First Quarter CQI Overview

**Successes:**

1. All three CQI levels established their teams and met for the first quarter within their scheduled timeframe. Please see the attached summary of 1st Quarter minutes.

2. Leader, Facilitator and Scribe roles were created within each team. Please see the attached list of members and roles for Levels 1, 2, and 3.

3. New and ongoing issues were identified and discussed along with smoking cessation. Interventions and best practices were shared within programs at the Level 2 meeting. It is truly exciting to hear about synergy at work!

**Process Revisions:**

1. Some programs submitted their activity log and separate meeting minutes to detail what was discussed at the Level 1 meeting. This was extremely helpful, informative and an effective way to capture all of the important information discussed. It can be difficult (due to limited space on the activity log) to write everything that is worth mentioning. Attached to this e-mail is a Word version of the Activity Log. If you meet in a room where there is already an accessible computer or you have a laptop, we encourage you to type the information into the activity log. Since it is a Word document, the spaces will expand to fit the content.

As part of the CQI process, there is much knowledge gained when interventions and best practices are discussed and shared to be implemented by others. The best way to capture this knowledge sharing is to have it documented. So, the more detail you can provide in your activity log and meeting minutes regarding the issues that are discussed, solutions discussed, action plans, etc. the more successful the CQI process will be. If an issue is discussed and resolved during the meeting, that is great; however, you still need to document what the issue was and highlight the details of the discussion as to how the issue was resolved. If the issue was not resolved but an action plan was discussed, outline the details of the action plan and the person’s name responsible for working on that specific action.

2. Timeline to submit activity log and meeting minutes:

   For the 2nd quarter, Level 1 teams will meet between January 14th and January 25th. The activity log and meeting minutes should be submitted to Kayla Turner at k.turnerehshv@hotmail.com by Wednesday, January 30th. Kayla is the scribe for Level 2. This will allow the Level 2 team enough time to prepare an agenda before their meeting scheduled for February 13th. Please also submit these documents from Level 1 teams to Melissa Kleffner-Wansing at Melissa.Kleffner-Wansing@health.mo.gov by January 30th. Melissa is the scribe for Level 3.

   The Level 2 minutes and activity log from the February 13th meeting should be submitted to Melissa Kleffner-Wansing by Wednesday, February 20th. This will allow enough time for the Level 3 team to prepare an agenda before their meeting.
In this Newsletter, we highlight...

1. The prevalence of postpartum depression and the importance of screening. Resources included. (Pages 3-4) **Potential item to discuss:** How do you screen for postpartum depression? Are you familiar with resources within your service area to refer your clients to when postpartum depression is identified?

2. A topic which has been mentioned by several of the contracting programs is difficulties with clients following through with referrals especially to mental health services. For your reference, please read this article published by the Substance Abuse and Mental Health Services Administration (SAMHSA) entitled “Case Management: Facilitated Referral Services.” This article addresses how to identify individuals who are at risk of developing a mental, emotional, or behavioral disorder and helping them understand the value in accepting a referral, matching them with the best available provider to ensure a good fit and ensuring successful connection through facilitated referral services for prevention and case management along with motivational interviewing. (Pages 5-7)

   **Potential item to discuss:** How do you address referral services for your clients and the client’s ability to follow through with the referral? Are you aware of the mental health resources within your area and how do you build or maintain relationships with those mental health service agencies? Once a referral is made, what kind of follow up do you do to increase the likelihood of the client following through? Are there some interventions more effective than others?

3. A word from HRSA and updated information regarding the MIECHV Steering Committee. (Page 8)

4. Smoking cessation success stories and a useful link for additional resources available through The Maternal & Child Health (MCH) Resource Library. (Page 9)

**List of Attachments**

1. Summary of 1st Quarter minutes.

2. List of members and their roles for Levels 1, 2, and 3.

3. Word version of the activity log.
Postpartum Depression and the Importance of Screening for Postpartum Depression

Postpartum Depression

Maternal Depression in MIECHV

Depression after having a baby can range from “baby blues” to postpartum depression (PPD). Baby blues usually last a few days or weeks, but PPD symptoms are more severe and last longer. PPD can actually interfere with daily life and caring for the baby. Symptoms of PPD may include:

- Sadness
- Loss of interest in activities
- Changes in eating, sleep and energy
- Problems in thinking, concentrating and making decisions
- Irritability and anger
- Feelings of inadequacy as a mother
- Feelings of worthlessness, shame or guilt
- Thoughts that life is not worth living
- Withdrawal from family and friends
- Thoughts of harming the baby or having negative thoughts that someone will take or harm the baby

An estimated 10-15 percent of mothers are affected by PPD in the year after delivery. Previous studies have found that young maternal age, partner-associated stress, traumatic or financial stress, physical abuse, delivery of a low birth weight infant, and tobacco use during pregnancy were associated with PPD. PPD is associated with not breastfeeding, early weaning and may affect maternal-infant relationships as well as infant behaviors.

