Strengths and Risks (STAR) Framework

Contents

Introduction

The Nurse-Family Partnership (NFP) Strengths and Risks (STAR) Framework is part of the NFP model and is designed to help nurses and supervisors systematically characterize levels of strength and risk exhibited by the mothers and families they serve. While assessing client strengths and risks the STAR Framework is primarily a risk assessment providing NFP teams with a common language and process for characterizing and organizing these characteristics. From the results of the randomized clinical trials we know that higher risk clients are those who benefit from NFP services. Therefore, it is expected that clients will have risks. When the STAR is coded the code is for the risk – this is not a judgement of the client. The STAR is intended to inform and support consistent clinical decisions made by nurses and supervisors regarding visit content and dosage. Early application of the STAR Framework also allows the nurse and the client to establish a discussion about what has happened to her in her life, and how these exposures have the potential to influence her current health behaviors and future health outcomes. In addition, the STAR Framework promotes identifying stages of behavioral change and appropriate corresponding actions and intervention to improve maternal and child health. By attending to specific strengths that mothers and family members bring to the program, the STAR Framework helps the nurse to identify families who are doing so well on their own that they may not need to be visited as frequently and to identify those that need more visits due to greater risk or need. Information organized within the STAR Framework informs nurses' ways of working with families and helps them align the program content and frequency with mothers' (and other family members') abilities and interests in engaging in the program.

The STAR Framework was developed by staff at the Prevention Research Center (PRC), the NFP National Service Office (NSO) and NFP nurses in Colorado, California and Minnesota. The STAR Framework was piloted by NFP nurses in Colorado and revisions were made based on their feedback. STAR is a work in progress; feedback from all nurses continues to guide further revisions.

Coding the STAR Framework occurs as the nurse and client get to know each other. Information obtained from the client's comments, the nurse's observations and clinical judgment are used to populate the STAR Framework. It is designed to guide clinical implementation of the program, client case management, individual supervision, and NFP case conferencing.

Conceptual Framework

NFP Outcomes

The STAR Framework is founded in NFP's bio-eco-behavioral model of early development and intervention, developmental science, nursing process, and epidemiologic data (Olds, Kitzman, Cole, and Robinson, 1997), and aims ultimately to support consistent assessment in all six NFP domains and consistent implementation across NFP agencies. It also seeks to promote achievement of the three NFP maternal and child health goals:

1. To improve pregnancy outcomes *by helping women improve their prenatal health and behavior*;

2. To improve children's health and development *by helping parents provide competent early care of their children*; and

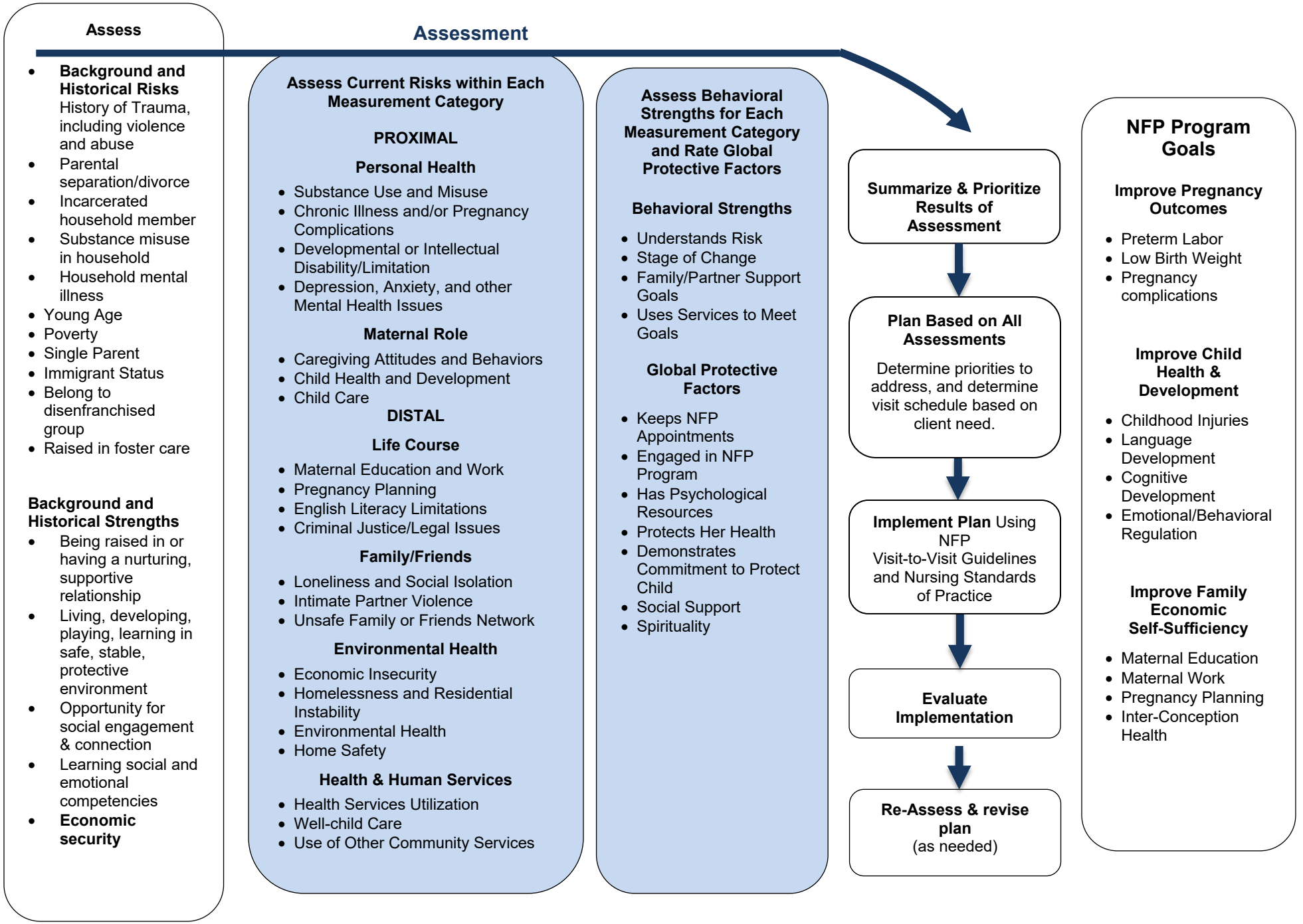
3. To improve mothers' life-course development *by helping mothers develop a vision for the kind of life they want for themselves and their children and by helping them make choices consistent with their values around planning of subsequent pregnancies, finishing their education, and finding work.*

The italicized words following each of the goals constitute the core nurse activities thought to improve maternal and child health directly. These activities (promoting prenatal health behaviors, care giving, pregnancy planning, finishing their education, and finding work), therefore, deserve to be treated with highest priority in planning individual interventions with families. These maternal and caregiver behaviors and health conditions need to be understood in terms of the material and social contexts in which families live. The STAR Framework is designed to help nurses synthesize the risks and strengths and set priorities for intervention. The risks listed in the STAR Framework fall within the scope of NFP nursing practice as they influence maternal and child outcomes directly, such as substance use during pregnancy and parental care of the child. In some cases, these risks create additional clinical challenges for nurses because of their indirect influence, such as homelessness or economic adversity.

STAR Framework Summary

The STAR Framework Conceptual Model (Figure 1) on the next page summarizes the process and outcomes associated with using this framework in practice. NFP goals are on the right. The risks and strengths that are revealed in each of the NFP's six program domains are shown in the second and third columns of the figure. The first highlighted column specifies the risks to be assessed within each of the domains. The second highlighted column shows specific conditions that reveal mothers' and families' strengths in relationship to each of the targeted risks, as well as mothers' and families' global strengths. The STAR Framework provides a comprehensive assessment of the client; it is the first step in the Nursing Process. The information on risks and strengths is used to develop a summary of specific risks and strengths, help nurses think about their priorities for action, and guide clinical implementation of the program. Nurses evaluate the implementation of their plan and continuously assess the mother, child, and family, using the STAR Framework. This work aligns with fundamental nursing process (Orlando, 1972). As a reminder, the general nursing process consists of five steps: 1) assessment; 2) diagnosis; 3) planning (outcomes); 4) implementation and 5) evaluation.

Figure 1: STAR Framework Conceptual Model



Current, Historical, and Background Risks

The STAR Framework identifies two levels of client risk: historical/background risk and current risk. The distinction between these types of risk is important.

Identification and discussion of historical/background risks and strengths provides insight to both the nurse and the client about "what has happened" to this individual – and how these past experiences might influence current or future health behaviors or outcomes, either positively or negatively.

However, the primary focus of the STAR Framework is assessment of current risk experienced by the client. Understanding client current risk is the focus because the STAR Framework is aimed at supporting achievement of the three NFP program goals based on the client's current functioning. Understanding the specific risks experienced by a client provides an opportunity for nurses to use NFP materials to target these areas for additional support to facilitate healthy growth and development for the client and her child. As indicated in Figure 1, current risk factors are identified within each of the six domains of the NFP program. These current risks can either be changed directly (e.g., reducing cigarette smoking during pregnancy) or their negative impacts can be moderated with intervention (e.g., helping parents cope with their own developmental disability or with a child with a congenital disorder).

Historical and Background Risks and Strengths

Historical and Background Risks and Strengths are often highly predictive of Current Risks and Strengths. The environments and experiences, whether positive or negative, that a client is exposed to in her childhood or adolescence can influence her behavior choices and health outcomes across the lifespan. A client's past experiences may also influence her caregiving capacities and the nature of the environment that the infant is raised in. Many historical or background risks might also be labelled as Adverse Childhood Experiences which may occur in Adverse Community Environments (Ellis & Dietz, 2017). Exposure to adverse childhood and community environments results in toxic stress and increases the likelihood of an individual engaging in health-risk behaviors as an adult and increases the likely occurrence of chronic illness or mental health problems.

