Louisville Kentucky
Plan of Safe Care

Deliverables
June 30, 2017

Prepared By:
Centerstone Kentucky
Pregnant & Parenting Women Division
2 Question Brief Screen
All Pregnant Women
Every Trimester & Delivery

Positive

Re-screen every trimester & at delivery

Screen with ASSIST
AUDIT or DAST (as indicated)

Positive

Warm Referral &
Assertive Linkage for
Assessment
(Centerstone Mobile Assessment)

Labor/Delivery
Post Partum or NICU
+ Toxicology

POS C
Risk Assessment
Release of Information
Assignment to Indicated Level of CM
- SUD Provider
- OTP Provider
- Hospital Staff
- DCBS
- MCO

Low Risk
Contact
Weekly 0-3 mos.
Monthly 4-12 mos.
Phone 0-6 mos.
Electronic or mail
7-12 mos.

High Risk
Contact
Weekly 0-12 mos.
2x month – 13-18 mos.
F-T-F Contact with capacity for home visits 0 – 12 mos.
Phone 13 – 18 mos.

Medium Risk
Contact
Weekly 0-3 mos.
2x month – 4-12 mos.
Monthly 13 – 18 mos
Phone Contact (voice or text) w/capacity for F-T-F

Notification
To DCBS

Louisville – KY
Plan of Safe Care
System Flow Chart
Louisville Kentucky Plan of Safe Care
Guiding Principles

- Interagency across health and social service agencies based on the results of a comprehensive, multidisciplinary assessment that is coordinated across agencies to address the infant’s and parents’ physical, social-emotional health and safety needs.
- Family-focused to meet the needs of each family member as well as the overall family functioning and well-being by building on each family members’ strengths, challenges and parenting capacity for the mother and father.
- Assesses immediate safety factors and risk of future maltreatment, including:
  - Safety: Deciding if a child is in danger of immediate maltreatment (Decision to remove)
  - Risk: Determining the possibility that a child may be maltreated in the future (Decision to open a child welfare investigation case)
  - Strengths: Assessing the family’s qualities and resources available to care for the child
  - Protective Capacities: Determining if the parent and family have the ability or support system available to provide an environment that keeps children free from harm
- Completed when possible prior to the birth of the infant to facilitate engagement of parent(s), and communication among providers; or, when not possible, prior to discharge of the infant from the hospital.
- Facilitated referrals to substance use disorder treatment and other health and social supports to ensure family members are able to participate in services.
- Specifies with whom the child will be discharged and ensures protective capacity of the parents and/or other family members are sufficient to care for the infant.
- Includes provisions for frequency and the entity responsible for follow-up with families including providing home visiting services when appropriate.
- Specifies the details of referrals of the child to developmental intervention.
- Is easily accessible to relevant agencies with the appropriate privacy safeguard.

Approved L-KY POSC Steering Committee 6/22/17
Louisville Kentucky Plan of Safe Care Collaborative

MEMORANDUM OF UNDERSTANDING (MOU)

This Memorandum of Understanding, while not a legally binding document, does indicate a voluntary agreement to assist in the implementation plans of the Louisville Kentucky Plan of Safe Care Collaborative. This agreement is between Centerstone KY and ________________________________.

The Louisville Kentucky Plan of Safe Care Collaborative includes the involvement of medical providers, hospitals, substance use disorder and opioid treatment providers, state agency representatives and community based agencies with an interest and commitment towards supporting the overarching goal of protecting infants who are affected by prenatal substance use and supporting their mothers and families in their capacity to provide care for them following hospital discharge. Organizations and individuals participating in the collaborative are making the commitment to work in partnership towards the achievement of Key Best Practices and guidance as stated in Attachment 1.

1) This MOU will remain in place for one year from the date of signature.

2) The lead agency for this collaboration is Centerstone KY. As lead agency Centerstone is responsible for scheduling meetings, determining location, disseminating meeting minutes and any deliverables developed. As lead agency Centerstone KY is responsible for fulfilling contractual obligations to DBHDID.

3) Partnering agencies entering into this MOU agree to designate a representative to participate in planning activities and to in good faith work towards the Key Best Practices and accompanying guidance (Attachment 1). Partnering agencies make a commitment toward cross disciplinary and cross agency communication and collaboration specific to the development and ongoing maintenance of a Plan of Safe Care for substance effected infants.

4) Either party, for any reason by giving 30 days written notice, can terminate this Memorandum of Understanding.

