB service contact**

Measure 6:

(Primary Driver 3)

% of women who screened + for MD and did **NOT** access EB services that **received a home visitor ‘check-in’** within 30 days

Measure 7:

(Primary Driver 4)

% of team members that reviewed and used CQI data in practice this month



The Successful Strategies

MD Tracking Forms

Beck's Depression Inventory

Scripts

DECISION TREES

Parent Editors

Process Maps

Policies and Procedures

Screening Administration Times

PHQ-9

Mothers and Babies

Mental Health First Aid

Therapist Intern

Referral Process

Perinatal Depression Handouts

Breathing Techniques

Parent Surveys

Reflective Supervision

Mental Health Consultants

Stress Reduction

Conversational Screenings

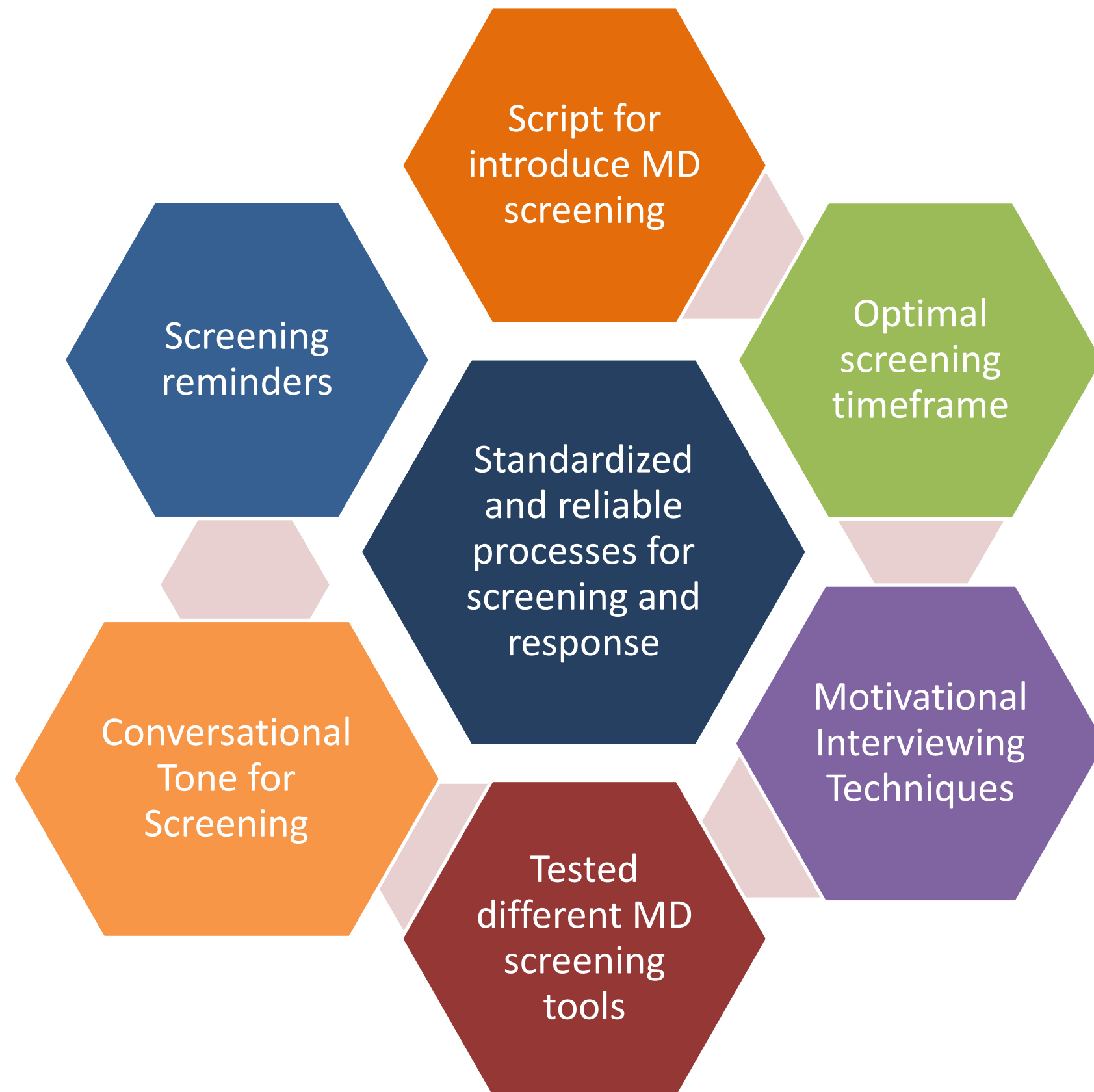
Parent Engagement

Depression Screening Numerator and Denominator

Motivational Interviewing

Parent Focus Groups

The Successful Strategies (Illinois) – Key Driver 1



Examples of Quantitative measures

- Comfort level scales
- Knowledge level scales
- Maternal Depression Screening scores