Adverse Childhood Experiences:

- Physical, emotional, or sexual abuse
- Physical or emotional neglect
- Childhood exposure to intimate partner violence (or other forms of domestic violence)
- Growing up in a home with maternal depression or individuals with other forms of mental illness
- Growing up in a home where there was substance misuse
- Experiencing household dysfunction and separation including divorce, an incarcerated family member, homelessness

Adverse Community Environments:

- Poverty
- Structural violence including racism, discrimination
- Community disruption
- Lack of opportunity, economic mobility and social capital
- Community violence
- Poor housing quality and affordability
- Food insecurity
- Environmental toxins (air & water pollution, exposure to second hand smoke, exposure to lead)

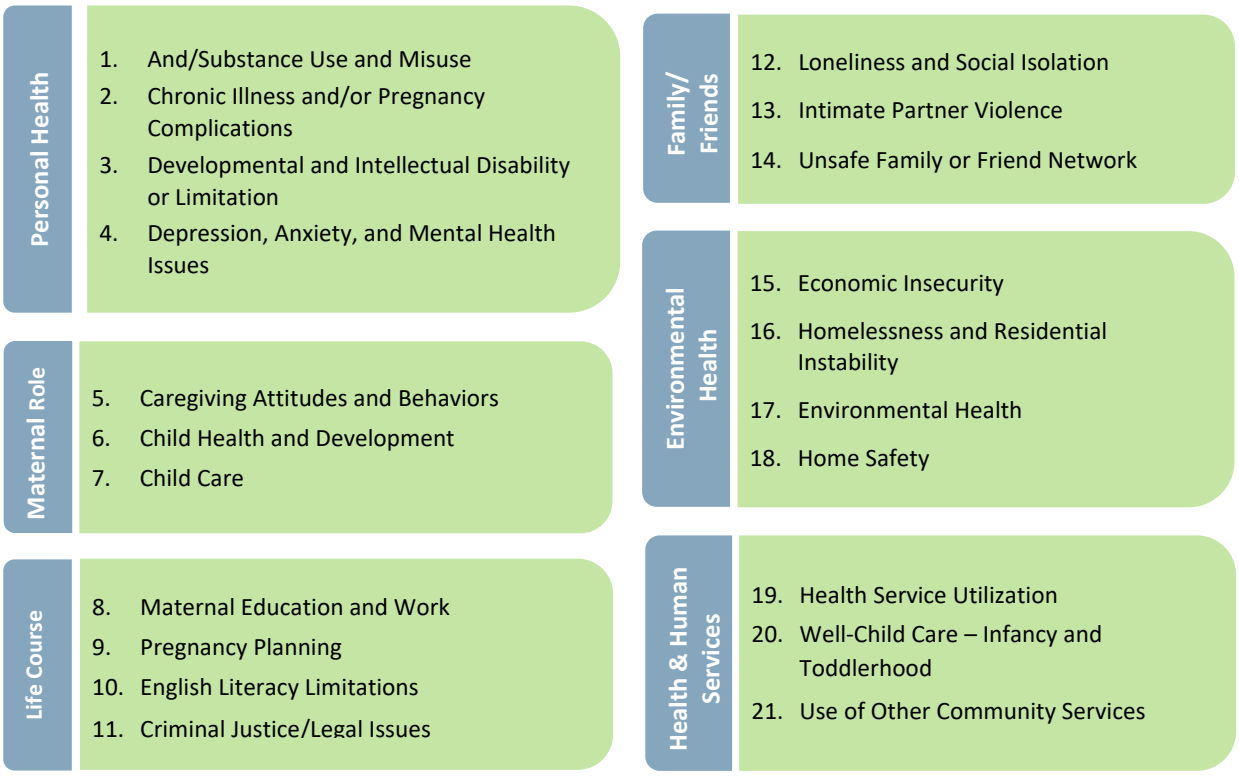
Background and Historical Strengths:

- Being raised in or having a nurturing, supportive relationship
- Living, developing, playing, learning in safe, stable, protective environment
- Opportunity for social engagement & connection
- Learning social and emotional competencies
- Economic security

NFP nurses cannot change what individual, family, or community level experiences a client may have been exposed too. However, uncovering these early experiences can help women understand and address current behaviors that stem from their backgrounds and histories. Equally important is to explore with clients what positive experiences they also had in their past. To help the client establish her goals for behavior change, caregiving, or completing school/finding a job identification and discussion of positive childhood experiences allow the nurse to focus future conversations on client strengths and experiences of resiliency. Categories of positive childhood experiences include: 1) being raised in or having a nurturing, supportive relationship with a caregiver or other significant adult figure; 2) living, developing, playing and learning in a safe and stable environment; 3) being given opportunities for social engagement and feeling connected to one's community or culture; and 4) learning social and emotional competencies (Sege & Brown, 2017).

Measurement Categories

The STAR Framework identifies the following measurement categories:



Within each of these categories, clients are classified into three levels of risk according to the degree to which conditions or symptoms are present that impair their functioning:

0 – Low risk

1– Moderate risk

2– High risk

For some of the measurement categories, the nurse may have existing information sources that serve as a foundation for making risk classifications. Nearly all categories are assessed across pregnancy, infancy, and toddler phases of the program. In addition, the STAR is dynamic—that is, it accommodates changes in clients' lives and experiences (e.g., loss of employment) and their willingness to disclose challenges over the course of the program. Recognizing changes in risks experienced by clients helps nurses support clients' achievement of their goals and the goals of the program. Specific guidance is provided regarding how each current risk is categorized and the clinical information needed to categorize each risk. At times, the nurse may feel that the client is at greater risk than would be indicated by the coding guidelines. In that case, rely on your nursing judgment and code accordingly.

Behavioral Strengths and Protective Factors

In addition to understanding the risks clients' experience, nurses need to know the strengths clients and their families possess to guide intervention planning. Strengths are the foundation for behavioral change. In this system, strengths are factors that can enable nurses to help women reduce the likelihood that risks become more significant or are translated into compromised maternal and child health. Strengths are divided into two categories: Behavioral Strengths and Global Protective Factors. A summary of these categories is provided in this introduction; please refer to the STAR Coding Guidelines for detailed descriptions.

Behavioral Strengths

Behavioral strengths are assessed in relation to each specific measurement category defined in the STAR. Behavioral strengths are included to help nurses determine and support clients' adaptive behavioral change based on Motivational Interviewing (Rollnick, Miller, & Butler, 2008), Self-Efficacy Theory (Bandura, 1977), Prochaska and Diclemente's (1984) Stages of Behavior Change Model, the social support mothers have among their family members and friends, and formal services for achieving their goals and the goals of the program (Olds, 1981). Within each of the risk domains, a place is provided for nurses to code whether the client understands the risk as a problem for achieving what she wants in life, reveals a desire to change, expresses realistic goals and plans for change, makes small changes, works toward her goal or achieves her goal, whether she has family, friends, or partners who support her specific goals, and whether she uses formal services to meet her goals. These behavioral strengths help nurses reflect on the specific behavioral assets clients hold in relation to each risk category. Nurses use this information to devise approaches to addressing individual families' needs by building on current strengths, with the aim of guiding clients toward success or reduced level of risk within each specific measurement category. Reflection on mothers' stages of change, confidence in addressing their needs, and support from family, friends, and formal services is at the heart of program planning, which is organized to help mothers clarify and achieve their goals (Olds, 2002).

Protective Factors

Protective factors are personal characteristics that clients or families bring to the program and which appear to be fundamental parts of their makeup. Protective factors include personal characteristics such as engagement in home visits and eagerness to learn from the program, the display of psychological resources (e.g., positive emotions, intelligence, ability to plan, behavioral regulation, advocates for self and child), strong healthy childrearing beliefs and behaviors, and the existence of a strong social support system. These factors are assessed globally across all areas of client functioning and can be used to identify mothers and families that have such fundamental protective factors that in the nurse's judgment they have sufficient resources to manage normal challenges that accompany early care giving and transition to economic self-sufficiency. This information is likely to help inform nurses' consideration of reducing families' visitation schedules. Decisions regarding protective factors are subjective and based on the assessment and the nurses critical thinking and clinical judgment. Lack of some protective factors will alert the nurse to possible vulnerabilities for the client.

Use in Practice

The STAR Framework is meant to be used flexibly as nurses gain a deeper understanding of maternal, child, and family strengths and needs. It is recommended that nurses code all measurement categories over several weeks and then review the categories at regular intervals. The approximate review periods are recommended to support care planning at critical stages in pregnancy and the life of the child, and important stages in the program. The STAR Framework supports the nurse in thinking through strengths and risks and is a place to organize critical thinking skills .

Review and Data Entry Timepoints

As the nurse gets to know the client over several weeks, the categories are completed. Ideally, all categories are assessed initially and by 36 weeks of pregnancy. The STAR Framework is utilized at each visit, reviewed and updated when there is a significant change in families' strengths and risks.

Data will be entered in the DCS at the following times:

1) Initial coding: complete assessments on all measurement categories over several visits. Initial coding will be based on the consolidated data, information, and nursing judgement.

