Nurse-Family Partnership
Helping First-Time Parents Succeed®

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 clients 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 clients with higher and multiple risk factors are those who benefit the most from NFP services. Therefore, it is expected that clients will have risks. When the STAR is coded as a risk, the purpose is to understand the client's challenges and needs—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 in the client's life, and how these exposures have the potential to influence the client's 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 client and child health. By attending to specific strengths that the client and family members bring to the program, the STAR Framework helps the nurse 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 client (and other family member) abilities and interests in engaging in the program.

The original STAR Framework was developed by staff at the Prevention Research Center (PRC), the 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 NFP nurses across the country continues to guide further revisions.

Coding the STAR Framework occurs as the nurse and client get to know each other and is revised throughout the intervention as new information is presented. 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 et al., 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 client and child health goals:

1. To improve pregnancy outcomes *by helping a client improve their prenatal health and behavior*.

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

3. To improve a client's life-course development *by helping clients 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 client and child health directly. These activities (i.e., 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 client 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 client 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 client and family strengths in relationship to each of the targeted risks, as well as client and family 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 client, 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. Nursing Diagnosis
3. Planning (Outcomes)
4. Implementation
5. Evaluation

Figure 1: STAR Framework Conceptual Model

Assessment

Assess

Background and Historical Risks

- History of Trauma, (physical, sexual, emotional abuse)
- Loss of parent: separation/divorce, death, abandoned
- Incarcerated household member
- Substance misuse in household
- Household mental illness
- Witness IPV, domestic violence
- Bullied
- Racism, discrimination
- Young age
- Poverty
- Single Parent
- Immigrant Status
- Raised in foster care

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

Assess Current Risks within Each Measurement Category

PROXIMAL

Personal Health
- Substance Use and Misuse
- Chronic Illness and/or Pregnancy Complications
- Developmental or Intellectual Disability/Limitation
- Depression, Anxiety, and other Mental Health Issues

Maternal Role
- Caregiving Attitudes and Behaviors
- Child Health and Development
- Child Care

DISTAL

Life Course
- Client Education and Work
- Pregnancy Planning
- English Literacy Limitations
- Criminal Justice/Legal Issues

Family/Friends
- Loneliness and Social Isolation
- Intimate Partner Violence
- Unsafe Family or Friends Network

Environmental Health
- Economic Insecurity
- Homelessness and Residential Instability
- Environmental Health
- Home Safety

Health & Human Services
- Health Services Utilization
- Well-child Care
- Use of Other Community Services

Assess Behavioral Strengths for Each Measurement Category and Rate Global Protective Factors

Behavioral Strengths

- Understands Risk
- Stage of Change
- Family/Partner Support Goals
- Uses Services to Meet Goals

Global Protective Factors

- Keeps NFP Appointments
- Engaged in NFP Program
- Has Psychological Resources
- Protects Own Health
- Demonstrates Commitment to Protect Child
- Social Support
- Spirituality

Summarize & Prioritize Results of Assessment

Plan Based on All Assessments

Determine priorities to address and determine visit schedule based on client need

Implement Plan

Use NFP Visit-to-Visit Guidelines and Nursing Standards

Evaluate Implementation

Re-Assess & revise plan

(as needed)

NFP Program Goals

Improve Pregnancy Outcomes

- Preterm Labor
- Low Birth Weight
- Pregnancy Complications

Improve Child Health & Development

- Childhood Injuries
- Language Development
- Cognitive Development
- Emotional/ Behavioral Regulation

Improve Family Economic Self-Sufficiency

- Client Education
- Client Work
- Pregnancy Planning
- Inter-Conception Health

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 the 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 childhood or adolescence can influence behavior choices and health outcomes across the lifespan. A client's past experiences may also influence 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 or 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. The level of long-term health risks increases exponentially as the number of exposures increase.

Experiences of racism, implicit bias, and discrimination impact "physical, social, and economic conditions that disproportionately threaten the healthy development of children of color and their families" (Shonkoff et al., 2021). Rochelle P. Walensky, Director of the Centers for Disease Control and Prevention (CDC), has stated that racism ". . . is a serious public health threat" (Centers for Disease Control and Prevention, 2021). The American Public Health Association (2020) has stated that,

"structural racism is a public health issue," with the adoption of policy statement LB20-04. In addition, research from the Center for American Progress shows that "LGBTQ2S+ people across the country continue to experience pervasive discrimination that negatively impacts all aspects of their lives" (Mirza & Rooney, 2018). As a nurse completes the Strengths and Risks (STAR) Framework, the impact of historical and current racism, implicit bias, and discrimination must be included as part of the assessment in each of the 21 measurement categories

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 depression or 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
- Loss of parent through death or abandonment
- Being severely bullied

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)
- Natural disasters

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 to. However, uncovering these early experiences can help a client understand and address current behaviors and health concerns that stem from their background and history. If a client experienced more than a few adverse experiences, the risk of long-term chronic health problems is significantly increased. Together, nurses and clients can discuss the importance of monitoring for health risks and making healthy choices to reduce the possibility or impact of chronic conditions. The nurse may also highlight all that the client has done to cope with and manage adversity in getting to this point in their life. Equally important is to explore with a client the positive experiences they had in their past. To help the client establish goals, the nurse can focus future conversations on client strengths and experiences of resiliency. The nurse can help the client build on these positive experiences to improve their life and manage their challenges. Categories of positive childhood experiences include (Sege & Browne, 2017):

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
4. Learning social and emotional competencies

Identifying adverse and positive client experiences during childhood and adolescence may be accomplished using a life history assessment. Throughout the STAR document you will notice reminders to use a life history assessment to obtain historical information.

Measurement Categories

The STAR Framework identifies the following measurement categories:

- 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 a client's life 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 the client helps nurses support achievement of client 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, the nurse should rely on their nursing judgment and code accordingly.

Behavioral Strengths and Protective Factors

In addition to understanding the risks a client experiences, nurses need to know the strengths that the client and their family possess to guide intervention planning. Strengths are the foundation for behavioral change. In this system, strengths are factors that can enable nurses to help clients reduce the likelihood that risks become more significant or are translated into compromised client 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 a client's 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 the client has among their family members and friends, and formal services for achieving the client's goals and the goals of the program (Olds, 1980). 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 the client wants in life, reveals a desire to change, expresses realistic goals and plans for change, makes small changes, works toward or achieves a goal, whether there are family, friends, or partners who support the client's specific goals, and whether formal services are used to meet the client's goals. These behavioral strengths help nurses reflect on the specific behavioral assets a client holds in relation to each risk category. Nurses use this information to devise approaches to addressing individual family needs by building on current strengths, with the aim of guiding the client toward success or reduced level of risk within each specific measurement category. Reflection on the client's 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 the client 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. They can be used to identify clients and families that—in the nurse's judgment—have sufficient protective factors and resources to manage normal challenges that accompany early care giving and transition to economic self-sufficiency. This information is likely to help inform the nurse's consideration of reducing or increasing family visitation schedules. Decisions regarding protective factors are subjective and based on the assessment and the nurse's 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 client, 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 the family's strengths and risks.

