Family Home Visiting Improving Caregiver Depression Follow-up

This document is a section of the Caregiver Depression Screening toolkit. This document focusing on how home visiting agencies can utilize continuous quality improvement (CQI) methods to improve caregiver depression follow-up practice.

Depression Referral Follow-up

Following up on a referral involves the home visitor, caregiver, and other service providers. Internally, a home visiting organization should set clear expectations for follow-up within their program and record these expectations in a referral protocol. It is best practice to incorporate family-centered decision-making into follow-up expectations. Family-centered decision-making involves working closely with the caregiver to determine what their highest priority is, what types of resources they prefer to receive, preferred communication strategies, and how they would like to be supported during the referral process.

For many caregivers, following-up on a referral could be stressful or confusing. A home visitor can support referral follow-up by helping the caregiver make a personal plan for acting on the referral. The home visitor and caregiver could agree on a plan for the home visitor to follow up with a phone call or visit in a few hours or days to provide support and encourage follow-through. If a caregiver has not acted on a referral, the home visitor could use motivational interviewing to identify barriers to acting on the referral. Barriers could include lack of transportation, limited availability of appointments, or confusion about next steps. Home visitors could complete a Fishbone Diagram (https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/fishbone.html) to identify barriers to referral completion or timely follow-up. A home visitor could also use "teach back" strategies to ensure that caregivers understand what the next step is in the referral process.

Home visitors can utilize relationships with referral partners to support improved follow-up. Information sharing, with permission from the caregiver, between a home visitor and service provider can reduce barriers by allowing home visitors to check on a referral status, support coordinating transportation, and provide medical information. For example, a home visitor with permission from the caregiver and a signed release of information could connect with a mental health clinic to share information on the best ways to contact the caregiver to make scheduling a first appointment a bit easier or to send health records.

Developing and utilizing a referral tracking system can improve referral follow-up by identifying internal and external barriers to referral completion. A referral tracking system could have many different forms, but many home visiting organizations might find it convenient to use electronic record systems to support home visitors managing referrals with different statuses. A referral tracking system should at minimum include the date a referral is made, what the referral is for,

the status of the referral, and a plan for following up with the caregiver and/or the service provider receiving the referral. A referral status could include:

- Not yet in process-family has not acted on referral
- In process-family has contacted service provider and is awaiting action
- Scheduled-family has an appointment scheduled with service provider
- Complete-family received at least one service or appointment from service provider
- Declined- family is not pursuing services
- Unavailable-referral providers was contacted and cannot provide services to family
- Ineligible-referral provider was contacted and family is not eligible for services

Documenting and Reporting Data

All home visitors should follow guidance provided in the MDH IHVE Data Collection Manual (https://www.health.state.mn.us/docs/communities/fhv/ihvedatacollmanual.pdf) when documenting and reporting data. The instructions for the screening form can be found on page 53. The instructions for the referral form can be found on page 61.

All screenings and referrals should be documented in IHVE as soon as possible after they occur. Documenting and reporting when a referral progresses through different statuses, such as when a family schedules an appointment or receives services, provides information on whether families are receiving referral services quickly, or if there are barriers that prevent families from acting on a referral. Regardless of the amount of time between when the referral is provided and when the referral status changes, it is important to report this information to document how home visitors support connecting families to resources.

Please note that IHVE data collection forms vary between electronic record systems. For technical assistance, contact the support email address listed below for the system your organization is using.

- Nightingale Notes: support@champsoftware.com
- PH-Doc: supportdesk.wpark@avenuinsights.com
- IHVE REDCap forms: Health.FHVData@state.mn.us

Resources:

- The Mothers & Babies Program (https://www.mothersandbabiesprogram.org)
- Postpartum Support Minnesota (https://www.ppsupportmn.org/handouts)
- More than the Blues Toolkit (https://store.samhsa.gov/system/files/sma14-4878.pdf)
- Breastfeeding and Antidepressant Medication Chart (https://www.ppsupportmn.org/resources/Documents/PPSMantidep.pdf)

- Wilder Research Home Visiting Engagement and Retention (https://www.wilder.org/wilder-research/research-library/home-visiting-engagement-and-retention)

Contact

If you have questions regarding this toolkit or continuous quality improvement efforts within the MDH Family Home Visiting Section, please email health.fhvcqi@state.mn.us.

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To obtain this information in a different format, call: 651-201-4090.