Centerstone KY Signature

Title

Date

Partner Signature

Title

Date

Approved L-KY POSC Steering Committee 6/22/17
Louisville Kentucky Plan of Safe Care Collaborative

Key Best Practices

1. Early identification, screening and engagement of pregnant women who are using substances. This includes universal screening for all pregnant women, ideally every trimester.
2. Outreach and engagement to ensure women receive prenatal care and are connected to treatment.
3. Appropriate treatment for pregnant women, including timely access to treatment; access to comprehensive medication assisted treatment.
4. Guidelines and standards for treatment that include preparing mothers for the birth of their infant who may experience withdrawal syndrome and potential involvement with Child Protective Services (CPS); and beginning the development of a plan of safe care prior to the birth event.
5. Consistent hospital policies for screening pregnant women, postpartum women and their infants; if universal screening is not feasible, then clearly defined, non-biased criteria for who is screened.
6. Hospital standards and practices for care of the infant and mother that promote infant/mother attachment and bonding (e.g., breastfeeding, rooming in, skin-to-skin contact).
7. Consistent hospital notifications to CPS, including:
8. Developing a set of questions and responses that will help CPS hotline workers assess risk and protective factors and safety concerns for the infant and mother;
9. Comprehensive assessments of the infant’s physical health and the mother’s physical and social/emotional health and parenting capacity, which will be used to develop a thorough discharge plan and inform a multi-disciplinary plan of safe care.
10. Memoranda of Agreement that allow for timely information sharing and monitoring infants and families across multiple systems.
11. Ongoing care plans for mothers and their infants that include home visitation, early intervention services and recovery supports;
12. Plans of safe care that are of sufficient duration to ensure a greater likelihood of family stability and well-being, with
13. Sufficient monitoring of maternal depression and anxiety, continuing recovery and parental capacity to meet her infant’s needs as well as her own.
Our overall goal is to simultaneously protect infants who are affected by prenatal substance use and to support their mothers and families in their capacity to provide care for them following hospital discharge.

This document is designed to provide guidance to providers participating in the Louisville Kentucky Plan of Safe Care Collaborative (L-KY POSC). The guidance in this document supports the practices organizations participating in the POSC are agreeing to work towards when signing the L-KY POSC Memorandum of Understanding.

Point of Intervention - Prenatal

All pregnant women are universally screened utilizing an evidence based screening tool during each trimester of pregnancy and at delivery.

- Utilize two (2) question brief screener, if positive conduct SBIRT or request mobile SBIRT team assistance through Centerstone KY
- Access to SBIRT web based tools, training and information:
- Facilitate mobile peer recovery coach support for assertive “warm” referral and linkage to assessment

Utilize guidelines and protocols to assure:

- Women provide informed consent for SBIRT or any components of SBIRT
- Women identified as using illicit opiates or prescription opiates for non medical purposes receive assertive linkage and referral to a SUD provider that ensures access to evidence based treatment including MAT with robust psychosocial clinical services
- Inclusion of POSC Collaborative Release of Information to support coordinated multi-disciplinary service provision
- All pregnant women receive education regarding NAS/NOWS
- Women have an opportunity to develop a birth plan including options for pain management during labor and delivery
- Women with a history of SUD receive education about non-opiate options for pain management during labor and delivery
- DCBS referral if a pregnant woman has other children and safety concerns exist
Information about and opportunity for referral to HANDS for all pregnant women

Outreach and Education is available to increase number of providers providing universal screening for substance use among pregnant women and referring women for needed services. Strategies may include:

- Grand rounds format training for physicians with CME
- Downloadable patient education brochure regarding perinatal substance use, NAS/NOWS available to providers
- Promote importance of early universal screening, identification and referral through presentations
- Utilization of social media to promote services for pregnant and parenting women benefits of seeking treatment for SUD during pregnancy, referral and admission process
- Impact of stigma in health care upon patients with substance use disorders
- Training focused on appropriate evidence based SUD treatment for pregnant women including the use of MAT

Responsive and collaborative process for further SUD assessment

- Following a positive screening medical provider staff have the option of contacting Centerstone KY (after completing release of information) to connect with the mobile Peer Recovery Coach who can come to an OB provider’s office, hospital post partum unit or NICU to conduct a more thorough screening or assessment. If indicated and desired the Peer Recovery Coach will facilitate the process for admission to SUD treatment
- Following admission SUD treatment providers can initiate wrap-around services including targeted intensive case management, Peer Recovery coaching and development of the POSC
- SUD provider case manager or peer recovery coach will continue to coordinate with medical providers and other partners to ensure POSC is facilitated