Data will be entered in the Data Collection System 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
6. PRN

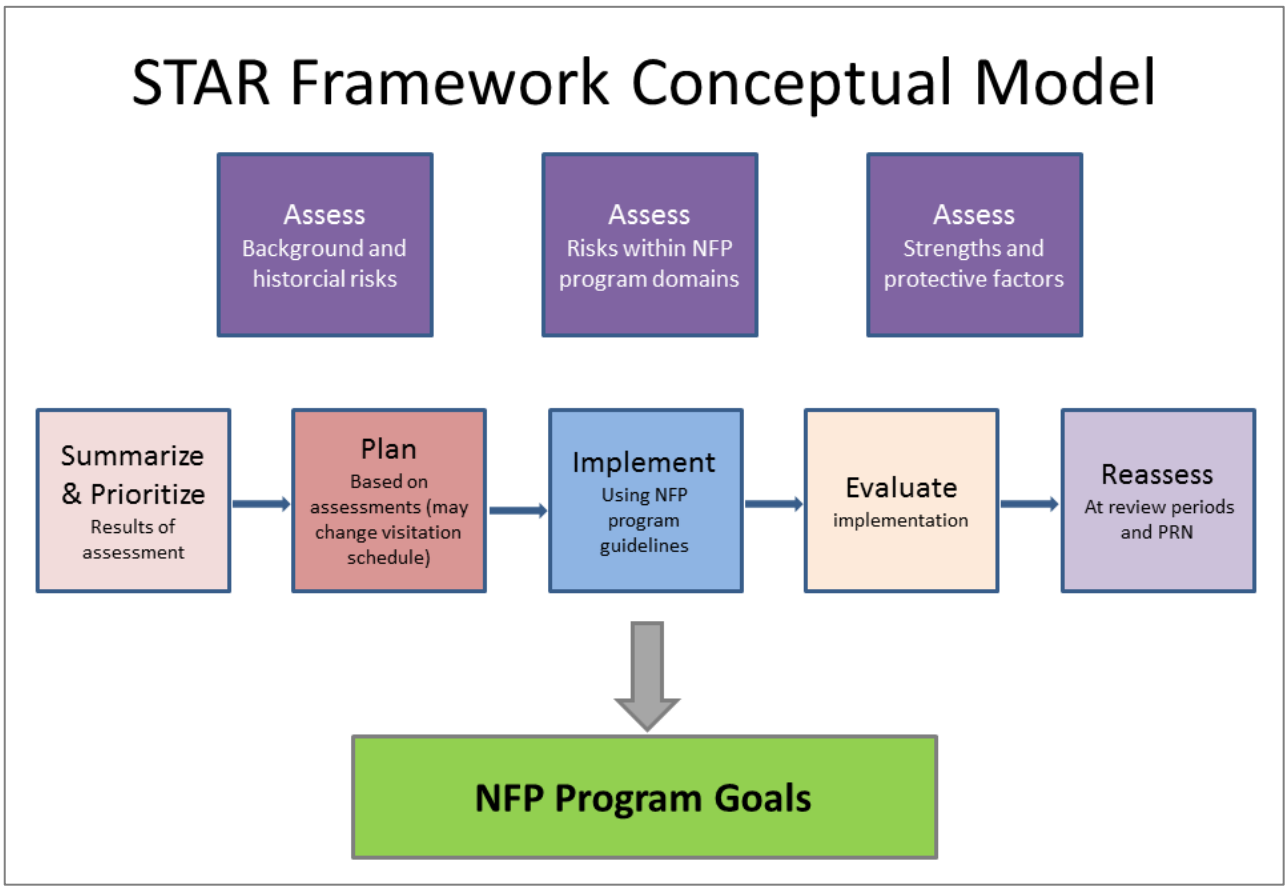
Emphasis that Improves Outcomes

The Measurement Categories that fall within the Personal Health and Maternal Role domains are given priority, as they constitute the core nurse activities thought to improve client 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 the client 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 network partners 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 the whole team on the implementation plan based on the 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 families with lower risk factors and to try to ensure consistent frequent visitation with families with higher risk factors, 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 families with lower risks (about 30% of all of those visited) whom nurses visited far less frequently after delivery, and those clients and children did very well without frequent visitation. These are families that nurses identify as doing well 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 the family's risks and strengths; this information can be used by nurses and parents to guide decisions about whether the family 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.

Offering a reduced visitation schedule for families with lower risks and an increased visit schedule for families with higher risks will align with the needs of many families for services. Many of those with low risks 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 families with lower risks in the program with a dramatically reduced visitation schedule designed to align with the family's 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. Even if the client chooses infrequent visits, the continued contact provides the parent with easy and quick access to the nurse when a crisis occurs or when child development challenges arise (tantrums, feeding issues, etc.)

The STAR Framework is meant to align with the work on client retention, which emphasizes that nurses should discuss family 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 (Ingoldsby et al., 2013). Effective implementation of the program requires that nurses listen to clients and families to calibrate the frequency of visitation.

As nurses become more comfortable using this STAR Framework, it will provide greater consistency in classifying family risks and strengths and it will guide the nursing plan, supervision, case conferencing, and shared discussions about family needs. This process of examining all aspects of client, child, and family functioning will help ensure that the entire NFP program is delivered with each family, and that nurse's actions are attuned with family 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 client is incarcerated and the infant is in the care of others, 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 client 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 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 client's caregiving, because either the nurse is unable to visit in the home or the child does not interact with the client during visits. The nurse documents the domains that can be assessed and reflects on the likely meaning of those domains of risk that cannot be observed. The inability to observe specific domains of risk needs to be factored into the nurse's characterization of the family's 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 in their state and agency. While the nurse's focus is on the index child, the nurse 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

Domain: Personal Health

Domain: Maternal Role

Domain: Life Course Development

Domain: Family and Friends

Domain: Environmental Health

Domain: Health and Human Services

Additional Information

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).
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.

1. Substance Use and Misuse

Notes: For this measurement category, there are different considerations when categorizing clients in pregnancy versus infancy/toddler phases of program. Please use guidance specific to the 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 clients and their babies. Prenatal tobacco, alcohol, and drug exposure are significant risks for compromised neurological development, fetal growth restriction, and preterm labor. Any substance use including cigarettes/nicotine is illegal for teens. Client use of opioids puts the newborn at risk for Neonatal Abstinence Syndrome. The American College of Obstetrician and Gynecologists recommends against the use of marijuana prior to becoming pregnant, and while pregnant and breastfeeding (Office of the Surgeon General, 2019). Other substance use risks include the risk of relapse for those in recovery and the risks associated with a support system of people who continue to use substances or not having a support system. Therefore, assessing client use of substances is of primary importance in the prenatal period because of the direct impact 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. Client exposure during childhood or adolescence to family members misusing substances can impact the client's later physical and mental health and has been shown to increase the risk of substance misuse as an adult. Client exposure to family members substance misuse may be identified using a life history assessment.

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. A history of experiencing trauma during childhood or adolescence may increase the risk of substance use (and other risks).