Examples of Qualitative Measures

- Reflection
- Observation

The Successful Strategies (Illinois) – Key Driver 2



Examples of Quantitative measures

- Comfort level scales
- Knowledge level scales
- Number of survey responses

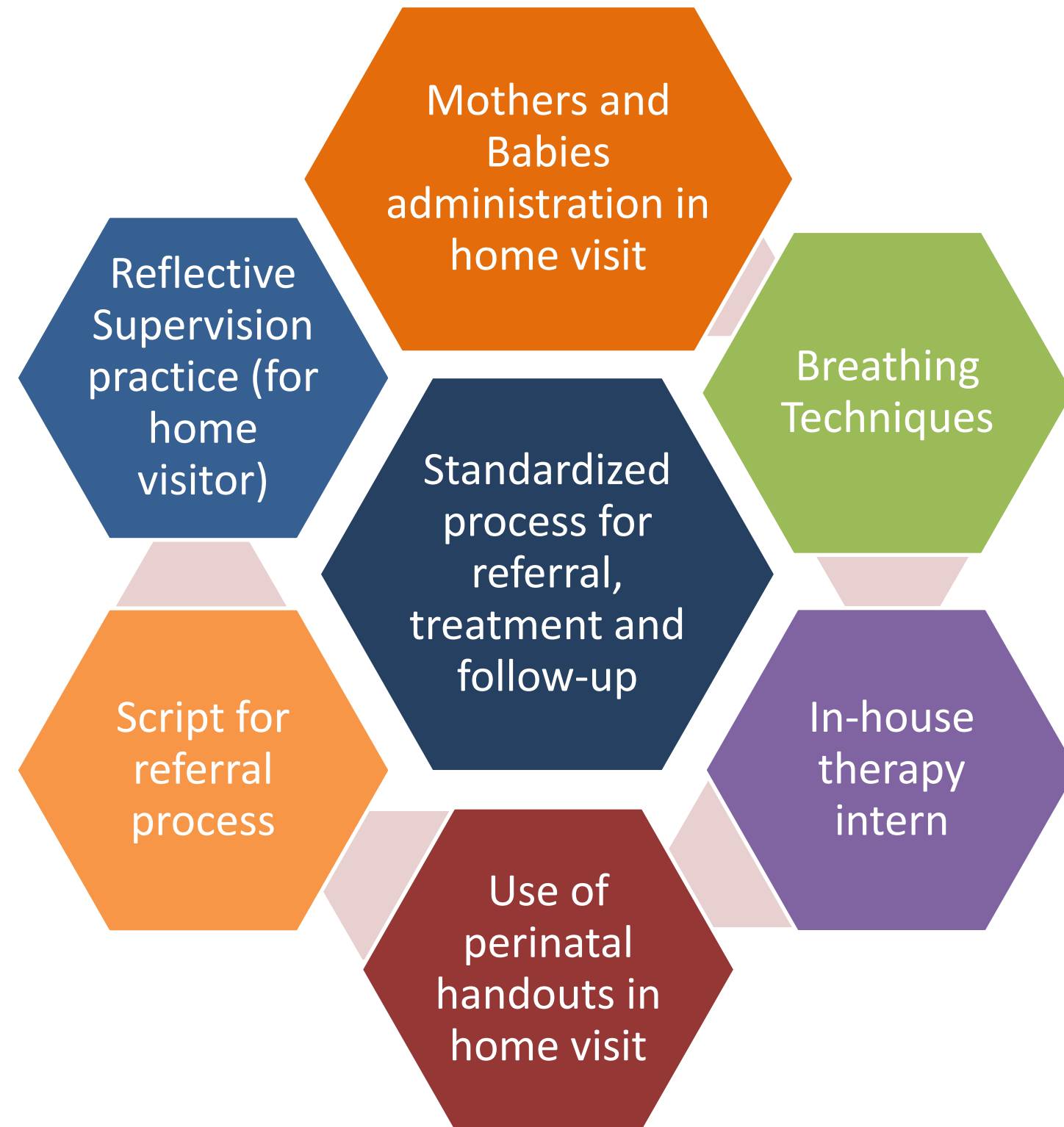
Examples of Qualitative Measures

- Reflection
- Observation



<https://www.mothersandbabiesprogram.org/>

The Successful Strategies (Illinois) – Key Driver 3



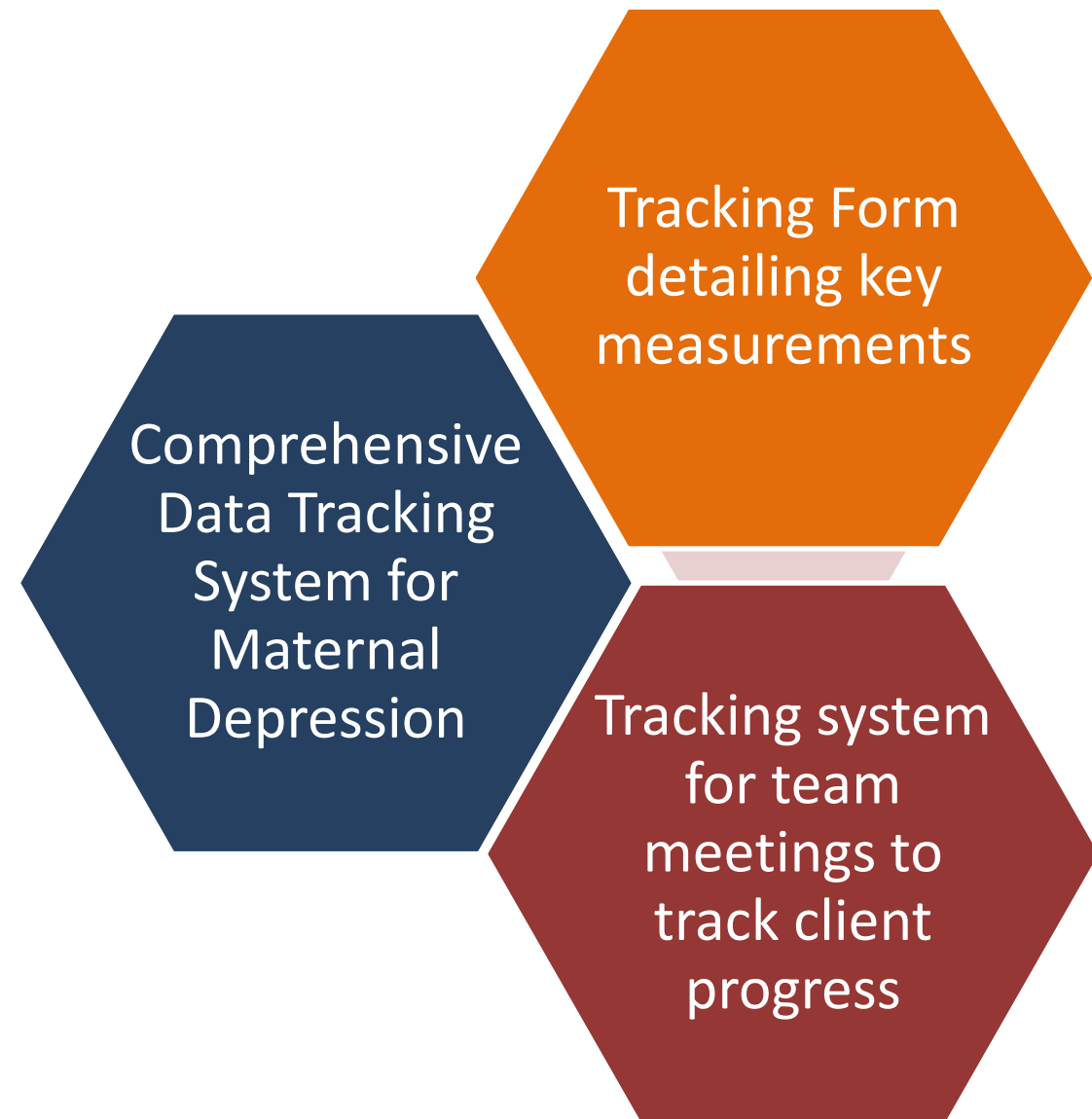
Examples of Quantitative measures

- Comfort level scales both with clients and parents
- MD screening scores
- Mood scale scores

Examples of Qualitative Measures

- Reflection
- Observation

The Successful Strategies (Illinois) – Key Driver 4



Examples of Quantitative measures

- Comfort level scales
- Knowledge level scales
- Maternal Depression Screening scores
- Time

Examples of Qualitative Measures

- Reflection
- Observation

The Outcomes

91% of mothers were screened for maternal depression during a timeframe designated as “best practice” by MIECHV, *median = 89%*