2) Before delivery, around 36 weeks in pregnancy

3) After delivery, around 8 weeks postpartum

4) Around 12 months child age

5) Around 18 months child age

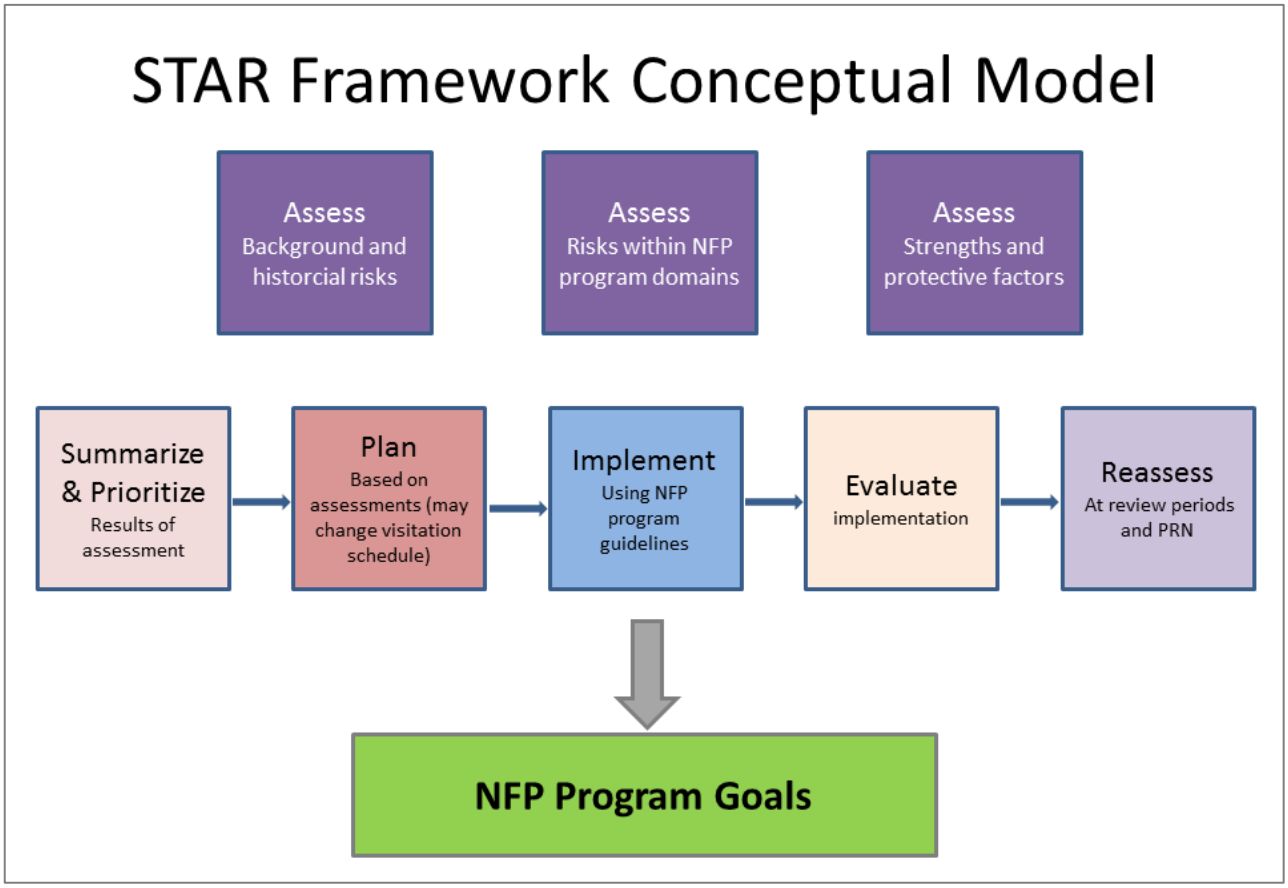
Emphasis that Improves Outcomes

The Measurement Categories that fall within the Personal Health and Maternal Role domains are given first priority, as they constitute the core nurse activities thought to improve maternal and child health directly. Interventions in these categories deserve to be treated with highest priority in planning individual interventions with families.

The nurse discusses the strengths and risks pertaining to her individual clients as a part of reflective supervision. Together, the nurse and the supervisor can collaborate on prioritizing and planning next steps for the nurse's work with the client. Periodically, as appropriate, the nurse and supervisor can reflect upon and evaluate how the plan is going with the client based on the nurse's continual assessment. This reflection and evaluation may result in staying the course in terms of implementing the program or in decreasing or increasing visit frequency. Some NFP agencies use formal nursing care plans to track the process of prioritizing planning, implementing, and evaluating.

The STAR Framework can also be helpful in structuring and discussing client risks and strengths in case conferences. As with reflective supervision, the case conference is used for the nurse to obtain more input from her whole team on her implementation plan based on her nursing assessment of a client's strengths and risks. The STAR form can be integrated into the nursing documentation in the

client's chart. Nursing teams may choose to replace existing documentation of client risks and strengths with the STAR Framework to promote a consistent approach.



Reducing or Increasing Visit Frequency

The STAR Framework is designed to be a general guide and is integrated into the work on program retention, which begins with the very first visit. Families choose their frequency of visitation after hearing the standard visitation schedule during visit one. Nurses in the Elmira and Memphis trials of NFP were guided to reduce the frequency of visitation for lower risk families and to try to ensure consistent frequent visitation with higher risk families, but they were not given the kind of deep guidance that the STAR Framework provides. Recent analyses of the Memphis program implementation data (Holland et al., 2013) confirm that there was a large group of lower risk families (about 30% of all of those visited) whom nurses visited far less frequently after delivery, and those mothers and children did very well without frequent visitation. These are families that NFP nurses currently identify who are doing just fine in terms of their own lives and care of their children. By the time the infant is 4 months of age (and in many cases well before this), nurses should have a deep sense of families' risks and strengths; this information can be used by nurses and parents to guide decisions about whether families may be served effectively with fewer visits. Without better guidance about risks and strengths, nurses in community replication are probably not allocating their scarce resources as effectively as they might.

Offering a reduced visitation schedule for lower risk families and an increased visit schedule for families with higher risks will align with many families' needs for services. Many of those at low risk

are in school and work, which makes frequent visitation difficult. Currently, families may choose to leave the program early because they are too busy to remain in the program with the standard visitation schedule. Retaining these low-risk families in the program with a dramatically reduced visitation schedule designed to align with families' needs and abilities to participate rather than having them leave early makes sense. All families can benefit from the support and guidance of the nurse around the promotion of child health and development through the challenges of late infancy and toddlerhood.

This STAR Framework is meant to align with the work on client retention, which emphasizes that nurses should discuss families' preferences and abilities to participate according to the standard visitation schedule. Research on this topic indicates that nurses who approach families with recognition that families are in the driver's seat about dosage have greater client retention and more completed home visits overall. Effective implementation of the program requires that nurses listen first and most importantly to mothers and families to calibrate the frequency of visitation.

As nurses become more comfortable using this STAR Framework, it will provide greater consistency in classifying families' risks and strengths and it will guide supervision, case conferencing, and shared discussions about families' needs. This process of examining all aspects of maternal, child, and family functioning will help ensure that the entire NFP program is delivered with each family, and that nurses' actions are attuned with families' needs. Having this conceptual framework to guide practice helps nurses more rapidly gain a sense of confidence in using the program to meet the needs of families, and to reduce their sense of being overwhelmed in the face of significant family complexity. Having a place to organize observations and systematically set priorities and develop plans helps ensure program effectiveness.

Using the STAR Framework in Varied Family Contexts

The STAR Framework is designed to be implemented in a way that takes into consideration varied family contexts. For example, if the mother is incarcerated and the infant is not with her, the nurse may choose to assess the context in which the child is living, knowing that not all aspects of the Framework can be assessed well. Similarly, if the mother loses custody and the nurse continues to visit the home in which the child lives, it may make sense for the nurse to assess aspects of the child's current home in an effort to understand the safety of the child's current living conditions.

In some cases, the nurse may not be able to assess the home environment or the mother's caregiving, because either she is unable to visit in the home or the child does not interact with the mother during visits. The nurse documents the domains that k she/he is able to assess and reflects on the likely meaning of those domains of risk she/he is unable to observe. The inability to observe particular domains of risk needs to be factored into the nurses' characterization of families' needs. When insufficient information is available to categorize client risk according to the provided guidance, code the client as not assessed for that measurement category.

There may be agency level differences in assessment of other children in the home, this guidance is written for focus on the index child. The nurse needs to be knowledgeable of mandated reporting requirements and laws that she/he will need to adhere to.

While the nurse's focus is on the index child, she/he must address other concerns seen in the home.

STAR Framework Coding Guidelines

The following pages outline the rationale and coding guidance for the STAR's measurement categories and protective factors. This guidance should be used with the STAR Coding Sheet.

Note: We understand new research is emerging on pregnancy outcomes. We will align our recommendations around those from the American College of Obstetricians and Gynecologists (ACOG), American Nurses Association (ANA), the American Academy of Pediatrics (AAP), and March of Dimes as new information becomes available.

Contents

Specific considerations for Client Goal setting in all Domains

Nurses assist clients with identifying life-course goals, successful goal setting, and goal achievement. Although having the ability to envision a goal is a strength in itself, a goal is the object or aim of an action. Whereas ***goal setting*** is defined as the development of a plan that motivates and guides clients toward their goal**.** Goal setting is an important process because it promotes growth and creativity, and ultimately helps clients to fulfill their potential and transform their lives and that of their family. As goals are shared, nurses have an opportunity to support clients in successful goal achievement by assessing the quality of their client's plan related to their goal.

Goal setting principles that nurses should consider include:

1) Goal Commitment: the client's expression of factors that make their goal personally important and their ability to achieve their goal (self-efficacy);
2) Goal Specificity: the degree that the goal shared by the client is specific, measurable, attainable, realistic, and time bound (SMART); and
3) Goal Complexity: the balance between ease and difficulty as goals should be challenging enough to promote motivation and performance, but not too complex to cause discouragement.

Classifying client's goals establishes a foundation to help nurses consider activities to enhance goal setting skills and action plans to support achievement.

1. Substance Use and Misuse

Notes: For this measure category there are different considerations when categorizing clients in pregnancy versus infancy/toddler phases of program. Please use guidance specific to your client's phase in the program to categorize client risk in this area.

Rationale

Pregnancy

Substance use and misuse create significant risks for the health of mothers and their babies. Prenatal tobacco and alcohol exposure are significant risks for compromised neurological development, fetal growth restriction, and preterm labor. Any substance use including cigarettes/nicotine is illegal for teens. Maternal use of opioids puts the newborn at risk for Neonatal Abstinence Syndrome. And, the American College of Obstetrician and Gynecologists recommends against maternal use of marijuana prior to becoming pregnant, while pregnant and breastfeeding. Other substance use risks include the risk of relapse for women in recovery and the risks associated with a support system of people who continue to use substance or not having a support system. Therefore, assessing maternal use of substances is of primary importance in the prenatal period because of the direct impact maternal substance use has on pregnancy outcomes and fetal growth and development. Child exposure to toxins in their environment, such as second-hand smoke during infancy and toddlerhood, is captured in the Home Safety Measurement Category.

Risk Classification

Guidance: Pregnancy

During pregnancy, any current substance use places a client in either the moderate or high-risk category. A client's previous use also needs to be considered because of the potential for relapse which continues to place a client at risk. This can be compounded if the client's partner or family is currently using illegal substances or misusing prescription drugs.

Data Gathering

- "Health Habits" data collection form and/or other data gathering
- General nursing assessment
- Coordinated care with providers

0 Low Risk	• No reported or observed use of substances combined with no past history of substance use/misuse
1 Moderate Risk	• Client currently smokes 1-4 cigarettes per day, chews tobacco, uses nicotine substitutes or electronic cigarettes. • Client lives with a partner of family member who is currently using illegal substances or misusing prescription drugs • Past history of substance use, in recovery/treatment, good support system*

1. Substance Use and Abuse, continued		
	2 High Risk	• Client reports or nurse observes current use of alcohol or marijuana; OR • Client currently smokes 5 or more cigarettes per day; OR • Client currently engages in illegal use of drugs ~~f~~or substances OR • Client engages in misuse of legal prescription medications whether for client or someone else OR • Client admits to not using substances now because she is pregnant but plans to resume as soon as the baby is born • Past history of substance misuse, in recovery/treatment, does not have good support system*
Rationale	***Infancy/Toddlerhood*** The biological risks associated with maternal substance use on child development and health are significantly reduced or eliminated, after the child is born. The reduced biological impact of maternal substance use on child health and development after delivery results in nurses' shifting focus to client impairment related to maternal substance abuse during infancy and toddlerhood. The exception to this is a child born addicted to opioids and being diagnosed or showing signs/symptoms of neonatal abstinence syndrome (NAS). Substance misuse refers to substance use that interferes with an individual's ability to function in his or her daily life activities and/or relationships (trouble going to school or work, interfering with one's role as a parent or partner). Assessment of maternal substance misuse during the infancy and toddler periods is clinically important as a client's misuse of drugs and alcohol after delivery of the child can compromise her ability to care for her baby, her functioning in school and work, and her relationships with family members and friends. Although child exposure to some substances still presents a risk to child health and well-being (e.g., exposure to second hand smoke), this category is designed to capture maternal substance misuse that undermines a client's ability to fulfill her role as a parent, student or worker. Child exposure to toxins in their environment, such as second-hand smoke during infancy and toddlerhood, is captured in the Home Safety Measurement Category. An infant experiencing NAS is captured in Child Health and Development.	