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

<table>
<tr><th colspan="3">1. Substance Use and Misuse</th></tr>
<tr><td rowspan="2"></td><td></td><td>• 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*
• Past history of family members misusing substances (childhood exposure)</td></tr>
<tr><td>2
High Risk</td><td>• 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 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 of the pregnancy 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*</td></tr>
<tr><td>Rationale</td><td colspan="2">Infancy/Toddlerhood

The biological risks associated with client substance use on child development and health are significantly reduced or eliminated, after the child is born. The reduced biological impact of client substance use on child health and development after delivery results in the nurse shifting focus to client impairment related to client substance abuse during infancy and toddlerhood. The exception to this is a child born addicted to substances 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 their daily life activities and/or relationships (trouble going to school or work, interfering with one's role as a parent or partner). Assessment of client 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 the client's ability to care for the baby, the client's functioning in school and work, and the client's 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 client substance misuse that undermines a client's ability to fulfill the role of 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 and other sequelae of substance misuse is captured in Child Health and Development.</td></tr>
</table>

*See Family and Friends Network System

1. Substance Use and Misuse

Risk Classification

Guidance: Infancy/Toddlerhood

After delivery, substance use that negatively impacts a client's ability to fulfill the role of parent, student, or worker, or that interferes with relationships with family members and friends, creates impairments that place the client 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 the client to be "functional", so the nurse should use astute judgment in assessing impairment. The following questions in the Substance Use and Misuse Questionnaire are a way of guiding a nurse's assessment of the client's substance misuse. Risk classification of substance misuse during infancy is based either on the nurse's observation/clinical judgment or based on direct administration of the questions to clients.

Data Gathering

- "Substance Use and Misuse 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 Misuse 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 Misuse Questionnaire; OR • Nurse observes impairment during visits • Client is actively using OR Nurse suspects client is using substance that leads to impairment

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

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

- If the client scores a "1" in any or all the Category A items but a "no" to all Category B items, they are coded as "1-Moderate Risk" on the STAR Framework.
- If the client scores a "2" in any or all the Category A items or a "yes" to any Category B items, they are 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 Misuse 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 their 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 the client's phase in the program to categorize client risk in this area.

Rationale	Clients 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 clients, 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 and 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. Client exposure during childhood or adolescence to various adverse events can increase the risk for the client's physical and mental health. Client exposure to adverse events may be identified using a life history assessment.	
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 18 months after delivery of previous child or miscarriage

<table>
<tr><th colspan="3">2. Chronic Illness and/or Pregnancy Complications</th></tr>
<tr><td></td><td>2
High Risk</td><td>• 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</td></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">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</td></tr>
<tr><td>0
Low risk</td><td>• No chronic illness present</td></tr>
<tr><td>1
Moderate Risk</td><td>• 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</td></tr>
<tr><td>2
High Risk</td><td>• 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</td></tr>
</table>

3. Developmental and Intellectual Disability or Limitation

Rationale

Clients with developmental disabilities or intellectual disabilities are at greater risk and may have greater challenges caring for themselves and their children. There are many 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 a client's ability to care for themself and their child.

A client's age and maturation level should be considered when assessing potential challenges for caring for themself and their child. Adolescent clients present unique issues related to parental 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 (Casey et al., 2008). Age should be considered and included as a part of coding this category. In general, younger clients will have more limited abilities to anticipate the consequences of their behavior and to plan (levels of executive functioning).

Risk Classification

Guidance

Nurses assess developmental/intellectual disability and/or limitations based on observation of the client, the client's medical record/communication with Primary Care Provider, the client's 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.

0 Low Risk	• No developmental or intellectual disability or limitation
1 Moderate Risk	• 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
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,

3. Developmental and Intellectual Disability or Limitation		
		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 clients in NFP are depression and anxiety, which can interfere with the parent's ability to achieve what they want for themself and their child. A parent also may exhibit other mental health problems that interfere with the ability to care for self and the child. Client exposure during childhood or adolescence to various adverse events can increase the risk to a client's physical and mental health. Client exposure to adverse events can be identified using a life history assessment.

Risk Classification

Depression

Data Gathering

- Patient Health Questionnaire (PHQ-9) **Note**: We strongly urge agencies to use the PHQ-9. It is more reliable postpartum than other measures. 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. A history of experiencing trauma during childhood or adolescence may increase the possibility of depression.

0 Low Risk	• No signs of depression or scores in "minimal depression" 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

Risk Classification

Anxiety

Given the frequency with which anxiety problems also affect clients in NFP, it is recommended that nurses consider employing the Generalized Anxiety Disorder-7 scale for assessing anxiety. A history of experiencing trauma during childhood or adolescence may increase the possibility of anxiety.

Data Gathering

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

4. Depression, Anxiety, and Mental Health Issues		
	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
Risk Classification	**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, the 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 (including anger management), and personality disorder, or evidence of thought disorders. A client may also experience temporary mental health challenges associated with grief and loss. A history of experiencing trauma during childhood or adolescence may increase the possibility of other mental health problems.	
	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
Risk Classification	**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 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.	

4. Depression, Anxiety, and Mental Health Issues		
	"How difficult is it for you to manage self-care? Do you 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** The overall risk classification of mental health problems is based on nurses' observation/clinical judgment as guided through the classifications of depression, anxiety, other mental health problems, and impairment. Please rate the overall level of risk using the following categories.	
	0 Low Risk	• Client is categorized with all "0"
	1 Moderate Risk	• Client is categorized with at least one "1" and no "2"
	2 High Risk	• Client is categorized with at least one "2"

5. Caregiving Attitudes and Behaviors

Notes: For this measure category there are different considerations when categorizing a client in pregnancy versus infancy/toddler phases of program. Please use guidance specific to the 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 lack of knowledge or parenting skills, 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. Client exposure during childhood or adolescence to various adverse events can impact the client's approach to caregiving. Completing a life history assessment may help the client and the nurse understand how past experiences may influence attitudes and beliefs and behaviors toward child rearing.	
Risk Classification	**Guidance: Pregnancy** During pregnancy, risk is revealed in the degree to which the pregnant person expresses 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 nurse assessment of the client's caregiving attitudes. A history of experiencing trauma during childhood or adolescence may increase the risk for the client having difficulty with caregiving.	
	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 the child's development and is not open to education; OR • Client has harsh/concerning beliefs about caregiving; OR • Client indicates that they do not want this child; OR • Client experienced abuse or neglect as a child/adolescent

5. Caregiving Attitudes and Behaviors

Risk Classification

Guidance: Infancy and Toddlerhood

Once the child is born, or if a client already has children in their care, nurses observe caregiving in the home including the use of the DANCE or NCAST feeding and/or teaching scales, as well as observations of the home environment using the HOME 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 and informal observations and clinical judgment considering the following:

- Limited, delayed, or inappropriate responsiveness to the child's needs and communications
- Limited interaction with the child, limited positive affect
- Harsh or intolerant responses to the child's behavior
- Ineffective responses to the child's distress
- Developmentally inappropriate expectations of the child
- Limited verbalizations to the child
- Limited promotion of the child's interest in the world and child development
- Limited efforts to protect the child from imminent harm
- Intrusiveness or poor pacing

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		
	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 on the client's ethnicity and the 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 a client in Pregnancy versus Infancy/Toddler phases of program. Please use guidance specific to the 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.