97% of mothers accessed with elevated maternal depression scores, were referred to evidence-based services; *median = 72.25%*

92% of mothers were referred, accepted the referral; *median = 67.75%*

87% of mothers who were referred, followed-up and received at least one service contact; *median = 42.5%*

78% of mothers who were referred and received evidence-based services, demonstrated a 25% reduction in maternal depression symptoms; *median = 0%*

90+ Mothers enrolled in the M&B Curriculum



MOTHERS & BABIES

The Outcomes – Illinois Participant Feedback

- Increased concrete, structural supports for mothers with elevated EPDS scores
- Training in the Mothers and Babies
- Increased maternal depression knowledge and comfort level in discussing maternal depression with caregivers
- Increased ability to create a successful survey and diagram a problem.
- Increased understanding of quantitative and qualitative data
- A greater and deeper understanding of the EPDS
- Enhanced maternal depression policies and procedures that can be shared with current and future staff
- Changed administration of the EPDS in order to elicit more honest responses from caregivers



The "Behind the Scenes" Support



Monthly **Coaching Logs**

460 **PDSA Reviews**

500+ **Data reports compiled manually**

Monthly **HV CoIIN 2.0 Faculty & Staff | State Awardees Communities of Practice**

IA	Team Info	WIB	Attended AP call (Y/N)	Data submitted (Y/N)	PDSA reviewed (Y/N)	Data errors (Y/N)	# of Parent Leaders on CoP Team	M1*	M2	M3	M4	M5	M6	M7	M8	Comments (include comments related to will, PDSA speed and testing)
1.	<input type="checkbox"/> All key team roles filled <input type="checkbox"/> Team meeting regularly Turnover?	Choose an item.														
2.	<input type="checkbox"/> All key team roles filled <input type="checkbox"/> Team meeting regularly Turnover?	Choose an item.														
3.	<input type="checkbox"/> All key team roles filled <input type="checkbox"/> Team meeting regularly Turnover?	Choose an item.														
4.	<input type="checkbox"/> All key team roles filled <input type="checkbox"/> Team meeting regularly Turnover?	Choose an item.														