Delivering hospitals have standardized and objective protocols in place for:

- Screening all women for substance exposure at delivery (see screening tool grid)
- Indications for the use of toxicology testing (mothers and/or infants)
- Notification of screening and/or toxicology results to mother including reporting requirements
- Completion of the Louisville KY POSC Risk Assessment and development of POSC for mothers and substance affected infants who are not participating in SUD treatment services (and do not want or have indicated need for referral)
- Notification of DCBS of all substance affected infants per CAPTA requirements
- Establish pediatric medical home (preference for providers with experience treating substance affected infants)
- Ensuring a case manager is facilitating POSC
- Assessing and documenting parent child interaction and indications of maternal bonding

Support is provided for mothers and infants that promotes maternal bonding while maintaining the medical and social/emotional needs of the infant as priority
- Pregnant women and new mothers are educated about what to anticipate if their infant has NAS and how to manage symptoms using effective strategies for calming babies that are experiencing withdrawal
- Post partum and NICU staff provide supportive coaching to mothers in a manner that optimizes opportunities for mothers to experience success in caring for their infants while developing a sense of competence
- Mothers receive education about NAS severity scoring system and are included in assessment and scoring to assure they understand how scores are determined
- Hospital staff and SUD treatment program staff know the criteria for breastfeeding practices for women on MAT and routinely discuss it with pregnant women prior to delivery
- Mothers have access to lactation consultation during and after infant’s hospital stay
- SUD treatment programs are encouraged to support mothers in being able to care for their infants (including provisions for breastfeeding on an infant driven schedule) during all phases of treatment programming at both residential and outpatient levels of care
- New mothers receive education about Safe Sleep practices and resources
- POSC provides assurance that new mothers have equipment necessary to provide safe sleep environment for infant upon discharge

POSC Collaborative Release of Information is in place to facilitate:
- Development of new POSC or update of existing POSC includes mother, her medical provider (or designee), infant’s medical provider, SUD provider, MCO Case Manager, DCBS staff, START, HANDS home visitor and others as appropriate
- Mother’s have a clear understanding of infant’s needs and discharge plans
- Ensure clear and consistent communication across providers keeping mother and infant’s needs as priority
- Ensure developmental screening at regular intervals utilizing a reliable and valid screening instrument
- Referral to HANDS for intensive home visiting to include parenting education, regular developmental screening, depression screening and IPV screening

Health care, DCBS, SUD, OTP and community support staff have received training on addiction and impacts of addiction upon maternal neurobiology specific to parenting and bonding
Support services, medical care and SUD treatment are coordinated following birth and into infant’s first year

- Providers work together to coordinate ongoing medical support for women and their infants, including supporting the mother in planning for her own SUD treatment needs (including MAT)
- Medical care staff, DCBS and SUD treatment program staff routinely talk with each mother about her plans for continuing MAT post delivery. Should a mother choose not to continue MAT SUD treatment program staff take the lead in developing an appropriate treatment and continuing care plan with the mother to support her continuing recovery.
- Specifics of mother’s treatment and continuing care plans are shared with all providers who are supporting the family

Substance Use Disorder and Opioid Treatment Provider Considerations

SUD and OTPs:

- Assure priority access to treatment for pregnant women
- Use evidence based tools to determine appropriate care
- Use evidence based practices to deliver clinical services
- Support referrals to MAT as indicated and assure access to robust psychosocial clinical services for those receiving MAT
- Provide services in a manner that supports maternal bonding and secure attachment for infants
- Provide education, support, coordination, assertive linkage and referral for contraception to be in place prior to delivery

Louisville KY POSC Collaborative Release of Information is routinely utilized to:

- Support coordination of care with other involved service and medical care providers
- Plan jointly to support pregnant women to prepare for delivery, pain management and potential NAS
- Work jointly with other providers to educate and support women about potential DCBS involvement after delivery, CAPTA requirements
- Work jointly to support mothers and address concerns regarding CAPTA requirements
- Provide DCBS with information regarding mothers participation in and status with SUD treatment including recommendations for MAT
- Support coordination among treatment providers to ensure mothers are able to receive robust psychosocial clinical services in conjunction with MAT
- Share results of toxicology testing with woman’s medical team
- Share changes in treatment participation with woman’s medical team

**Plan of Safe Care Specific Considerations**

Ongoing Plans of Safe Care for mothers and their infants are developed collaboratively with the goal of ensuring the supports needed to ensure a greater likelihood of family stability and reduce incidence of out of home placement