Client exposure during childhood or adolescence to various adverse events can impact the client's coping skills. Coping skills may be identified through a life history assessment.

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, developmental disability, or if the client is using substances or is receiving medical treatment for substance use. Pregnant clients without prenatal diagnosis of infant congenital disorder, developmental delay, chronic illness, or substance 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.

Client history of experiencing trauma during childhood or adolescence may influence client coping skills.

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

6. Child Health and Development		
	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

7. Child Care

Rationale	Clients can easily find themselves in situations with less than optimal childcare 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 childcare provider lacks adequate preparation or interest in providing care, or lacks the physical, developmental, or emotional capacity to care for a young child.	
Risk Classification	**Guidance** Nurses should discuss childcare arrangements frequently, as the arrangements will change as frequently as the client's situation changes. Factors that influence a client's choice of childcare 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 caregiver's age and maturation level should be considered when assessing potential challenges for caring for the client's children. The minimum age for "babysitting" varies by 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 babysit. Nurses usually will not be able to directly rate childcare risk. They will have to discuss these issues with parents using the childcare facilitators and make their judgment based upon the client's responses. Parents may have multiple childcare arrangements; risk should be classified for the highest risk childcare environment.	
	0 Low Risk	• Child is cared for in a licensed home or childcare 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
	1 Moderate Risk	• Client has placed the child in the care of an unlicensed childcare 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
	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

7. Child Care		
		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 use; 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)

<table>
<tr><th colspan="3">8. Client Education and Work</th></tr>
<tr><td>Rationale</td><td colspan="2">Helping clients become more economically self-sufficient is a core goal of the program. When clients 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, having additional children may be their primary goal, or they may be from a culture or in a relationship where the client 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 a client's education and employment-related goals.</td></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">Data Gathering
Demographics Data Collection Form administered to clients at Intake and 6, 12, 18, and 24 months following the birth of the child.</td></tr>
<tr><td>0
Low Risk</td><td>• Client is making regular progress in education, employment, or training to meet goals; OR
• Client is in school and is committed to completing high school</td></tr>
<tr><td>1
Moderate Risk</td><td>• Client is involved inconsistently in education (including truancy), employment, or training to meet 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 life-course goals and client has some difficulty meeting non-essential needs for self and child (e.g., cable and internet)</td></tr>
<tr><td>2
High Risk</td><td>• Client is not involved in education, employment, or training to meet individual goals; AND
• Client does not have adequate resources to meet basic needs for self and/or child (e.g., food, shelter, clothing, or supplies for the child)</td></tr>
</table>

9. Pregnancy Planning

Note: For this measurement category there are different considerations when categorizing a client in Pregnancy versus Infancy/Toddler phases of program. Please use guidance specific to the 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. Closely spaced subsequent pregnancies are at greater risk for preterm delivery, low birth weight, child autism, and infant mortality.

Risk Classification

A 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 the client's plans for future pregnancy planning after delivery of their child. 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, such as long-acting reversible 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 reliable method of contraception such as long-acting reversible 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 their first child; OR • The client's partner is encouraging another pregnancy within 18 months of the birth of the first child • Client is not planning to use any birth control methods

Risk Classification

Guidance: Infancy and Toddlerhood

In infancy and toddlerhood, nurses assess a client's 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

9. Pregnancy Planning		
	0 Low Risk	• Client has chosen to delay subsequent childbearing 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
	1 Moderate Risk	• Client expresses a desire to postpone pregnancy or is ambivalent about getting pregnant, but client is not using a LARC or is using a less effective method of contraception
	2 High Risk	• Client expresses a desire to become pregnant with another child within18 months of the birth of the first child; OR • Client is pregnant with a subsequent pregnancy conceived prior to 18 months since the previous birth; OR • The client's partner is encouraging another pregnancy within 18 months of the birth of the previous child • The client's partner is controlling the client's access to contraception

10. English Literacy Limitations

Rationale

English language literacy limitations can interfere with a client's ability to care for self and child, to be successful in school or the workplace, 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 is important for nurses to know how well clients 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. A client 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 the client's 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 grade, 8th to 9th grade, 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)

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 the client had an Individual Education Plan (IEP) that indicated a literacy limitation

10. English Literacy Limitations		
	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 limits a client's ability to care competently for the 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 is important to note that this category assesses a client's 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 nurse regardless of current involvement in legal proceedings. When a client is involved with criminal justice, the nurse may need to coordinate alternative visit schedules, provide additional information/resources, and coordinate with other community service providers. A history of experiencing trauma during childhood or adolescence that includes family members being incarcerated may increase the possibility of physical or mental health concerns in the client and increase their risk of adjudication, depression, loss, etc. Identifying a history of family member incarceration may be accomplished using a life history assessment.	
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

12. Loneliness and Social Isolation

Rationale	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 many factors, such as recent moves away from family and friends and difficulty forming intimate relationships, leading a client to feel empty and unwanted. Loneliness can affect a client's abilities to care for their child and their willingness to use community resources. Although 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 client and child health outcomes. It is not a matter of how many people are available to the client, but the quality of the emotional and social support received and the sense of intimacy with others that accounts for positive client and child health outcomes. Understanding the client's perceived sense of social isolation provides valuable information for targeting NFP intervention planning.	
Risk Classification	**Guidance** A brief loneliness/social isolation measure is provided below to be used in conjunction with facilitators to guide the nurse's assessment of a 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 the nurse's 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 • The nurse's observation/clinical judgement; facilitator responses (e.g., My Parachute, My supports, Life History Assessment)	
	0 Low Risk	• 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
	1 Moderate Risk	• 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
	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

13. Intimate Partner Violence

Rationale	One of the most serious situations faced by clients in NFP 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. Those who are abused by their partners are at greater risk for miscarriage and preterm delivery, depression, anxiety, PTSD, injury, and death. 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. Because the interventions and the levels of lethality are different, abuse by individuals other than the client's partner is captured in the next measurement category (Unsafe Family or Friend Network). A history of childhood or adolescence exposure to IPV among their caregivers or other forms of domestic violence in the home is a risk indicator for a client to experience IPV in their own current intimate relationship. Assessing for childhood exposure to IPV as a child may be accomplished using a life history assessment.	
Risk Classification	Some clients may not feel safe to share when they experience violence. They may be reluctant to share, they may be waiting until it feels safe to share, or they may not understand that coercive control in the absence of physical assault is abuse (Ponic et al., 2016). 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 • Danger Assessment • The nurse's observation/clinical judgement	
	0 Low Risk	• No evidence of IPV
	1 Moderate Risk	• 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
	2 High Risk	• 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 or evidence of IPV during home visit

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 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 abusive or controlling partner
- For women, having a male partner who is employed less than part-time
- Having a partner who has a problem with drug or alcohol use
- A client 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 client is exposed to, the risk for being abused within an intimate relationship increases.