Driver Planning and Process Aim

Details

Agency * Topic

Primary Driver

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in an improvement? (Please select all that apply)

Status: Active



1	Maternal Depression Reporting Template - HV CoIIN 2.0												
2	Month	Total N enrolled women	N women enrolled 90 or more days ago	N women who gave birth 90 or more days ago	N women enrolled 90 or more days ago screened for MD within 3 months of enrollment	N women who gave birth 90 or more days ago screened for MD within 3 months of giving birth	% women screened for MD within 3 months of enrollment	% women screened for MD within 3 months of giving birth	N women with +MD screen not already in EB svcs	N women with +MD screen not in EB svcs that were offered a referral to EB svcs	N women with +MD screen not in EB svcs that verbally accepted a referral to EB svcs	% women w +MD screen not in EB svcs that verbally accepted a referral to EB svcs	N of women with +MD screen 30 or more days ago that did not access EB svcs within 30 days
3	Feb-21												
4	Mar-21												
5	Apr-21												
6	May-21												
7	Jun-21												
8	Jul-21												
9	Aug-21												
10	Sep-21												
11	Oct-21												
12	Nov-21												
13	Dec-21												
14	Jan-22												
15	Feb-22												
16	Mar-22												
17	Apr-22												

The CQI Specialist - Insights



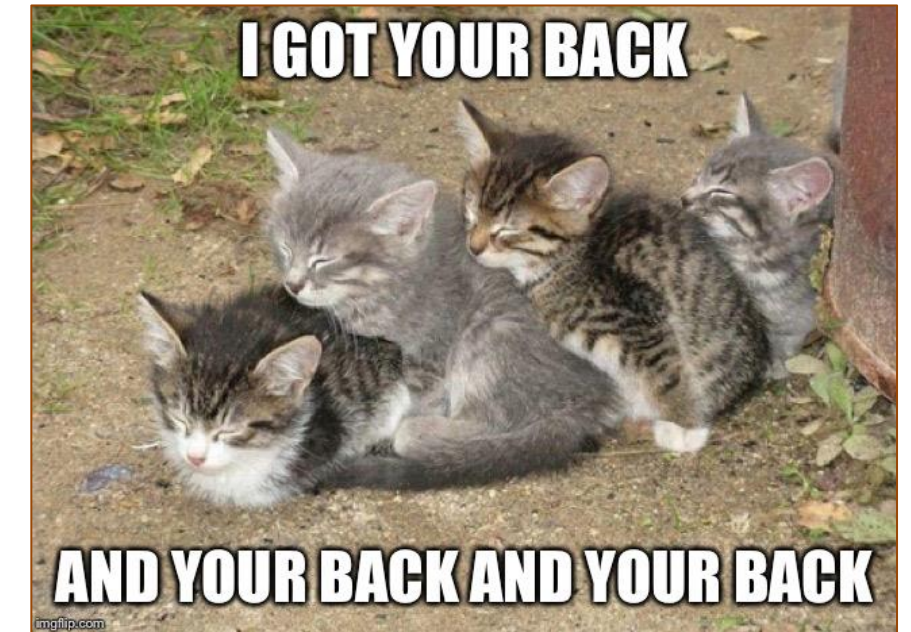
Build **a trusting** relationship

Provide an extra **layer of organization**

Provide each team with the **support** they **request**

Meet teams at their level of CQI knowledge and experience

Value team members' **emotional & physical well-being** over the CQI work



Contact Information

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Panel Presentation



PRIMO CENTER

Dana Benn

Senior Director of Early Learning Services
Primo Center for Women and Children



children's home & aid

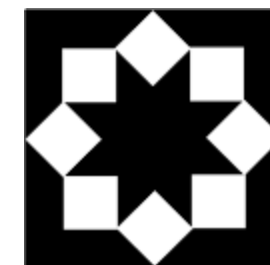
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Aunt Martha's | Kankakee | Illinois



STEPHENSON COUNTY
HEALTH
DEPARTMENT
building a healthy community



Devan Spellman

Coordinator
Stephenson County's All Our Kids (AOK) Network