- Louisville Kentucky POSC Collaborative Risk Assessment is completed within 5 business days of identification of substance effected infant or in the case of a pregnant woman indications for potential of substance exposed infant
- Entity for provision of primary case management is determined based upon level of risk indicated in assessment
- Primary entity for provision of case management is responsible for development of Plan of Safe Care for women identified prenatally
- Delivering hospital is responsible for development of Plan of Safe Care for women and infants identified at time of delivery
- In each instance Plan of Safe Care is developed with input from the mother and community partners involved in supporting the mother
- Multidisciplinary systems have a role in shaping the plan of safe care
- Ongoing Plan of Safe Care is coordinated across systems
- Includes assurance for regular and ongoing developmental screening, referral to early First Steps and routine depression screening along with follow-up services as indicated

Approved L-KY POSC Steering Committee 6/22/17
Louisville Kentucky Plan of Safe Care Collaborative

Screening & Management Guide for Substance Use During Pregnancy

Ask-Screen

- Ask all pregnant and postpartum women at the first visit, at every trimester and at delivery. Verbal screening is the standard of care.
- Ask about use/abuse prior to pregnancy recognition as well as current use.
- Develop an office protocol to ensure that all women are screened in a respectful and non-judgmental manner. Normalize the process and model your approach (see practice preparation tips). Explain why all women are asked about use/abuse.
- Make informed consent for screening standard practice.
- Protect confidentiality.
- Remember, how screening is handled impacts the pregnant woman’s use of prenatal care.
- Provide information and encourage permission for referral to HANDS (all prenatals—not specific to SUD).

Assess-Intervene

- Provide feedback on screen results (see interview tips/scripts).
  - Positive screen: How the use/abuse affects her health, pregnancy, and life.
  - Readiness to change behavior/accept treatment: “Would you like help to stop?”
  - Signs of acute withdrawal or intoxication.
- Assess and validate women’s reaction and discuss her feelings and thoughts.
- Assess her ability to change.
- Level of risk – use/abuse/addiction. Screening alone does not diagnose a substance abuse disorder. Naloxone to diagnose opioid dependence is contraindicated in pregnancy.
- If acute alcohol or sedative withdrawal, refer to inpatient management. If opioid dependence arrange for “warm” referral and assertive linkage depending on comorbidities and presence of withdrawal.
- Check record in KASPER.

Advise – Everyone, even women who deny use/abuse

- Ask what she knows about effect of substance on pregnancy/newborn.
- Express concern about level of use (if appropriate) “I know you want a healthy pregnancy and baby, it’s important you don’t use any___while pregnant because…”
- Share medical advice related to use/abuse and impact on pregnancy and outcome. Advise all women, even non-users.
- Advise to stop all use. If physically dependent, refer for appropriate resources.
to stop safely (see above).
“I’m glad you let me know you’ve using____ because it may harm your baby.”

Assist and Arrange
• Offer help based on her readiness to change. “**We both have the same goals, healthy pregnancy and baby.**” Ask what she will do and agree on a plan.
• Praise all efforts to change.
• Arrange for “warm” referral and assertive linkage for assessment to specialty SUD treatment
• Complete Louisville Kentucky Plan of Safe Care Risk Assessment
• Determine indicated level of case management per POSC

• Obtain consent/release for coordination with SUD treatment providers.
• Provide overdose education and information on where to obtain Naloxone kits if using opioids.

Manage Pregnancy Medical Issues
• Screen for untreated medical problems, injuries, and infections as appropriate.
• Screen for mental illness and interpersonal violence and refer.
• Routine blood work and labs plus hepatitis, TB, STI, and HIV.
• For opiate users, confirm enrollment or refer to methadone or buprenorphine maintenance.
• Schedule random urine tox screens to monitor how the woman is doing. Use positive screens as opportunity to talk (if patient is in SUD Tx coordinate with provider).
• Schedule more frequent visits to identify additional medical and psychosocial problems early.
• Monitor fetal growth, development, and well-being based on current use or abstinence. Monitor comorbidities/pregnancy complications.
• Discuss possible effects on the newborn.
• Discuss birth plan including pain management
• Discuss contraceptive methods and make a plan. Consider LARC as first line option. Insert immediate postpartum if possible.
• Obtain consent for tubal ligation after delivery if the woman chooses this method.
• Discuss breastfeeding and alcohol and drug use issues.
• Coordinate with addiction and mental health treatment providers.
• Coordinate with SUD Tx provider to ensure education regarding NAS has been provided and mother is prepared regarding DCBS notification.