1. Substance Use and Abuse, continued

Risk Classification

Guidance: Infancy/Toddlerhood

After delivery, substance use that negatively impacts a client's ability to fulfill her role as a parent, student, or worker, or that interferes with her relationships with family members and friends, creates impairments that place her in the moderate and high-risk categories. While impairment is an added concern in infancy/toddlerhood, substance use also impacts the client's personal health and any assessment of substance use or potential relapse needs to be included in the nursing plan of care to support a client's optimal health. Impairment also falls along a continuum; one client's impairment may still allow her to be "functional", so the nurse should use astute judgment is assessing impairment. The following questions in the Substance Use and Abuse Questionnaire are a way of guiding nurses'

assessment of mothers' substance misuse. Risk classification of substance misuse during infancy is based either on nurses' observation/clinical judgment to respond to the items below or based on direct administration of the questions to clients.

Data Gathering

- "Substance Use and Abuse Questionnaire" on the following pages
- Other clinical data gathering
- General nursing assessment
- Coordinated care with providers

0 Low Risk	• No client impairment and no concerns about impairment.
1 Moderate Risk	• Client reports a total score of 1 on the Substance Use and Abuse Questionnaire; OR • Nurse has concerns but no direct evidence of impairment. • Nurse is knowledgeable about recent or past substance use that led to impairment
2 High Risk	• Client reports a total score of 2 on the Substance Use and Abuse Questionnaire; OR • Nurse observes impairment during visits. • Client is actively using OR Nurse suspects client is using substance that lead to impairment

*See Family and Friends Network System

Substance Use and Abuse Questionnaire Instructions

Nurse Response

Looking at the table on the following page, in the past three months, how often has the client experienced the following due to alcohol or drug use?

Administered to Client

If directly asking the client to respond to these questions, you can use the following script (grounded in an MI approach) as a guide for eliciting potentially sensitive information. You do not need to ask the assessment questions verbatim as written here. You may make your inquiry more conversational by using language you normally use with consideration to the stated timeframe (i.e., past three months). For example, you might ask:

> *"Has it been hard to care for your child in the past three months?"*
>
> *"In the past three months, how often have you experienced the following?" (Have the client respond to each item in the table).*
>
> *"Has anyone expressed concern that the things you have experienced could be related to alcohol or drug use?"*
>
> *"Do you have any concerns that your alcohol or drug use could be part of the reason you are experiencing these things?"*

Scoring

If client reports experiencing the items in the Substance Use and Abuse Questionnaire, but there is no concern that the experiences are due to alcohol or drug use, then client score is 0 (no concerns about impairment due to alcohol or drug use).

If concern is expressed, score the Substance Use and Abuse Questionnaire as follows:

- If the client scores a "1" in any or all of the Category A items but a "no" to all Category B items, she is coded as "1-Moderate Risk" on the STAR Framework.
- If the client scores a "2" in any or all of the Category A items or a "yes" to any Category B items, she is coded as "2-High Risk" on the STAR Framework.
- If the client denies any of the items in Category A or B but you have strong reason to believe differently document this discrepancy in the client's chart and proceed with interventions that support the safety of the client and child.

Substance Use and Abuse Questionnaire

You may ask the following questions directly or make your inquiry more conversational.

Category A ***Have any of the following occurred in the last three months?***	Never	Once in the Last Three Months	Twice in the Last Three Months
Missed work or school	0	1	2
Had trouble at work or school	0	1	2
Had trouble with family or friends	0	1	2
Difficulty providing care for her child (e.g., missed activities or appointments, less energy, less responsive, increased conflict)	0	1	2

Category B

Have any of the following occurred in the last three months?		
Motor vehicle accident or traffic violation	No	Yes
Arrest or incarceration	No	Yes
Treatment for alcohol or drug use (including overnight stays for detox).	No	Yes

2. Chronic Illness and/or Pregnancy Complications

Notes: For this measure category there are different considerations when categorizing clients in pregnancy versus infancy/toddler phases of program. Please use guidance specific to your client's phase in the program to categorize client risk in this area.

Rationale	Mothers with pregnancy complications and chronic illnesses are at greater risk for poor pregnancy outcomes (preterm delivery, fetal growth restriction, alterations in fetal development) and may have greater challenges caring for themselves and their children. Some examples of pregnancy complications include gestational diabetes mellitus, genitourinary tract infections, presence or history of STIs, and preeclampsia. The presence of chronic illnesses in expectant mothers, such as obesity, type 1 diabetes, or multiple sclerosis, may increase the risk of poor pregnancy outcomes and pregnancy complications. In addition, clients with closely spaced pregnancies and those pregnant with multiples (e.g., twins and triplets) are also at increased risk for poor pregnancy outcomes. Any condition, that the nurse identifies as a risk to the client &/or pregnancy. Chronic illness/disease such as obesity, diabetes, MS, and so forth, should be noted throughout the program including during infancy & toddlerhood and included as a part of coding this category.	
Risk Classification	***Guidance Pregnancy*** Nurses are expected to review medical history and provide physical assessment in keeping with their Nursing Scope of Practice and agency policy and procedures. Generally, a minimum of client baseline weight and blood pressure and subsequent weight and blood pressure measurements along with regular review for danger signs of pregnancy are completed on each client. ***Data Gathering*** • Maternal Health Assessment data collection form • Coordinated care with primary care physicians • Nursing assessment and clinical judgement	
	0 Low Risk	• No pregnancy complication or chronic illness.
	1 Moderate Risk	• Pregnancy complication or chronic illness is present, but currently well-managed (e.g., client makes and keeps appointments, accepts resources and referrals, manages care of child, and so forth); OR • Client becomes pregnant than18 months after delivery of previous child or miscarriage.

2. Pregnancy Complication and/or Chronic Illness, continued		
	2 High Risk	• Pregnancy complication or chronic illness is present and is not well-managed (e.g., client does not make or keep appointments, or client refuses resources and referrals, and so forth). Coping is uncertain and poses risk to client or child; OR • Client is pregnant with multiples; OR • Client becomes pregnant fewer than 6 months after delivery of previous child or miscarriage.
Risk Classification	***Guidance Infancy/Toddlerhood*** After delivery nurses continue to review medical history and provide physical assessment in keeping with their Nursing Scope of Practice and agency policy and procedures. Chronic illness assessed in pregnancy still impact a client's overall health and well-being. ***Data Gathering*** • Maternal Health Assessment/Other clinical assessment • Coordinated care with primary care physicians • Nursing assessment and clinical judgement	
	0 **Low risk**	• No chronic illness present
	1 **Moderate Risk**	• Pregnancy complication continues into Post-partum period • Chronic illness is present, but currently well-managed (e.g., client makes and keeps appointments, accepts resources and referrals, manages care of child, and so forth); OR • Client becomes pregnant with subsequent child less than 18 months after delivery of previous child
	2 **High Risk**	• Chronic illness is present and is not well-managed (e.g., client does not make or keep appointments, or client refuses resources and referrals, and so forth). Coping is uncertain and poses risk to client or child; OR • Client becomes pregnant with subsequent child fewer than 6 months after delivery of previous child

<table>
<tr><th colspan="3">3. Developmental and Intellectual Disability or Limitation</th></tr>
<tr><td>Rationale</td><td colspan="2">Mothers with developmental disabilities or intellectual disabilities are at greater risk and may have greater challenges caring for themselves and their children. There are many different ways intellectual and developmental disabilities are experienced by clients. Some examples include: blindness and deafness; conditions that impact intellectual functioning (e.g., ADHD, Down syndrome, Fragile X syndrome, Autism Spectrum Disorders); and motor impairment (e.g., cerebral palsy). The presence of these types of disabilities can impact clients' ability to care for themselves and their children.

A client's age and maturation level should be considered when assessing potential challenges for caring for themselves and their children. Adolescent mothers present unique issues related to maternal role development. The prefrontal cortex, one of the last regions of the brain to reach maturation is responsible for cognitive analysis, abstract thought, and the control of correct behavior in social situations, which explains why some adolescents exhibit behavioral immaturity. The fact that brain development is not complete until near the age of 25 years refers specifically to the development of the prefrontal cortex. Age should be considered and included as a part of coding this category. In general, younger mothers will have more limited abilities to anticipate the consequences of their behavior and to plan (Levels of executive functioning).</td></tr>
<tr><td rowspan="3">Risk Classification</td><td colspan="2">Guidance
• Nurses assess developmental/intellectual disability and/or limitations based on observation of the client, client's medical record/communication with Primary Care Provider, client report of an Individualized Education Program (IEP), and SSI eligibility. This may include, undiagnosed challenges the nurse assesses that impact delivery of NFP material, such as reading level or understanding of material. This may include age. American Academy of Pediatrics identifies adolescence as 11 to 21 years of age, dividing the group into early (ages 11–14 years), middle (ages 15–17 years), and late (ages 18–21 years) adolescence.</td></tr>
<tr><td>0
Low Risk</td><td>• No developmental or intellectual disability or limitation</td></tr>
<tr><td>1
Moderate Risk</td><td>• Developmental or intellectual disability, or limitation present and poses limited impact on activities of daily living (e.g., self-care, making or keeping appointments, caregiving, meal preparation, or housekeeping), decision making, and care of the child.
• Late Adolescence
• Nurse discovers that client has an Individual Education Plan (IEP) for an existing a limitation.</td></tr>
</table>

3. Developmental and Intellectual Disability or Limitation, continued		
	2 High Risk	• Developmental or intellectual disability or limitation is present and significantly impacts activities of daily living (e.g., self-care, making or keeping appointments, caregiving, meal preparation, or housekeeping), decision making, and care of the child. • Early or Middle Adolescence • Nurse discovers that client has an Individual Education Plan (IEP) for a severe limitation.