Recognizing the prevalence of PPD, a national Healthy People objective was developed to increase the proportion of women giving birth who attend a postpartum care visit with a health care worker.

Socio-Demographic Characteristics:

An estimated 14 percent of Missouri women reported PPD symptoms. PPD symptoms were more common among women who were:

- Younger
- Less than high school educated
- Non-Hispanic Black
- Unmarried
- Covered by Medicaid for delivery

PPD symptoms were approximately two times more common among women with a history of partner-related physical abuse or who had health problems during pregnancy.

Missouri Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, population based survey designed to identify and monitor select maternal experiences, attitudes and behaviors that occur before, during and shortly after pregnancy among women delivering a live born infant.
For mothers who give birth to a child while participating in the Missouri MIECHV program, between 4-8 weeks postpartum, home visitors use the assessment tool Edinburgh Postnatal Depression Scale to screen participants for the presence of PPD. As of September 30th, 92.9% of mothers who gave birth to a child while participating in the MIECHV program were screened for PPD.

Given the above mentioned information, PPD is a serious concern especially given the high-risk population of the MIECHV program. Home visitors have done a great job of screening for maternal depression, and it is very important to continue to screen new mothers for depression symptoms shortly after the birth of a child in order to encourage women to seek help from a health care provider immediately if screening results indicate further evaluation and treatment is necessary. For more information, please visit the following resources:

**Missouri Department of Health and Senior Services:** *Perinatal & Postpartum Depression*  The following website has information about perinatal and postpartum depression for pregnant women, new moms, family and friends, and health care providers: [http://health.mo.gov/living/families/womenshealth/perinataldepression](http://health.mo.gov/living/families/womenshealth/perinataldepression)

**Postpartum Support International**  [http://www.postpartum.net](http://www.postpartum.net)  
Phone: 800-944-4PPD (800-944-4773)  
Information on treatment, support groups and resources in the United States and 25 countries

**American College of Obstetricians and Gynecologists (ACOG)**  [http://www.acog.org](http://www.acog.org)  
Phone: 800-762-2264  
Resources for you and your health care provider

**SAMHSA National Mental Health Information Center**  [http://mentalhealth.samhsa.gov](http://mentalhealth.samhsa.gov)  
Phone: 800-789-2647  
Information on depression, including a locator to find a mental health center in your area

**National Institute of Mental Health**  [http://www.nimh.nih.gov](http://www.nimh.nih.gov)  
Phone: 866-615-6464  
Links to health information and research studies on depression

**Postpartum Education for Parents**  [http://www.sbpep.org](http://www.sbpep.org)  
Phone: 805-967-7636  
24-hour support line available for one-to-one support, from basic infant care to the baby blues and other perinatal topics (this may be a long distance call)

**National Mental Health Association**  [http://www.nmha.org](http://www.nmha.org)  
Phone: 800-969-6642  
Information on Perinatal Depression, including a locator to find a mental health center or provider in your area

**National Women’s Health Information Center**  
Phone: 1-800-311-BABY (1-800-311-2229)  
In Spanish: 800-504-7081  
Information on prenatal services in your community
SERVICE DEFINITION: Case management: Facilitated Referral Services for Prevention (facilitated referral) combines the established concepts of case management and motivational interviewing to identify individuals who are at risk of developing a mental, emotional or behavioral disorder and helping them understand the value in accepting a referral, matching them with the best available provider to ensure a good fit and ensuring successful connection with a prevention practitioner.

The facilitated referral includes discussing strategies to deal with economic and logistical barriers and identifying cultural elements needed for a successful connection to a new provider. This service is designed to help a patient or family find and accept an appropriate preventive intervention in their community to prevent or delay the onset of mental, emotional or behavioral disorders, including substance abuse.

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Individuals, couples, parents, and families, identified as being at-risk for the development of a mental, emotional or behavioral disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Requirements</td>
<td>Facilitated referrals are typically made face-to-face during an appointment with the referring practitioner; however, this should be left up to the discretion of the referring practitioner, especially in rural and frontier areas where telemedicine technology may be used.</td>
</tr>
</tbody>
</table>

Activities for this service may include:

- Case identification/risk assessment—the assessment/clinical process that identifies the need for a referral to another service provider. This step requires the provider to have knowledge of evidence-based preventive services available in the local community.

- Understanding decision-making—the assessment process that looks at the person or family that is the focus of the referral within a cultural and community context to understand how decisions are made with the individual or family in order to identify how the referral is most likely to be successful.