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

14. Unsafe Family or Friend Network

Rationale	Although 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 a client's 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 the child. In this category, the family and friend network include all individuals the client has regular contact with, such their 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 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 the nurse's 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). A history of childhood or adolescent trauma including child abuse and neglect increases the risk of health conditions, abuse by others in adulthood, and engagement in unsafe practices.	
Risk Classification	Risk classification of unsafe family or friend network is based on reflection after completing NFP facilitators and/or on the nurse's 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 their family or friends have a relationship that is characterized by moderate conflict†; OR • Client has friends or family members not residing in their household who expose the client to criminal, violent, or emotionally abusive behavior, substance misuse, or violence; OR • Client lives in a household where criminal activities, substance use, or violence are suspected
	2 High Risk	• Client and their friends or family have a relationship that is characterized by significant conflict†, OR • Client lives in a household where criminal activities, substance misuse, or violence are evident; OR • Client is exploited; OR • Client is experiencing bullying at work/school/home or cyberbullying • There is an open CPS case related to maltreatment/neglect of the client

†Conflict is characterized by engaging in verbal fights/arguments and/or physical/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 a client's 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 Form at Intake and 6, 12, 18, and 24 months following the birth of the child • Considerations: Clients that are not able to 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 self. The client 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 a client's ability to obtain consistent housing, not the degree to which they move between stable housing options available to them—such as a client that lives primarily with their mother, but also has stable housing available at their grandmother's home and frequently move 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 release
	1 Moderate Risk	• Client has housing accommodations that are temporary or unstable; OR • Client is currently incarcerated but following 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 the child or parent 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 client 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 a client's 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 the nurse's 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 client 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

18. Home Safety

Rationale

This category is designed to capture risks present in the client's home environment and the extent to which the client is safeguarding their home 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 (e.g., buckets, toilets, pools, etc.), suffocation hazards (e.g., plastic bags, latex balloons), exposures to toxins (e.g., 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 regarding 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).

Risk Classification

Risk classification is based on reflection after completing the NFP program facilitators and/or on the nurse's observation/clinical judgment.

0 Low Risk	• No risks identified
1 Moderate Risk	• Risks identified for pregnancy or child's current or future stage of development; working to rectify
2 High Risk	• Imminent safety hazards for pregnancy or child's current or future stage of development; no action

<table>
<tr><th colspan="3">19. Health Services Utilization</th></tr>
<tr><td>Rationale</td><td colspan="2">Client 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. A client's effective use of primary care is also a crucial element in the NFP approach to protecting the client's health. This is important for the 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 clients with chronic illnesses or disabilities. Appropriate use of primary care can reduce unnecessary emergency department visits and hospitalizations and help clients care for themselves and their children. Nurses may need to spend more time in planning or conducting visits with clients who do not make use of primary care. Although NFP nurses may not be able to change the system of care, they can affect (to some degree) the client's use of available prenatal and primary care.</td></tr>
<tr><td rowspan="4">Risk Classification</td><td colspan="2">Risk classification of a 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
The nurse's assessment of the client's ability to access health care</td></tr>
<tr><td>0
Low Risk</td><td>Client attends scheduled prenatal, postpartum, and primary 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 primary care visits following enrollment in NFP, but does not appear to have pregnancy complications, chronic illness, or disability that poses risk to the client's health or the child's health and well-being</td></tr>
<tr><td>2
High Risk</td><td>Client inconsistently attends scheduled prenatal, postpartum, and primary care visits following enrollment in NFP and has pregnancy complications, chronic illness, or disability that create risks for the client's health or the child's health and well-being
Client does not attend scheduled prenatal, postpartum, and well-primary care visits
Client has barriers to accessing health care (e.g., lack of insurance or payment source)</td></tr>
</table>

20. Well-Child Care – Infancy and Toddlerhood

Rationale	A client's establishment of a consistent provider of well-child care for their child 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 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 a parent's 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.	
Risk Classification	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 the nurse's 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 • The nurse's assessment of the client's ability to access care for their child	
	0 Low Risk	• 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
	1 Moderate Risk	• 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
	2 High Risk	• 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

21. Use of Other Community Services		
Rationale	Other community services can be used to help ensure the health of the client, 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 • The nurse's assessment of the client's 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 (e.g., lack of insurance or payment source, 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 the client's stage of behavior change, as well as the presence of social support available to the client and their 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 the client to determine if the 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.

	Behavioral Strengths	
Understands Risk	Stage of Behavior Change	Social Support and Services
• Yes • No	• 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. The nurse should consider how they might engage these strengths to assist the client in meeting their 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 themself and their 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 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 parent, 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 a protective foundation and worldview, meaning, and purpose for life.

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Strengths and Risks (STAR) Framework

Coding Sheets

STAR Framework Coding Sheet

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Site Name:		Client Name:	
Nurse Home Visitor ID:		Nurse Home Visitor Name:	
Client ID	Client DOB		

Stage of Change Codes		
PC = Pre-Contemplation/ Not ready to change	P = Preparation / Getting ready to change	M = Maintenance / Working toward goals
C = Contemplation/ Thinking of changing	A = Action / Making small changes	SE = Self-Empowerment / Keeping it up

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0,1,2	Understands risk/needs	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
Personal Health	1. Substance Use and Misuse ☐ Continued on a new sheet							
	2. Chronic Illness and/or Pregnancy Complication ☐ Continued on a new sheet							
	3. Dev. and Intellectual Disability/ Limitation ☐ Continued on a new sheet							

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STAR Framework Coding Sheet

	Measurement Category	Date	Risk Level NA, 0, 1, 2	Behavioral Strengths (Y/N) Understands risk	Behavioral Strengths (Code) Stage of Change	Behavioral Strengths (Y/N) Friends/family support goals	Behavioral Strengths (Y/N) Uses services to meet goals	Comments Strengths | Risks
	4. Depression, Anxiety and other Mental Health Issues ☐ Continued on a new sheet							
Maternal Role	5. Caregiving Attitudes and Behaviors ☐ Continued on a new sheet							
	6. Child Health and Development ☐ Continued on a new sheet							
	7. Child Care ☐ Continued on a new sheet							

STAR Framework Coding Sheet

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
Life Course	8. Client Education and Work ☐ Continued on a new sheet							
	9. Pregnancy Planning ☐ Continued on a new sheet							
	10. English Literacy Limitations ☐ Continued on a new sheet							
	11. Criminal Justice/Legal Issues ☐ Continued on a new sheet							

STAR Framework Coding Sheet

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
Family/Friends	12. Loneliness and Social Isolation ☐ Continued on a new sheet							
	13. Intimate Partner Violence ☐ Continued on a new sheet							
	14. Unsafe Family or Friend Network ☐ Continued on a new sheet							

STAR Framework Coding Sheet

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
Environmental Health	15. Economic Insecurity ☐ Continued on a new sheet							
	16. Homelessness and Residential Instability ☐ Continued on a new sheet							
Environmental Health	17. Environmental Health ☐ Continued on a new sheet							
	18. Home Safety ☐ Continued on a new sheet							