4. Depression, Anxiety, and Mental Health Issues

Rationale

The most common mental health challenges experienced by NFP clients are depression and anxiety, which can interfere with a mother's ability to achieve what she wants for herself and her child. A mother also may exhibit other mental health problems that interfere with her ability to care for herself and her child.

Depression

Data Gathering

- Patient Health Questionnaire (PHQ-9) **Note**: We strongly urge agencies to use the PHQ-9. It has been found to be more reliable postpartum. Additionally, the questions are more aligned with diagnostic criteria and therefore may be more useful when referring to providers.
- Edinburgh Postpartum Depression Screen (EPDS)
- Other Depression Screening Tools

Nurses will use each tool's standard thresholds to screen for severity of symptoms and classify clients into three levels.

0 Low Risk	• No signs of depression or scores in "not depressed" range on depression screen.
1 Moderate Risk	• Signs of mild depression or scores in "mild" depressive symptom severity range on depression screen.
2 High Risk	• Signs of moderate to severe depression or scores in the "moderate" or "severe" depressive symptom severity range on depression screen; OR • Signs of moderate to severe depression and refuses to be screened.

4. Depression, Anxiety, and Mental Health Issues, continued

Anxiety

Given the frequency with which anxiety problems also affect mothers in the NFP, it is recommended that nurses consider employing the Generalized Anxiety Disorder-7 scale for assessing anxiety.

Data Gathering

- Generalized Anxiety Disorder-7 scale
- Other Anxiety Screening Scale

0 Low Risk	• No signs of anxiety or scores in "no or low" anxiety range on the GAD-7.

	1 Moderate Risk	• Signs of mild anxiety or scored in “mild” anxiety range on the GAD-7.
	2 High Risk	• Signs of moderate to severe anxiety or scored in “moderate” to “severe” anxiety range on GAD-7; OR • Signs of moderate to severe anxiety and unable to be screened.
	Other Mental Health Problems It is not uncommon for clients to have other mental health problems that interfere with their abilities to care for themselves and their children. Nurses assess (based on observation/client communication, client’s medical record) the degree to which a client has a known diagnosis and/or is in treatment for a mental health problem, such as bipolar disorder, obsessive compulsive disorder, eating disorders, emotional and behavioral disorders (including anger management), or evidence of thought disorders. Clients’ may also experience temporary mental health challenges associated with grief and loss.	
	0 Low Risk	• No other mental health problems.
	1 Moderate Risk	• Signs and symptoms or diagnosis and managing well with treatment or self/other care.
	2 High Risk	• Signs and symptoms or diagnosis and not managing well with treatment; OR • Signs and symptoms or diagnosis and not managing well and not receiving treatment.

4. Depression, Anxiety, and Mental Health Issues, continued

Impairment

In addition to the information obtained through depression, anxiety, and other mental health screenings, the question below is a way of guiding nurse assessment of a client's functional status as a result of her mental health problems. Responses to this question can be based either on nurse judgment or direct questioning to the client. If asking this directly to the client, you may use language that makes sense to you and you feel more comfortable using within this conversation.

"How difficult is it for [the client/you] to manage self-care, do [her/your] work, take care of things at home, or get along with other people due to [mental health challenges/your mental health condition]?"

0 Low Risk	• No impairment—not difficult at all.
1 Moderate Risk	• Moderate impairment—somewhat difficult.
2 High Risk	• Significant impairment—very to extremely difficult.

Risk Classification

Overall

Risk classification of mental health problems is based either on direct assessment using the items below or based on nurses' observation/clinical judgment as guided through the classifications listed below.

Please rate the overall level of risk using the following categories.

0 Low Risk	• Client is categorized with all "0" below.
1 Moderate Risk	• Client is categorized with at least one "1" and no "2" below.
2 High Risk	• Client is categorized with at least one "2" below.

5. Caregiving Attitudes and Behaviors

Notes: For this measure category there are different considerations when categorizing clients in pregnancy versus infancy/toddler phases of program. Please use guidance specific to your client's phase in the program to categorize client risk in this area.

Rationale	One of the most important processes that shape the lives of very young children is the interaction they have with their primary caregivers. Evidence in support of the relationship between early parental care and child outcomes has made a significant contribution to our understanding of adaptive and maladaptive child development. Child abuse, neglect, and excessively harsh treatment of children are associated with internalizing and externalizing behavior problems, compromised verbal and intellectual development, and later violent behavior. Childrearing risk can be observed through caregiving attitudes in pregnancy and observations of caregiving behaviors in infancy and toddlerhood. When risks for compromised caregiving are revealed, nurses must spend more time working with parents to reduce risks and support more competent care.	
Risk Classification	***Guidance: Pregnancy*** During pregnancy, risk is revealed in the degree to which mothers express a lack of desire for the child or express strongly held unrealistic beliefs about infants and harsh beliefs about parenting that pose risks for maltreatment. Nurse observation and client responses to facilitator questions guide nurses' assessment of client's caregiving attitudes.	
	0 Low Risk	• No concerns about expressed caregiving attitudes.
	1 Moderate Risk	• Client expresses inaccurate (but not harsh/concerning) beliefs or unrealistic expectations about child development or caregiving but is receptive to education; OR • Client has significant ambivalence about having this child.
	2 High Risk	• Client expresses unrealistic expectations about child's development and is not open to education; OR • Client has harsh/concerning beliefs about caregiving; OR • Client indicates that she does not want this child.

5. Caregiving Attitudes and Behaviors, continued

Guidance: Infancy and Toddlerhood

Once the child is born, or if a client already has children in her care, nurses observe caregiving in the home using the DANCE or NCAST feeding and/or teaching scales, as well as observations of the home environment using the HOME assessment and nurse assessment. Nurses also collect information on injuries and child abuse and neglect reports. Nurses assess the degree to which a caregiver's behaviors are concerning based on these formal observations and clinical judgment considering the following:

- Limited responsiveness to child's needs and communications
- Limited positive affect
- Harsh or intolerant responses to child's behavior
- Developmentally inappropriate expectations of the child
- Limited verbalizations to the child
- Limited promotion of child's interest in the world and child development
- Limited efforts to protect the child from imminent harm
- Intrusiveness

Data Gathering

DANCE Observation or other assessment scale

***Note*: We strongly encourage reliance on DANCE when making these determinations**.

0 Low Risk	• No concerns about caregiving behaviors; OR • **DANCE**: Client coded as Area for Enhancement in 0-2 DANCE Behaviors [excluding: Negative Touch, Negative Verbal Content, Negative Comments about the Child to Others, or Positioning (less than 50%)]. All other behaviors are Area of Strength.
1 Moderate Risk	• Moderate concerns about caregiving behaviors or home environment; however, client is willing and able to make changes to reduce the risk to the child; OR **DANCE:** • Client coded as Area for Enhancement in 3-5 DANCE behaviors [excluding: Negative Touch, Negative Verbal Content, Negative Comments about the Child to Others, or Positioning (less than 50%)]; OR • Client coded as Area for Growth for 1-3 DANCE behaviors [excluding: Negative Touch, Negative Verbal Content, Negative Comments about the Child to Others, or Positioning (less than 50%)].

5. Caregiving Attitudes and Behaviors, continued		
	2 High Risk	• Nurse has significant concerns regarding caregiving behaviors; OR • Nurse has moderate concerns and client is unwilling or unable to make changes; OR • Client or family has been referred for child maltreatment or neglect. **DANCE:** • Client coded as Area for Growth or Enhancement for any of these DANCE behaviors: Negative Touch, Negative Verbal Content, Negative Comments about the Child to Others, or Positioning (less than 50%); OR • Client coded as Area for Enhancement for 6 or more DANCE behaviors; OR • Client coded as Area for Growth in 4 or more DANCE behaviors **NCAST:** • Client scores in the bottom 10th percentile (based client's ethnicity and child's age) on the NCAST feeding or teaching scales; OR **HOME:** • Client's score on the HOME is less than 28.

6. Child Health and Development

Note: For this measurement category there are different considerations when categorizing clients in Pregnancy versus Infancy/Toddler phases of program. Please use guidance specific to your client's phase in the program to categorize client risk in this area.

Rationale

When children are disabled, chronically ill, or exhibiting problem behaviors that are aversive to parents (such as long periods of crying), or not displaying adequate physical growth, nurses may need to increase their availability to families depending on the client's support system, knowledge, and coping strategies. Therefore, risk is conceptualized primarily in terms of how much support the client needs to develop a set of coping strategies to manage the challenges of caring for a child with special needs.

Risk Classification

Guidance

In most cases, nurses will only be able to determine if the index child has a congenital disorder, developmental challenge, or chronic illness after the child is born using information obtained from ASQ, ASQ-SE scores reported on the DCS Infant Health Form, data gathered in the Infant Birth Form, and in consideration of the partial list of infant health and behavior problems provided on the next page. However, nurses should also classify this category if a client is pregnant and knows the developing fetus has a congenital disorder or developmental disability or if the client is using opioids or is receiving medical treatment for opioid use. Pregnant clients without prenatal diagnosis of infant congenital disorder, developmental delay, chronic illness or opioid use are categorized as "0" (low risk) in this category. Based on observation, nurses further assess the degree to which the client has sufficient support, knowledge, and coping strategies to manage the child's condition.

Data Gathering

- ASQ, ASQ-SE scores reported on the Infant Health form
- Infant Birth form
- Partial list of infant health and behavior problems provided on the next page
- Parent report or nursing observation of chronic illness, development delays or behavioral challenges of children in the client's care

0 Low Risk	• No known child health or developmental problem.
1 Moderate Risk	• Child health or developmental problem exists, but client exhibits adequate support, knowledge, and coping to manage the child's condition.
2 High Risk	• Child health or developmental problem exists, and client lacks adequate support, knowledge, or coping to manage the child's condition.