- Identification of the referral barriers—the analysis of key barriers to accepting the new service, such as cost, travel impediments, or other logistical issues. This step requires that the provider engage the client/patient in a discussion about the need for this service and why a specific provider will match their needs, including identified cultural factors, and help them address relevant barriers.

- Identification of the receiving structure and preparation for receiving the patient—the analysis of the quality of potential referrals and if they can meet the service needs of the patient.

- Follow-up—at a subsequent appointment or via an alternative form of communication (e.g. email or telephone) referring professional will inquire about the outcome of the referral.

Activities in this service should not include referrals to treatment services or extensive ongoing case management services that coordinate long-standing treatment, social services, supportive employment or other services.
# PREVENTION SERVICES:
## Case Management: Facilitated Referral Services

| **Provider Requirements** | A facilitated referral would be provided in the setting of the professional making the referral, such as a primary care setting, mental health office, or clinic, substance abuse service setting, or Federally Qualified Health Centers (FQHCs). |
| **Staffing Requirements** | Education/qualifications required for provider:  
Licensed state mental health practitioners (MD, PhD, MSW, MSN, Licensed, Family Therapists, and Licensed Professional Counselors), licensed state primary care providers (Medical Doctors, Doctors of Osteopathy, Nurse Practitioners, Physicians Assistants, RNs), OR  
- Certified substance abuse prevention specialists and substance abuse treatment providers and other state licensed health professionals who are trained to deliver a facilitated referral for preventive services  
- Paraprofessionals such as Health Promotion Advocates and Health Educators under supervision by any of the above professionals may also provide facilitated referral services  
- Paraprofessionals such as Health Promotion Advocates and Health Educators under supervision by any of the above professionals may also provide facilitated referral services  
The competencies required to provide this service include:  
- Basic interpersonal and communication skills  
- Effective listening skills  
- Ability to create and sustain a therapeutic relationship  
- Ability to engage in shared decision making  
Ongoing provider training may include:  
- How to identify risk factors for MH/SUD  
- Knowledge of or ability to access database containing:  
  - The types of local preventive services currently  
  - The types of providers offering the services (including evidence of certified training)  
  - The cost of these services  
  - Other relevant cultural and linguistic factors associated with the providers and services  
  - Feedback from those who have received the services |
| **Documentation Requirements** | The documentation should include the following:  
- The rationale for making the referral including the identified risk factors to be addressed by the preventive intervention services  
- A description of the decision-making dynamics explored with the client including cultural and community factors  
- A comprehensive identification of barriers (e.g., cost, transportation, etc.) and subsequent strategies developed with the client to surmount the barriers |
The rationale for making a referral to the specific source, including identified qualifications, training, and fit with the client in aspects of culture and other personal preferences to make the referral process a successful one.

<table>
<thead>
<tr>
<th>Service Exclusion</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions/Service Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Continuing Service Criteria</td>
<td>Typically a facilitated referral could be completed in one session. However, a second session may be required as part of helping the client accept the need for the referral. For example, in a primary care setting, a mother may accept the need for evidence-based (preventive) parent training, but needs to have her husband speak with the referring professional before he would accept the referral.</td>
</tr>
<tr>
<td>Discharge Criteria</td>
<td>N/A</td>
</tr>
<tr>
<td>Service Authorization Period</td>
<td>A facilitated referral is intended as a transitional service. Typically this service would be offered for one session and on occasion two sessions. The referring professional would decide when the referral process had reached the expected outcome or that the client/patient would not accept the referral at this time.</td>
</tr>
<tr>
<td>Service Authorization Unit</td>
<td>N/A</td>
</tr>
<tr>
<td>Benefit Limits</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The Case management: Facilitated Referral Services article copied from the original article published is at the link listed below:
http://www.samhsa.gov/healthReform/docs/Prevention_Service_Definitions_Facilitated_Referral_Services_Reformatted_20101129.pdf
A word from HRSA…

Dr. Willis’ take home messages:

1) Early Childhood Systems integration is key to Home Visiting and Early Childhood program success;

2) Emphasis on the first 2000 days is required for building health and education readiness for the next generation of children;

3) Home Visiting programs and Early Childhood programs have an unprecedented opportunity to unite and coordinate with a unified vision.

David Willis, M.D., FAAP is the new Director of the Division of Home Visiting and Early Childhood Systems in the Maternal Child Health Bureau of the Health Resources and Services Administration (HRSA). He spoke at the Region VII MIECHV meeting in Denver in November 2012. Some of the MIECHV Program Staff were able to attend and listen to his aspirations about the importance of system integration to the success of MIECHV.

Check out this link http://www.ounceofprevention.org/news/downloads.php for a very inspirational video entitled “Change the First 5 Years and You Change Everything.”