STAR Framework Coding Sheet

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
Health & Human Services	19. Health Services Utilization ☐ Continued on a new sheet							
	20. Well-Child Care *Infancy /Toddlerhood Only* ☐ Continued on a new sheet							
	21. Use of Other Community Services ☐ Continued on a new sheet							

Global Protective Factors	Y?	Comments
Keeps NFP Appointments/Engaged in NFP Program		
Has Psychological Resources		
Protects Health		
Demonstrates Commitment to Protect Child		
Social Support (Partner, Family, Friends)		
Spirituality		

STAR Framework Coding Sheet

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Site Name:		Client Name:
Nurse Home Visitor ID:		Nurse Home Visitor Name:
Client ID	Client DOB	

Stage of Change Codes		
PC = Pre-Contemplation/ Not ready to change	P = Preparation / Getting ready to change	M = Maintenance / Working toward goals
C = Contemplation/ Thinking of changing	A = Action / Making small changes	SE = Self-Empowerment / Keeping it up

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk/needs	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
Personal Health	1. Substance Use and Misuse							
	2.Chronic Illness and/or Pregnancy Complication							
	3. Developmental and Intellectual Disability/ Limitation							
	4. Depression, Anxiety, and Mental Health Issues							
Maternal Role	5. Caregiving Attitudes and Behaviors							
	6. Child Health and Development							
	7. Child Care							
Life Course	8. Client Education and Work							
	9. Pregnancy Planning							
	10. English Literacy Limitations							
	11. Criminal Justice/Legal Issues							

STAR Framework Coding Sheet

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
Family and Friends	12. Loneliness & Social Isolation							
	13. Intimate Partner Violence							
	14. Unsafe Family or Friend Network							
Environmental Health	15. Economic Insecurity							
	16. Homelessness and Residential Instability							
	17. Environmental Health							
	18. Home Safety							
Health & Human	19. Health Services Utilization							
	20. Well-Child Care – Infancy and Toddlerhood							
	21. Use of Other Community Services							

Global Protective Factor	**Y?**	**Comments**
Keeps NFP Appointments/ Engaged in NFP Program		
Has Psychological Resources		
Protects Health		
Demonstrates Commitment to Protect Child		
Social Support (Partner, Family, Friends)		
Spirituality		

v7.07.2021

STAR Framework Coding Sheet

Nurse-Family Partnership
Helping First-Time Parents Succeed®

Site Name:		Client Name:	
Nurse Home Visitor ID:		Nurse Home Visitor Name:	
Client ID	Client DOB		STAR page # _____

Stage of Change Codes		
PC = Pre-Contemplation/ Not ready to change	P = Preparation / Getting ready to change	M = Maintenance / Working toward goals
C = Contemplation/ Thinking of changing	A = Action / Making small changes	SE = Self-Empowerment / Keeping it up

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk/needs	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
	_____ (write in category)							
	_____ (write in category)							
	_____ (write in category)							

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STAR Framework Coding Sheet

				Behavioral Strengths				
				(Y/N)	(Code)	(Y/N)	(Y/N)	
	Measurement Category	**Date**	**Risk Level** NA, 0, 1, 2	Understands risk	Stage of Change	Friends/family support goals	Uses services to meet goals	**Comments** Strengths | Risks
	_____ (write in category)							
	_____ (write in category)							
	_____ (write in category)							

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STAR Framework Coding Sheet

Global Protective Factors	Y?	Comments
Keeps NFP Appointments/Engaged in NFP Program		
Has Psychological Resources		
Protects Health		
Demonstrates Commitment to Protect Child		
Social Support (Partner, Family, Friends)		
Spirituality		

v7.07.2021

Strengths and Risks (STAR) Framework

Tools and Assessments

Substance Use and Misuse Questionnaire

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 their 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

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to sleep or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Rapid **E**stimate of **A**dolescent **L**iteracy in **M**edicine **(REALM) Teen©**

Terry Davis, PhD · Joseph Bocchini, MD · Sandy Long, PhD · Michael Wolf, PhD

Patient Name/ Reading Level _____
Subject # _____ Date of Birth _____ Grade Completed _____

Date _____ Clinic_____ Examiner _____

List 1		List 2		List 3	
eye	**____**	**fever**	**_____**	**nutrition**	**_____**
pill	**____**	**pimple**	**_____**	**alcoholism**	**____**
fat	**____**	**virus**	**_____**	**antibiotic**	**_____**
skin	**____**	**calories**	**_____**	**complications**	**__**
throat	**____**	**allergy**	**_____**	**delinquency**	**___**
blood	**____**	**marijuana**	**_____**	**penicillin**	**_____**
weight	**____**	**pelvic**	**_____**	**puberty**	**_____**
stress	**____**	**asthma**	**_____**	**menstrual**	**_____**
death	**____**	**emergency**	**_____**	**pneumonia**	**____**
liquid	**____**	**infection**	**_____**	**constipation**	**____**
disease	**____**	**exercise**	**_____**	**diagnosis**	**_____**
drug	**____**	**medicine**	**_____**	**nausea**	**_____**
mouth	**____**	**violence**	**_____**	**acne**	**_____**
ounce	**____**	**prevention**	**_____**	**anemia**	**_____**
heart	**____**	**suicide**	**_____**	**hepatitis**	**_____**
risks	**____**	**depression**	**_____**	**adolescent**	**_____**
diet	**____**	**prescription**	**_____**	**bulimia**	**_____**
teaspoon	**____**	**abnormal**	**_____**	**fatigue**	**_____**
period	**____**	**injury**	**_____**	**anorexia**	**_____**
cancer	**____**	**ointment**	**_____**	**tetanus**	**_____**
stomach	**____**	**seizure**	**_____**	**bronchial**	**_____**
headache	**_____**	**diabetes**	**_____**	**obesity**	**_____**

Rapid **E**stimate of **A**dolescent **L**iteracy in **M**edicine

(REALM-Teen)

Administration Manual

Terry Davis, PhD
Joseph Bocchini, MD
Robert Byrd, MD
Sandy Long, PhD
Michael Wolf, PhD

Table of Contents

Background

Low literacy is a prevalent social problem in the United States.[1,2] Almost half (43%) of American adults have basic or below-basic literacy levels according to the 2003 National Assessment of Adult Literacy, and 66 percent of high school students have similarly low levels on the National Assessment of Educational Progress.

Identifying low literacy in adolescents could be helpful to health professionals, as a screen for academic problems, a potential marker for health risk behaviors, and to know when to tailor health information. We know that low literacy is a risk factor for school failure and school drop out, [3, 4] both of which are associated with increased health risk behaviors in teens.[13 - 16]

Approximately one quarter of American adolescents are reading well below grade level.[4] These students do not have the reading skills to comprehend information found in their text books and are at risk for falling further behind and eventually dropping out of school. Currently, almost one third of ninth grade students (one half among minority students) do not finish high school.[17]

The authors have developed a brief literacy screening test for use with adolescents in health care settings. The test is modeled on the Rapid Estimate of Adult Literacy in Medicine (REALM),[20, 23, 24] the most commonly cited literacy test in adult health care settings. This test will allow health professionals to screen youth in grades 6-12 for below-grade reading.