Partial List of Infant Health and Behavior Problems

Newborn Health Problems

- ☐ Preterm birth and/or low birth weight
- ☐ NICU or Special Care Nursery Admission
- ☐ Associated health problems (e.g., bronco-pulmonary dysplasia)
- ☐ Congenital disorders

Developmental Disability or Concerns

- ☐ Cerebral palsy
- ☐ Neurodevelopmental disorders (e.g., cognitive delay)
- ☐ Blindness
- ☐ Deafness
- ☐ Seizures
- ☐ Not meeting expected developmental milestones
- ☐ Not meeting physical growth trajectory

Chronic Illnesses

- ☐ Asthma
- ☐ Diabetes
- ☐ Cystic fibrosis
- ☐ Spina bifida
- ☐ Sickle cell anemia
- ☐ Cancer
- ☐ HIV

Behavior Problems

- ☐ Excessive crying
- ☐ Compromised nutrition/feeding
- ☐ Dysregulated sleeping

<table>
<tr><th colspan="3">7. Child Care</th></tr>
<tr><td>Rationale</td><td colspan="2">Clients can easily find themselves in situations with less than optimal child care due to lack of funds to pay for care, lack of access to quality child care facilities, and/or lack of appropriate family, friends or other support network to provide safe child care. Children are at risk for physical and emotional harm when a child care provider lacks adequate preparation or interest in providing care or lacks the physical, developmental or emotional capacity to care for a young child.</td></tr>
<tr><td rowspan="3">Risk Classification</td><td colspan="2">Guidance

Nurses should discuss child care arrangements with clients frequently as the arrangements will change as frequently as clients' situations change. Factors that influence clients' choice of child care include: preference for home-based or center-based care, atypical school and work schedules, limited income to spend on child care, lack of access to child care due to transportation issues, and lack of a support network. A caregivers age and maturation level should be considered when assessing potential challenges for caring for client's children. The minimum age for "babysitting" varies b state; many do not have any specific laws. Nurses should check with their State Department of Health and Welfare or Children and Family Services to determine the legal age to being babysitting. Nurses usually will not be able to rate directly child care risk. They will have to discuss these issues with parents using the childcare facilitators and make their judgment based upon clients' responses. Parents may have multiple child care arrangements; risk should be classified for the highest risk child care environment.~~ Child care risk is coded for all children in the client's care.~~</td></tr>
<tr><td>0
Low Risk</td><td>• Child is cared for in a licensed home or child care center; OR
• Child is cared for by a known individual who has the emotional, physical and developmental ability to care for a young child and the expressed interest in caring for the child. The home is child-proofed and child-friendly; AND
• Child has no physical, emotional or developmental disabilities that require specialized care, attention or patience.</td></tr>
<tr><td>1
Moderate Risk</td><td>• Client has placed her child in the care of an unlicensed child care home or center; OR
• Client is depending on family or friends to care for the child and the environment is not child- proofed or child friendly; OR
• Caregiver has mild emotional, physical or developmental challenges that could interfere with care of the child; OR
• Child has emotional, physical or developmental challenges that require special care.</td></tr>
</table>

7. Child Care, continued		
	2 High Risk	• Child is cared for by whomever (family member or friend) is available at the time; OR • Child is cared for by individuals who are emotionally, physically or developmentally unable to care for a young child or who have expressed lack of interest or commitment in caring for the child; OR • Child is cared for by intimate partner with history of domestic violence; OR • Child is cared for by a person with current substance abuse; OR • Child is cared for by a person with criminal history of assault or sexual abuse; OR • Child has severe physical, emotional or development disabilities that are not accommodated when selecting child care arrangements; OR • Child is placed with caregiver with a known history of abuse or neglect; OR • Child is placed in a dirty, unsafe or unsanitary environment.(see #18 Home Safety for examples)

8. Maternal Education and Work

Rationale	Helping clients become more economically self-sufficient is a core goal of the program. When women drop out of school, are not participating in training, or are unemployed, the likelihood of living a life in poverty increases. Nurses help clients develop a vision for what their lives might be like and help them plan for continuing their education and finding and maintaining employment. For some clients, however, having additional children may be their primary goal, or they may be from a culture or in a relationship where a mother is expected to remain in the home to take care of the household. It is important that goals be realistic in the context of the client's situation, and that nurses recognize individual or cultural values when considering client's education and employment-related goals.	
Risk Classification	***Data Gathering*** Demographics Data Collection Form administered to clients at Intake and 6, 12, 18, and 24 months following the birth of the child	
	0 Low Risk	• Client is making regular progress in education, employment, or training to meet her goals; OR • Client is in school and is committed to completing high school.
	1 Moderate Risk	• Client is involved inconsistently in education (including truancy), employment, or training to meet her goals; OR • Client is in school but is not committed to completing high school. • Client has life-course goals that do not include education, employment, or training but does not have adequate resources (e.g., financial, social, psychological, etc.) to achieve her life-course goals and client has some difficulty meeting non-essential needs for herself and her child (e.g., cable and internet).
	2 High Risk	• Client is not involved in education, employment, or training to meet her goals; AND • Client does not have adequate resources to meet basic needs for herself and/or her child (e.g., food, shelter, clothing, or supplies for her child).

9. Pregnancy Planning

Domain: Maternal Role

Note: For this measurement category there are different considerations when categorizing clients in Pregnancy versus Infancy/Toddler phases of program. Please use guidance specific to your client's phase in the program to categorize client risk in this area.		
Rationale	The timing of subsequent pregnancies is a key objective of NFP. Women with closely spaced subsequent pregnancies are at greater risk for preterm delivery, low birth weight, child autism, and infant mortality.	
Risk Classification	For this Measurement Category there are different considerations when categorizing clients in pregnancy versus infancy/toddler phases of program. Please use guidance specific to your client's phase in the program to categorize client risk in this area. Client's current and future pregnancy planning are scored across pregnancy, infancy, and toddler phases of the program. ***Guidance: Pregnancy*** During pregnancy, nurses should consider clients' plans for future pregnancy planning after delivery of their children. The promotion of thoughtful pregnancy planning along with regular use of a reliable method of contraception is a core element of NFP.	
	0 Low Risk	• Client has chosen to delay subsequent child bearing and plans to use a reliable method of contraception after delivery; OR • Client expresses a desire for another child conceived at or after 18 months of the birth of the first child .
	1 Moderate Risk	• Client expresses a desire to delay subsequent pregnancy but is not communicating a plan to use a Long Acting Reversable contraception; OR • Client is planning to use the pill or other form of birth control that requires user action.
	2 High Risk	• Client expresses a desire to become pregnant with another child within 18 months of the birth of her first child; OR • Client's partner is encouraging another pregnancy within 18 months of the birth of the first child • Client is not using any family planning methods

<table>
<tr><th colspan="3">9. Pregnancy Planning, continued</th></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">Guidance: Infancy and Toddlerhood

In infancy and toddlerhood, nurses assess clients' current use of contraception or intentions regarding subsequent pregnancies. The promotion of thoughtful pregnancy planning along with regular use of a reliable method of contraception is a core element of NFP.

Data Gathering

Demographics Update DCS Form collected at 6, 12, 18, 24 months following the birth of the child</td></tr>
<tr><td>0
Low Risk</td><td>• Client has chosen to delay subsequent child bearing and is consistently using a long acting reversible contraceptive method (LARC); OR
• Client expresses a desire for another child conceived <18 months after the birth of the first child.
• Client is pregnant with a subsequent pregnancy conceived at least 18 months or more following the previous birth</td></tr>
<tr><td>1
Moderate Risk</td><td>• Client expresses a desire to postpone pregnancy or is ambivalent about getting pregnant, but she is not using a LARC or is using a less effective method of contraception.</td></tr>
<tr><td>2
High Risk</td><td>• Client expresses a desire to become pregnant with another child within18 months of the birth of her first child; OR
• Client is pregnant with a subsequent pregnancy conceived prior to 18 months since previous birth; OR
• Client's partner encouraging another pregnancy within 18 months of the birth of the previous child</td></tr>
</table>

10. English Literacy Limitations

Rationale

English language literacy limitations can interfere with a mother's ability to care for herself and her child, to be successful in school or the work place, and to learn the content of the NFP program. In addition, individuals with limited English literacy are at increased risk for experiencing challenges in accessing information and navigating health or community services. These challenges can result in higher rates of hospitalization and decreased use of preventive health services. For these reasons, it's important for nurses to know how well mothers in the program can read and understand common health terminology so nurses can make appropriate adjustments in their delivery of the program. Low English literacy may result in a nurse needing to spend more time in visit preparation to identify appropriate materials. Low levels of English literacy may also result in increased time or frequency of visits to deliver content in other modalities or at an alternative pace. Please note this category specifically captures client English language literacy. Clients may be literate in other languages, but given the inconsistency and often absence of information available in languages other than English across communities in the U.S., assessing clients' English language literacy provides important information regarding the challenges this client may experience when accessing and navigating community services.

Risk Classification

It is recommended that nurses have English-speaking clients (including clients who speak English as a second language) complete the REALM–Teen or REALM, a valid and reliable reading recognition tool that allows health professionals to screen for below-grade reading. This tool takes less than three minutes to administer and classifies individuals into five reading level categories: 3rd grade and below, 4th to 5th grade, 6th to 7th, 8th to 9th, and 10th grade and above. The tool is free to use and available under the "Tools and Assessments" section. Note that it only is available for determining English language word recognition.

Data Gathering

- REALM–Teen
- Nursing assessment (observed client not engaged with facilitators or reading content, inconsistent responses to interactive facilitators)
- Other clinical data gathering
- Coordinated care with other providers, e.g. school system reports reading level limitation

Pregnancy

0 Low Risk	• Client reads at the 10th grade level or above or client is younger than 10th grade and reading English at grade level.
1 Moderate Risk	• Client reads between the 6th and 9th grade levels. • Client admits to difficulty reading facilitators • Nurse discovers that client had an Individual Education Plan (IEP) that indicated a literacy limitation

10. English Literacy Limitations, continued		
	2 High Risk	• Client reads below the 6th grade level. • Client unable to read facilitators • Nurse discovers that client had an Individual Education Plan (IEP) that indicated a severe literacy limitation

*11. Criminal Justice/Legal Issues		
Rationale	Involvement with criminal proceedings, arrests, and incarcerations limit a client's ability to care competently for her child. Additionally, involvement in the criminal justice system creates added stress and has the potential to increase financial burden due to loss of income and court related expenses. It's important to note that this category assesses clients' actual involvement with criminal justice. Being an undocumented U.S. resident is illegal, an undocumented client is categorized as having some risk, determined as moderate or high by the nurses regardless of current involvement , in legal proceedings. When clients are involved with criminal justice, nurses may need to coordinate alternative visit schedules, provide additional information/resources, and coordinate with other community service providers.	
Risk Classification	Based on communications with the client or other family members, please rate the level of risk using the following categories.	
	0 Low Risk	• Client has no current interaction with legal/criminal justice system outside of minor parking and traffic violations.
	1 Moderate Risk	• Client is on probation, house arrest, and/or completing community service for a previous crime; OR • Client has been arrested and is released to the community awaiting trial or court appearance. • Client is working towards permanent resident status
	2 High Risk	• Client is incarcerated, detained: OR • Client has been convicted and is awaiting sentencing.