Dr. Willis is also a firm believer in the power of sharing success stories. Please keep this in mind as you see your clients and families grow and learn how to be successful parents and form loving and supportive families. Submit these stories to Melissa Kleffner-Wansing.

MIECHV Steering Committee Merger

Effective November 2012, the MIECHV State Steering Committee merged with the Early Childhood Comprehensive System (ECCS) Steering Committee. This merger will lead to a greater capacity to further develop Missouri’s plans for a comprehensive early childhood system.

The State Steering Committee for the MIECHV program met on September 28, 2012 and was given information on ECCS. The ECCS Steering Committee met on October 23, 2012 and was provided information on MIECHV. Many of the same agencies are represented on both committees and in many cases they are the same people. The attendees at the meetings on September 28th and October 23rd agreed that having one meeting to attend as opposed to two would be beneficial for them. The attendees that are not currently on both committees were very positive about learning more about the other program. Those in attendance at these two meetings agreed that the Department of Health and Senior Services should move forward with the merger.

At the ECCS Steering Committee meeting on October 23, 2012 there were also four local stakeholder team leaders in attendance, two of which are from Jasper County and Pemiscot/Dunklin County regions of the state that receive MIECHV funding. These stakeholder team leaders spoke positively of the merger. They believe that this provides a model of collaboration at the state level and would help to model, enhance and improve collaboration at the local level.

The first merged meeting will take place on January 8th.
Smoking Cessation Success Stories

This success story is from the Malden area...

This is a twenty year old first time pregnant, single mother, who smoked 7-10 cigarettes a day. She was living with the mother of the baby’s father; he was incarcerated. Client was 25 weeks pregnant when I enrolled her. She had only received one prenatal visit at this time. I gave her the smoking cessation support number (1-800-784-8669) during my first and second visit. On my third visit with her she had completely quit smoking. She didn’t use the number due to the lack of having minutes on her phone. I had told her during both prior visits that every time she takes a puff off of a cigarette she is cutting her baby’s oxygen off. I asked her how she felt when she couldn’t catch her breath. She gave birth on 6/27/12 to a 7lb 14oz baby boy. She did not start smoking again after the delivery but she has since moved to Indiana to be near her family.

This success story is from the Joplin area…

When I started serving this family they reported smoking a pack a day. She smoked in the home and the car with the children present. One time I went on a visit and the children were sick with upper respiratory issues. The mom was frustrated because the children had been sick for nearly 2 weeks and did not seem to be recovering. She had missed work and the children had missed childcare. I talked to her about the way her smoking was affecting her children's ability to recover from this illness. She put out her cigarette. The next visit we had she did not smoke the entire visit. (This was a first). The next week they moved into a new home. When I arrived I noticed an ash tray on the front porch and the house did not smell like smoke. I complimented her new home and commented about the lack of cigarette smell. She said that they would not be smoking in their new home. It has now been 6 weeks and the home is still smoke free. Mom and dad have both reduced the number of cigarettes they smoke a day to less than half a pack. What a great choice they made for their children!!!

The Maternal & Child Health (MCH) Library Resource

Here is a link to a very good general resource for information home visitors might use in their work with pregnant women. Many resource topics are found at this link to the MCH Library, including one for Tobacco, Alcohol, and Substance Use During Preconception and Pregnancy:

http://www.mchlibrary.info/KnowledgePaths/kp_pregnancy.html

Description - This knowledge path directs readers to a selection of current, high-quality resources that analyze data, describe effective programs, and report on policy and research aimed at improving access to and quality of preconception and prenatal care to improve perinatal health outcomes. This knowledge path can be used by health professionals, program administrators, policymakers, and researchers to learn more about preconception and pregnancy, for program development, and to locate training resources and information to answer specific questions. A separate brief lists resources for families. This knowledge path has been developed by the MCH Library at Georgetown University and will be updated periodically. View Related MCH Library Resources for guides about childbirth, fertility and infertility, medications, nutrition during preconception and pregnancy, and more.

Final Notes and Reminders

The call-in number for the Level 2 CQI meeting on February 13th is toll free (866) 630-9348. For the Level 3 CQI meeting on March 11th, the toll free number is (866) 630-9348 and local is 573-526-5622.

For Level 1 Teams, remember to submit your detailed activity log and meeting minutes to Kayla Turner at k.turner@health.mo.gov and Melissa Kleffner-Wansing at Melissa.Kleffner-Wansing@health.mo.gov by Wednesday, January 30th.

For the Level 2 team, please submit your detailed activity log and meeting minutes to Melissa Kleffner-Wansing at Melissa.Kleffner-Wansing@health.mo.gov by Wednesday, February 20th.
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