Pertinent Definitions

Literacy in the United States is defined as "an individual's ability to read, write and speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals and develop one's knowledge and potential."

Health Literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Word Recognition Tests are tests in which an individual reads aloud from a list of individual words. These tests measure an individual's ability to pronounce words in ascending order of difficulty. Though not designed to measure comprehension, word recognition tests are useful predictors of general reading ability in English. If an individual has difficulty pronouncing words in isolation, which is a beginning level reading skill, he or she is likely to have difficulty with comprehension (a higher order skill).

Examples: REALM-Teen, Slossan Oral Reading Test-Revised (SORT-R), Wide Range Achievement Test-Third Edition (WRAT-3) Reading subtest, Peabody Individual Achievement Test-Revised (PIAT-R) Reading Recognition Subtest.

Reading Comprehension Tests measure an individual's ability to derive meaning from printed words. Comprehension can focus on an individual's understanding of a word, phrase, sentence, longer passage or an individual's interpretation of the information. Most reading comprehension tests assess the individual's ability to understand text written at different levels of difficulty.

Examples: Comprehension Subtest, Cloze Technique, Test of Functional Health Literacy in Adults (TOFHLA), PIAT-R Comprehensive Subtest.

Description of the Test

The Rapid Estimate of Adolescent Literacy or REALM-Teen is a valid, reliable, easy-to-administer tool that will allow health professionals to screen youth in grades 6-12 for below-grade reading.

The REALM-Teen can be administered and scored in under three minutes with minimal training, and is strongly correlated with standardized literacy assessments such as the SORT-R and the WRAT-3 tests.

The REALM-Teen is a reading recognition instrument, modeled after the Rapid Estimate of Adult Literacy in Medicine (REALM), the most commonly used tool to screen adults for low literacy in health care settings. The REALM-Teen is a reading recognition instrument which measures an individual's ability to pronounce words in ascending order of difficulty. All test words are commonly used adolescent health terms.

This one-page instrument consisting of 66 health words arranged in increasing order of difficulty on three widely spaced columns on lime green paper. Adolescents taking the REALM-Teen are asked to say the words out loud beginning with the first word in the left-hand column.

All words on the REALM-Teen come from words used in Academy of Pediatrics patient education materials for adolescents.

Dictionary pronunciation is the scoring standard (A dictionary is the recognized guide for people seeking help in pronouncing unfamiliar words, regardless of their culture or the region of the country in which they reside). An adolescent's raw score is the total number of correctly pronounced words.

Test scores, expressed as grade-level estimates, can be compared to a patient's current grade level to determine reading skills below grade level. For instance, an adolescent patient enrolled in the 9th grade who scores a 54 on the REALM-Teen (6th-7th grade level) would be assessed as reading below grade level. In this manner, this tool can aid in alerting clinicians and researchers to possible reading and academic difficulties and may serve to identify teens at greater risk for engaging in negative health behaviors.

The REALM-Teen is a *word recognition* test-not a reading comprehension instrument. Adolescents are asked to de-code or pronounce words.

Design and Development

We recruited adolescents for one-time, in-person interviews from a pediatric private practice primary care clinic, five middle schools, three high schools, and two summer programs in Louisiana and in North Carolina. A total of 1, 533 adolescents participated in structured interviews that included a general demographic survey.

Validity

Criterion validity was based on correlations between REALM-Teen raw scores and the raw scores of the most current versions of two standardized reading tests commonly administered to adolescents, the Slosson Oral Reading Test-Revised (SORT-R) [22] and the Wide Range Achievement Test-3 (WRAT-3).[21]

Table 1

Correlation of REALM with SORT and WRAT-3		
	SORT	**WRAT-3**
Correlation Coefficient	**.93**	**.83**
P Value	**p<.0001**	**p<.0001**

Reliability

Test-retest reliability was determined by calculating the Pearson r correlation between scores on the REALM-Teen at baseline and at one-week follow-up.

Table 2

Reliability
Test-Retest
(n=100)
.98

When to use the REALM-Teen

Before deciding to screen adolescents for below-grade level literacy, health professionals need to consider

- where patients will be tested.
- who will do the testing, and how they will be trained.
- how results will be used and documented. *Note: For some adolescents, particularly those with low literacy, test-taking may be an unpleasant experience in school; being given a literacy test in a health care setting, no matter how it is presented, can be a stressful.*

Previous studies in adult medicine found patients with low literacy are often ashamed and try to hide their problem. Clinicians and research assistants must be sensitive to these possibilities in screening for low literacy in adolescents.

REALM-Teen Administration

Testing Materials Needed:

- Laminated patient word list.
- Examiner record form.
- Clipboard.
- Pencil.

Personal Data Lines:

***Patient Name/Subject #*:** Record the patient's name or assigned subject number.

***Race*:** Record the patient's race.

***Gender*:** Record the patient's gender.

***Age*:** Record the patient's age.

***Grade*:** Record current grade of the patient.

***Date*:** Record the date of administration.

***Site*:** Record the location.

***Examiner*:** Record the examiner's name.

Administration and Scoring:

1. Give the patient the laminated copy of the REALM-Teen word list. Attach the examiner record form to the clipboard. Hold the clipboard at an angle such that the patient is not distracted by your scoring procedure.

In your own words, introduce the REALM-Teen to the patient:

In a research setting of for research purposes:

- *"We are trying to get an idea of what health words people your age are familiar with."*
- *"What I need you to do is say each of the words out loud to me starting here* [point to first word with pencil]*."*
- *"Say all the words you know. If you come to a word you don't know, you can sound it out or just skip it and go on."*
- If the patient stops, say, *"Look down this list,* [point] *are there any other words you recognize?"*

In a clinical setting:

- *"Sometimes in this office, we may use medical words that patients aren't familiar with."*
- *"We would like you to take a look at this list of words to help us get an idea of what medical words you are familiar with. This will help us know what kinds of patient education to give you."*
- *"Start with the first word,* [point to first word with pencil] *please say all of the words you know."*
- *"If you come to a word you do not know, you can sound it out or just skip it and go on."* If patient stops do as above.

> *Special Note: Do not use the words "read" and "test" when introducing and administering the REALM-Teen. These words may make patients feel uncomfortable and unwilling to participate.
>
> *"Please say these words for me."*

2. If the patient takes more than 5 seconds on a word, encourage the patient to move along saying, "*Let's try the next word.*"

If the patient begins to miss every word of appears to be struggling or frustrated, tell the patient,

"*Look down at the list, are there any other words on this list that you recognize?*"

3. Count as an error any word that is not attempted or mispronounced (see "Special Considerations" for pronunciation/scoring guidelines).

4. Scoring options:

   a. Place a check mark (✓) in the box next to each word the patient pronounces correctly.
   OR
   b. Place an X in the box next to each word the patient does not attempt or mispronounces.

Scoring should be strict, but take into consideration any problems which could be related to dialect or articulation difficulties. Use the dictionary if in doubt. Count as correct any self-corrected word.

5. Count the number of correct words in each list to give you the "Raw Score". Match this score with its grade equivalent fond in Table 3.