<table>
<tr><th colspan="3">12. Loneliness and Social Isolation</th></tr>
<tr><td>Rationale</td><td colspan="2">Loneliness and a sense of social isolation are related to poor mental and physical health outcomes, increasing the risk for depression. However, loneliness does not simply reflect depression. A sense of social isolation may be due to a variety of factors, such as recent moves away from family and friends, difficulty forming intimate relationships, leading clients to feel empty and unwanted. Loneliness can affect clients' abilities to care for their children and their willingness to use community resources. While understanding the extent to which a client has access to social supports is important, the presence of a social support network alone is not a strong predictor of maternal and child health outcomes. It is not a matter of how many people are available to the mother, but the quality of the emotional and social support she receives and her sense of intimacy with others that accounts for positive maternal and child health outcomes. Understanding the client's perceived sense of social isolation can provide valuable information for targeting NFP intervention planning.</td></tr>
<tr><td rowspan="3">Risk Classification</td><td colspan="2">Guidance
A brief loneliness/social isolation measure is provided below to be used in conjunction with facilitators to guide nurses' assessment of client's loneliness or social isolation. Risk classification of loneliness/social Isolation is based either on direct assessment using the "Loneliness/Social Isolation Scale" on the next page or based on nurses' observation/clinical judgment. If administering the Loneliness/Social Isolation Scale, sum scores for client responses to each question to arrive at a total score for the client.
Data Gathering
• Loneliness/Social Isolation Scale on the next page
• Nurses' observation/ clinical judgement; facilitator responses e.g. My Parachute, My supports, Life History Calendar,</td></tr>
<tr><td>0
Low Risk</td><td>• Client total score on the Loneliness/Social Isolation Scale is less than 4; OR
• Client has not expressed a sense of loneliness or social isolation in the past two months.</td></tr>
<tr><td>1
Moderate Risk</td><td>• Client total score on the Loneliness/Social Isolation Scale is 4-5; OR
• During one home visit in the last two months client has expressed a sense of loneliness or social isolation: OR
• Client may not have expressed a sense of loneliness, but the nurse has assessed that the client has a limited social network</td></tr>
</table>

12. Loneliness and Social Isolation, continued		
	2 High Risk	• Client total score on the Loneliness/Social Isolation Scale is 6-9; OR • During more than one home visit in the past two months client has expressed a sense of loneliness or social isolation: OR • Client may not have expressed a sense of loneliness, but the nurse has assessed that the client has no social network

Loneliness/Social Isolation Scale

	Hardly Ever	Sometimes	Often
How often do you feel you don't have a friend to turn to?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

<table>
<tr><th colspan="3">13. Intimate Partner Violence</th></tr>
<tr><td>Rationale</td><td colspan="2">One of the most serious situations faced by NFP clients is intimate partner violence (IPV). IPV includes psychological terrorism characterized by power and control, including any one of or combination of physical abuse, sexual abuse, verbal or emotional abuse, threats, intimidation, threats of harm to the child or pregnancy, financial abuse, etc. Women who are abused by their partners are at greater risk for miscarriage and preterm delivery, depression, anxiety, PTSD, injury and death, etc. Their children are at greater risk for a host of health, behavioral, and socio-emotional problems. In the Elmira trial of NFP, the presence of IPV decreased the impact of the program on child abuse and neglect. Abuse by individuals other than the client's partner is captured in the next measurement category (Unsafe Family or Friend Network).</td></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">Many clients do not reveal when they are victims of violence. They may be reluctant to share, or they may not understand that coercive control in the absence of physical assault is abuse. Nurses often need to rely on other cues that may suggest violence in the relationship. A list of clinical and situational risk factors associated with IPV exposure, which nurses may observe during home visits, is located on the following page.

Data Gathering
• Clinical IPV Assessment form
• Nurses' observation/clinical judgement.</td></tr>
<tr><td>0
Low Risk</td><td>• No evidence of IPV.</td></tr>
<tr><td>1
Moderate Risk</td><td>• Presence of clinical and situational risk indicators for IPV but client denies current IPV exposure; OR
• Client disclosure of past IPV (>12 months ago) and no evidence of imminent risk.</td></tr>
<tr><td>2
High Risk</td><td>• Client disclosure of current or past IPV (<12 months ago) by current or past partner; OR
• Client disclosure of past IPV (>12 months ago) and evidence of reengagement (e.g., reunion with perpetrator) with evidence of potential risk (e.g., verbal threat); OR
• Nurse Home Visitor observes IPV during home visit</td></tr>
</table>

IPV Clinical and Situational Risk Factors

Clinical Risk Factors

Somatization:

- Client regularly reports mental and physical health symptoms that have been linked to IPV and are not accounted for by other conditions. Such symptoms include: a lack of energy, fatigue, sleep disruptions, feeling disconnected, difficulty concentrating, feeling sad or anxious, gastrointestinal complaints, general aches and pains, or chronic pain (including headaches, back pain, swollen or painful joints, and pelvic pain).
- The client presents with injuries that are consistent with IPV (particularly injuries of the head, neck, and abdomen).
- A past history of injuries, a history of abuse or assault, depression, suicide attempts, or anxiety.
- Current substance use and/or reports of depression, anxiety, PTSD, suicidal ideation.

Situational Risk Factors

Identification of situational factors known to increase women's vulnerability to IPV such as:

- Recently separating from her partner
- Having a male partner who is employed less than part-time or who has a problem with drug or alcohol use
- A woman living with significant disabilities
- Social isolation
- Marital conflict
- Economic dependence on the partner

The effect of these factors is additive. For every additional factor a woman is exposed to, her risk for being abused within an intimate relationship increases.

You may also observe how the woman acts in the presence of her partner; for example, she may become intimidated, compliant, let her partner speak or answer questions on her behalf.

14. Unsafe Family or Friend Network		
Rationale	While the presence of a supportive family and friend network offers important guidance and assistance to clients, it is not uncommon for clients to have frequent contact or live with family members or friends who are involved in criminal or violent activity or emotionally abusive behavior. This can include clients' social media network. This category also captures the degree to which these individuals may influence a client to make unsafe choices that compromise the health and development of the client and her child. In this category, the family and friend network includes all individuals the client has regular contact with, such as her own mother, father, grandparents or siblings, as well as the father of the child and/or the client's significant other/romantic partner. Specific concerns of intimate partner violence or abuse within the client's relationship with her significant other or the father of the child are captured within the Intimate Partner Violence measurement category. The presence of a client's supportive social network is captured as a behavioral strength and global protective factor to help guide nurses' intervention planning. The absence of a family and/or friend network may present additional challenges to clients that are captured in different measurement categories (e.g., loneliness and social isolation, mental health, homelessness and residential instability, economic adversity).	
Risk Classification	Risk classification of unsafe family or friend network is based on reflection after completing NFP facilitators and/or on nurses' observation/clinical judgment.	
	0 Low Risk	• Client's family and friends are supportive and not involved in dangerous or illegal activities or emotionally abusive behavior.
	1 Moderate Risk	• • Client and her family or friends have a relationship that is characterized by moderate conflict[3]; OR • Client has friends or family members not residing in her household who expose her to criminal, violent, or emotionally abusive behavior, substance abuse, or violence; OR • Client lives in a household where criminal activities, substance abuse, or violence are suspected.
	2 High Risk	• Client and her friends or family have a relationship that is characterized by significant conflict[3]; OR • Client lives in a household where criminal activities, substance abuse, or violence are evident; OR • Client is exploited; OR • Client is experiencing cyberbullying • There is an open CPS case related to maltreatment/neglect of the client.

[3] Conflict is characterized by engaging in verbal fights/arguments and/or physical or emotional abuse or emotional disengagement

15. Economic Insecurity		
Rationale	Extreme economic hardship poses immediate risks to maternal and child health and in many cases will be associated with residential instability. This category is designed to determine clients' source of income and their ability to cover costs of necessities, such as rent/mortgage, utilities, food, medical expenses, transportation, phone, and so forth).	
Risk Classification	***Data Gathering*** • Demographics DCS form at Intake and 6, 12, 18, and 24 months following the birth of the child • Considerations: clients that are not able contribute to their own support, such as adolescents, immigrants, incarcerated, physical or mental disabilities	
	0 Low Risk	• Client is able to meet financial needs for necessities with income generated by herself, . She may receive assistance from Medicaid, SSI, or SNAP, but not TANF.
	1 Moderate Risk	• Client is dependent upon others to meet financial needs for necessities; OR • Client receives TANF or other state-based cash assistance; OR • Client's ability to cover the necessities is inconsistent; OR • Client is sometimes at-risk for having utilities shut off, eviction, insufficient food supply, and so forth; OR • Client has sufficient income, but income is not managed to cover costs for necessities.
	2 High Risk	• Client is consistently unable to meet financial needs; OR • Client regularly requires emergency assistance with housing, food, or other essentials.

16. Homelessness and Residential Instability		
Rationale	Homelessness or residential instability (couch surfing, living on the street or in cars) create vulnerabilities for clients and their children because of the uncertainty and likely insufficiency of shelter. This category is designed to assess clients' ability to obtain consistent housing, not the degree to which they move between stable housing options available to them, such as a client lives primarily with her mother, but also has stable housing available at her grandmother's home and frequently moves between the two homes.	
Risk Classification	***Data Gathering*** • Demographics Form at intake and 6, 12, 18, and 24 months following the birth of the child	
	0 Low Risk	• Client has stable housing OR • Client is currently incarcerated but has stable housing following her release.
	1 Moderate Risk	• Client has housing accommodations that are temporary or unstable; OR • Client is currently incarcerated but following her release has housing accommodations that are temporary or unstable. • Client has moved three or more times in the past 12 months • Living conditions are overcrowded to the point where the child's movement and developmental exploration is constrained OR • Living conditions are such that child does not have a consistent, safe location to sleep
	2 High Risk	• Client is homeless; OR • Client is currently incarcerated and has no housing options following release.

17. Environmental Health		
Rationale	Unsafe neighborhoods and environmental hazards pose significant risks to children's early health and development. Dangerous neighborhoods or housing represent a significant stressor to families, requiring increased vigilance and support to minimize exposure to violence around the home. Other hazards are risks to maternal and child health during pregnancy and after delivery, such as structural hazards or infestations with vermin (including mice and bedbugs), exposure to lead, unsafe drinking water or sewage and safety concerns related to various animals inside and outside of the home. These risks may be primarily outside of clients' control but pose significant risk to the health and safety of the family.	
Risk Classification	Risk classification of environmental health is based on reflection after completing the NFP program facilitators and/or on nurses' observation/clinical judgment. Factors that should be taken into consideration include neighborhood crime (e.g. drug dealing and pervasive property crime) and violence. Additional factors that should be weighed include things such as potentially dangerous road conditions, proximity to major pollution sources, and other injury risks such as abandoned buildings.	
	0 Low Risk	• No unusual or extraordinary risks for mother or child.
	1 Moderate Risk	• Some unusual or extraordinary risks may be present but can be effectively managed by the client.
	2 High Risk	• Unusual or extraordinary risks are present that are nearly impossible to be managed by the client without moving.