Special Considerations for Administration and Scoring:

Examiner Sensitivity:

Many low literate patients will attempt to hide their deficiency. Ensure that you approach each patient with respect and compassion. You may need to provide encouragement and reassurance.

A positive, respectful attitude is essential for all examiners. (Remember, many people with low literacy feel ashamed.) Be sensitive.

Pronunciation:

Dictionary pronunciation is the scoring standard.

Count a word as correct if the word is pronounced correctly and no additions or deletions have been made to the beginning or ending of the word. For example: A patient who says "alcohol" would not receive credit for the word "alcoholism"; "eyes" would not receive credit for the word "eye"; "nervous" and "nerve" would not receive credit for "nerves". Words pronounced with a dialect or accent should be counted as correct provided there are no additions or deletions to the word. Particular attention should be paid for patients who use English as a second language.

Comprehension and Interpretation of Words:

Reading recognition does not imply comprehension or proper interpretation. The REALM-Teen is a reading-recognition test. If a patient indicates that he/she knows the meaning of the word but is unable to say it, no credit is given. Persons interested in assessing patient comprehension are referred to the PIAT Comprehensive Subtest.

Patients Who Speak Another Language:

The REALM-Teen is a reading-recognition test and is a reliable screening instrument to assess literacy in English. Reading-recognition is not useful in assessing literacy in other languages. For example, Spanish literacy is affected by the nature of the Spanish language. Spanish has regular phoneme-grapheme correspondence, meaning that one sound is usually represented by one letter and vice versa. Therefore, compared to English, it is relatively easy to sound out and pronounce words in Spanish if one can recognize letters, making it relatively easy for low-level readers to score high on word recognition tests. The REALM-Teen has not and cannot be translated into other languages for valid administration. Persons wishing to assess Spanish-speaking patients are referred to the Test of Functional Health Literacy in Adults-Spanish (TOFHLA-S). However, it has not been tested with adolescents.

Score Interpretation

Table 3

Raw Score	Grade Range Equivalent	Literacy Skills
0-37	3rd Grade and Below	These adolescents will have a 5 fold quarter likelihood of reading below grade level. They are reading below grade level and may be at risk of school failure.
38-44	4th to 5th Grade	
45-58	6th to 7th Grade	Will struggle with most patient education materials; may have skills to pass GED.
59-62	8th to 9th Grade	
63-66	10th Grade and Above	Will be able to read most patient education materials.

Ordering the REALM-Teen

Additional copies of the REALM-Teen and supplies can be obtained through the Health Education and Literacy office of the Louisiana State University Health Sciences Center-Shreveport. Contact: Terry Davis, PhD, Department of Pediatrics, P.O. Box 33932, Shreveport, LA 71130; (318) 675-5813; tdavis1@lsuhsc.edu.

Other Literacy Instruments Used in Health Care Settings

Word Recognition:

Slossan Oral Reading Test-Revised (SORT-R)
Slossan Educational Publications, Inc.
P.O. Box 280
East Aurora, NY 14052
1-800-828-4800; Fax: 1-800-655-3840

Wide Range Achievement-Third Edition (WRAT-3)
Jastak Associates, Inc.
P.O. Box 3410
Wilmington, DE 19804
1-800-221-9728

Peabody Individual Achievement Test-Revised (PIAT-R)
American Guidance Service, Inc.
P.O. Box 99
Circle Pines, MN 55014
612-786-4343

Health Comprehension (English and Spanish):

Test of Functional Health Literacy in Adults (TOFHLA) and Spanish-TOFHLA (S-TOFHLA)
Peppercorn Books and Press
PO Box 693
Snow Camp, NC 27349
877-574-1634

Instrument for Diagnosis of Reading (Instrumento Para Diagnosticar Lecturas)

Kendall Hunt Publications
Dubuque, I

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

Life History Calendar

Birth date:

Age:	1	2	3	4	5	6	7	8	9	10	11	12
Living with mother or step-mother												
Living with father or step-father												
Living with grandparents												
Living with siblings												
Other living arrangements (e.g. friends, foster parents) 1. 2. 3.												
Living with spouse or partner												
Housing (indicate any moves)												
School												
Working												

Life History Calendar

Age:	13	14	15	16	17	18	19	20	21	22	23	24
Living with mother or step-mother												
Living with father or step-father												
Living with grandparents												
Living with siblings												
Other living arrangements (e.g. friends, foster parents) 1. 2. 3.												
Living with spouse or partner												
Housing (indicate any moves)												
School												
Working												

Life History Calendar

Age:												
Living with mother or step-mother												
Living with father or step-father												
Living with grandparents												
Living with siblings												
Other living arrangements (e.g. friends, foster parents) 1. 2. 3.												
Living with spouse or partner												
Housing (indicate any moves)												
School												
Working												

Stages of Change

Not Ready to Make A Change	Thinking About Making a Change	Getting Ready to Make a Change	Making the Change	Keeping It Up	Feeling Great!
Pre-Contemplation	**Contemplation**	**Preparation**	**Action**	**Maintenance**	**Self-Empowerment**
Unaware or unconcerned about risks. Unable to see link between behavior and consequences. Unwilling to change. Demoralized. More cons, few pros for making a change.	Does not fully understand risks. Aware of problem but on the fence. Ambivalent. Trying to understand causes and cures of the problem. Pros and cons about equal.	Committed to taking action. More pros for change than cons. Focus less on problem and more on solution. Asking for support for change. Making plans.	Beginning new behaviors, stopping old ones or changing frequency, duration or intensity of a behavior. Commitment of time and energy for change. Some slips or lapses common.	Experiencing long lasting change and more confident of ability to sustain behavior. Should be aware of and continuing to avoid triggers. Some behaviors such as alcoholism may require a lifetime of maintenance.	Achieved their goal! No desire to return to old behavior. New identity: Experience self as a person without the problem or behavior. (“I am a non-smoker.”)
Tips for Providing Nursing Support in Each Stage					
Join with client; walk in her shoes & be curious. Use reflective listening. Give information and raise awareness. Build self-confidence and self-esteem. **Don’t give advice.** Listen for change talk.	Explore the ambivalence & consider pros/cons. Assess values, consider past success at change, and needs to be able to overcome the “cons.” Help client see possibilities. Link behavior to positive social outcomes. **Don’t give advice.**	Establish a SMART plan. Remove triggers. Plan countering behaviors. Engage support system. Use scaling questions to assess commitment and readiness for change. Prepare for lapses. Use Ask-Provide-Ask to share information.	Check in frequently & provide feedback, use visit form. Set up written record. Focus on successes. Manage triggers. Process inevitable slips: empathize, normalize, consider what was learned both by the positive efforts and the slip or lapse.	Continue to monitor. Keep awareness of why change was made. Process a relapse (when client goes back to old behavior **and** earlier stage of change). Consider triggers, coping, motivation, barriers, commitment. (Did client say one thing and mean another?)	Provide efficacy information for future change. (“Remember when you were so successful at…How can we use some of what you learned to…”) Raise consciousness in periods of stress so they avoid triggers, etc. Share positive emotions; link them to her heart’s desire.