<table>
<tr><th colspan="3">18. Home Safety</th></tr>
<tr><td>Rationale</td><td colspan="2">This category is designed to capture risks present in the clients' home environment and the extent to which clients are safeguarding their homes in the interest of child safety. This category includes the caregiver's attitudes towards home safety and attempts to reduce the risks in the home.

During pregnancy home safety risks may include unsafe stairways, toxic fumes, litter boxes, second hand smoke, lack of air conditioning or heat.

Some home safety risks may have greater importance for infants or toddlers; for example,
risks of injury such as burns, falls, electric shocks, choking hazards, strangulation, drowning, hazards (buckets, toilets, pools, etc.), suffocation hazards (plastic bags, latex balloons), exposures to toxins (including secondhand smoke, vaping liquids or broken e-cigarettes, chemical fumes, marijuana edibles and other drugs, and other substances such as laundry pods, batteries, magnets, etc.).
unsafe cribs and sleeping locations .
Classification for this category also factors the age of the child with regard to safety. For example, unprotected stairs or accessible open windows observed during pregnancy would not be considered a safety risk, whereas these same environmental conditions would be a risk for a mobile child. Risk classification should also factor in whether caregivers have set in motion anticipatory actions to reduce later risk (e.g., protecting stairs before the child begins to crawl).</td></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">Risk classification is based on reflection after completing the NFP program facilitators and/or on nurses' observation/clinical judgment.</td></tr>
<tr><td>0
Low Risk</td><td>• No risks identified.</td></tr>
<tr><td>1
Moderate Risk</td><td>• Risks identified for pregnancy or child's current or future stage of development; working to rectify.</td></tr>
<tr><td>2
High Risk</td><td>• Imminent safety hazards for pregnancy or child's current or future stage of development; no action.</td></tr>
</table>

<table>
<tr><th colspan="3">19. Health Services Utilization</th></tr>
<tr><td>Rationale</td><td colspan="2">Clients' use of prenatal care is a central part of the NFP model in that office-based care is required for the diagnosis and treatment of emerging pregnancy complications, and management of chronic illness and other health problems during pregnancy that can affect the outcomes of pregnancy and subsequent child health and development. Client's effective use of primary care is also a crucial element in the NFP approach to protecting client's health. This is important for client's postpartum care, access to birth control, and early identification and treatment of emerging health problems. Access to and appropriate use of primary care is especially important for women with chronic illnesses or disabilities. Appropriate use of primary care can reduce unnecessary emergency department visits and hospitalizations, and help women care for themselves and their children. Nurses may need to spend more time in planning or conducting visits with clients who don't make use of primary care. Although NFP nurses may not be in a position to change the system of care, they can affect (to some degree) client's use of available prenatal and well-woman care.</td></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">Risk classification of client's health services utilization is based on reflection after using NFP facilitators, and/or completing data collection forms and screening tools in addition to their observation/clinical judgment.
Data Gathering
Maternal Health Assessment-Intake form
Use of Government Services form
Nurses assessment of the clients' ability to access health care</td></tr>
<tr><td>0
Low Risk</td><td>Client attends scheduled prenatal, postpartum, and well woman care visits on a consistent basis following enrollment in NFP.</td></tr>
<tr><td>1
Moderate Risk</td><td>Client inconsistently attends scheduled prenatal, postpartum, and well-woman care visits following enrollment in NFP, but does not appear to have pregnancy complications, chronic illness, or disability that poses risk to her health or her child's health and well-being.</td></tr>
<tr><td>2
High Risk</td><td>Client inconsistently attends scheduled prenatal, postpartum, and well-woman care visits following enrollment in NFP and has pregnancy complications, chronic illness, or disability that create risks for her health or her child's health and well-being.
Client does not attend scheduled prenatal, postpartum, and well-woman care visits.
Client has barriers to accessing health care i.e. lack of insurance or payment source</td></tr>
</table>

<table>
<tr><th colspan="3">20. Well-Child Care – Infancy and Toddlerhood</th></tr>
<tr><td>Rationale</td><td colspan="2">Clients' establishment of a consistent provider of well-child care for their children is a central part of the NFP model. Office-based care with good communication between parents and the child's primary care provider is required for the diagnosis and treatment of children's health problems, assessments of growth and development, and immunizations. Appropriate use of well-child care can reduce unnecessary emergency department visits and hospitalizations. Although NFP nurses may not be in a position to change the system of care, they can affect parents' knowledge and use of well-child care that is available. Nurses may need to spend more time conducting visits with clients who do not use well-child care. Such clients may have challenges such as transportation barriers, misunderstanding of the importance of well-child care, lack of family routines, or a cognitive or physical disability that may interfere with a client's use of community services.</td></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">This category is only assessed during the infancy and toddler phases of the program. NFP program guidelines include a variety of facilitators to support discussions of well-child care across pregnancy, infancy, and toddlerhood. Risk classification of well-child care visits is based on reflection after completing NFP facilitators and/or data collection forms as well as on nurses' observation/clinical judgment. Nurses are expected to provide physical assessment in keeping with their Nursing Scope of Practice and agency policy and procedures. Generally, a minimum of baseline weight, length, and head circumference should be measured, and subsequent measurements be completed to monitor physical growth.

Data Gathering
Infant Health Care form
Use of Government Services form
Nurses assessment of clients' ability to access care for her child</td></tr>
<tr><td>0
Low Risk</td><td>Child attends all recommended well-child care visits and immunizations are up-to-date, has a consistent primary care provider or health care clinic, and uses E.R./urgent care for emergencies or after-hours care only.</td></tr>
<tr><td>1
Moderate Risk</td><td>Child attends recommended well-child visits but may not have a consistent primary care provider or health care clinic, and may use ER/urgent care for routine illness on occasion.</td></tr>
<tr><td>2
High Risk</td><td>Child does not attend recommended well-child visits; OR
Immunizations are not up to date and client is not making efforts to immunize or choosing not to immunize OR
Does not have a primary care provider or health care clinic and uses ER/urgent care for routine care often.</td></tr>
</table>

21. Use of Other Community Services		
Rationale	Other community services can be used to help ensure the health of the mother, child, and family. These services may include financial resources, food and nutrition, housing, transportation, mental health, and childcare. Gaining access to and using these services is an essential element of the NFP model for improving maternal and child health.	
Risk Classification	***Data Gathering*** • Encounter form collected at every visit • Use of Government & Community Services Form • Nurses assessment of the clients' ability to access services	
	0 Low Risk	• Client has no need for other community services; OR • Client needs other community services and accesses those services appropriately.
	1 Moderate Risk	• Client has some needs for other community services, occasionally accesses those services, and would benefit from more consistent utilization.
	2 High Risk	• Client needs other community services but infrequently accesses these services; OR • Refuses use of most needed community services. • Client has barriers to accessing services i.e. lack of insurance or payment source, or service is not available.

Behavioral Strengths

Behavioral strengths are assessed in relation to each specific measurement category defined in the STAR. They are included to help nurses determine client's stage of behavior change, as well as the presence of social support available to clients and clients' use of formal services within each category. This information can help nurses determine how best to support a client experiencing a specific risk by identifying a client's readiness for behavioral change, and then selecting intervention materials that are appropriate for that stage of change.

After nurses categorize client risk within each STAR Measurement Category, they can reflect on their interactions with clients to determine if a client has shared any information regarding their desires to change a behavior or address risks they face. The behavioral strengths in the STAR include six stages of behavior change and allow the nurse to indicate if the client has support (social support and service utilization) to meet their needs as they work to address a specific risk (listed below).

When to Code Behavioral Strengths

Nurses mark observed client behavioral strengths for all STAR Measurement Categories classified as **1-Moderate Risk** or **2-High Risk**. If the code is 0, the nurse will not need to code behavioral strengths. Exception- If a client has moved from moderate/high risk to low risk, code the Stage of change and social support to demonstrate client growth, use of support, and nursing intervention.

Behavioral Strengths	
Stage of Behavior Change	**Social Support and Services**
• Understands risk • Pre-Contemplation/Not ready to change • Contemplation/Thinking of changing • Preparation/Getting ready to change • Action/Making small changes • Maintenance/Working toward goals • Self-Empowerment/Keeping it up	• Friends/family/partner support goals • Uses services to meet goals

Protective Factors

Protective factors are personal characteristics that clients or families bring to the program and appear to be a fundamental part of their makeup. These factors are assessed globally across client functioning and with consideration of client background and history.

After categorizing client risks and behavioral strengths across the defined STAR measurement categories, nurses reflect on the following protective factors (see definitions below). For every protective factor the client displays, the nurse fills in Y in the corresponding column and add comments to the Global Protective Factors table located on the STAR Coding Sheet and consider how you might engage these strengths to assist the client in meeting her goals.

Definitions

Keeps NFP Appointments	Client keeps most, if not all, scheduled NFP appointments and/or is proactive in alerting nurse to cancelations.
Engaged in NFP Program	Client is actively engaged in the program, is receptive to materials, eager to learn, follows nurse recommendations, etc.
Has Psychological Resources	Refers to one or more of the following traits: positive affect (client is cheerful, pleasant, has a good attitude, and so forth); intelligence and/or maturity; motivation and determination to succeed, independent, tenacious and/or hard worker; client has clear sense of efficacy and advocates for herself and her child; client has strong relationship skills (patience, empathy, good communication styles, conflict resolution skills, and so forth). Client has character strengths such as resilience, perseverance, determination, and organizational skills.
Protects Her Health	Takes action to eat balanced diet, avoid substance use, avoid excessive weight gain, practice safe sex, and so forth.
Demonstrates Commitment to Protect Child	Displays behaviors such as: motivation to be a good mother, breast feeds, shows good communication with child, provides developmentally appropriate educational materials, provides cognitive stimulation, is protective of child's health and safety, and so forth.
Social Support	The client is connected to a network of family and/or friends who provide emotional (warmth, empathy, love, nurturance) and instrumental (financial, concrete goods and services) support to the client.
Spirituality	The client has spiritual belief and practices that provides her with a protective foundation and worldview, meaning and purpose for her life.

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