Manage Intrapartum
• Complete history and physical exam.
• Repeat hepatitis screen, serologic test for syphilis, and HIV rapid test.
• Repeat urine toxicology.
• Alert pediatric and nursing staff.
• Alert social services if necessary.
• Continue methadone or buprenorphine on schedule – consider split dosing.
• Determine method of delivery depending on obstetrical indicators.
• Pain management: assure pain will be managed. Maximize and schedule non-opioid analgesia, and provide adequate opioid analgesia when indicated. Anticipate opioid-dependent women will require higher doses of opioid pain medication but for the same duration. Epidural anesthesia can be used per hospital protocol.

**Post-partum**

• Encourage continuation in a therapeutic drug treatment program; coordinate with programs.
• Encourage and provide appropriate contraceptive method: consider LARC as first line option and consider starting before discharge.
• Close follow up for pain management.
• Coordinate with treatment – may need dose adjustment.
• Consider more frequent postpartum visits.
• Support breastfeeding as appropriate. Breastfeeding is typically recommended in methadone or buprenorphine maintenance but is contraindicated if the woman is HIV positive or using illegal drugs (including marijuana).
• Coordinate with social services for a safe discharge plan.

### Screening Tools*

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description/Time it takes to complete</th>
<th>Sensitivity</th>
<th>Screens for</th>
<th>Validation</th>
<th>Training Available</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUDIT-C</strong></td>
<td>3 questions/ approximately 1-2 mins <a href="http://www.integration.samhsa.gov/images/res/tool_auditc.pdf">http://www.integration.samhsa.gov/images/res/tool_auditc.pdf</a></td>
<td>67%-95% sensitivity 85% specificity Positive predictive value 92%-100%</td>
<td>EtOH use</td>
<td>For prenatal patients Sensitivity varies widely in different studies</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td><strong>CRAFFT</strong></td>
<td>Validated for use in patients aged 15-24 6 questions/ approximately 2-3 mins <a href="http://ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf">http://ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf</a></td>
<td>76% sensitivity 94% specificity</td>
<td>EtOH and drug use</td>
<td>Recently for prenatal patients</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td><strong>4P’s Plus</strong></td>
<td>5 questions with follow-up if positive; 2-5 mins Parents, partners, past, present, pregnancy <a href="http://aja.berkeley.edu/media/pdf/chasnoff_4ps.pdf">http://aja.berkeley.edu/media/pdf/chasnoff_4ps.pdf</a></td>
<td>87% sensitivity 76% specificity</td>
<td>All substance</td>
<td>For prenatal patients</td>
<td>Yes</td>
<td>Requires permission for use</td>
</tr>
<tr>
<td><strong>Substance Use Risk Profile Pregnancy Scale</strong></td>
<td>3 questions/approximately 2 mins <a href="http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/SubstanceUseRiskProfile.pdf">http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/SubstanceUseRiskProfile.pdf</a></td>
<td>1% sensitivity 98% specificity</td>
<td>EtOH and THC</td>
<td>Recently developed Specifically for prenatal patients</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td><strong>T-ACE</strong></td>
<td>4 questions/ approximately 1-2 mins <a href="http://www.mirecc.va.gov/visn22/T-ACE_alcohol_screen.pdf">http://www.mirecc.va.gov/visn22/T-ACE_alcohol_screen.pdf</a></td>
<td>69%-88% sensitivity 1%-89% specificity</td>
<td>EtOH only – for heavy use</td>
<td>For prenatal patients</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td><strong>TICS</strong></td>
<td>2 questions/ &lt;1 min <a href="http://www.mirecc.va.gov/visn22/TICS.pdf">http://www.mirecc.va.gov/visn22/TICS.pdf</a></td>
<td>80% sensitivity 80% specificity Negative predictive value 92.7%</td>
<td>EtOH and drug use</td>
<td>Easy to implement in primary care setting</td>
<td>No</td>
<td>Free</td>
</tr>
<tr>
<td><strong>TWEAK</strong></td>
<td>5 questions/approximately 1-2 mins <a href="http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/74_TWEAK.pdf">http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/74_TWEAK.pdf</a></td>
<td>71%-91% sensitivity 73%-83% specificity</td>
<td>EtOH only – effective for heavy use</td>
<td>For prenatal patients</td>
<td>No</td>
<td>Free</td>
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## Screening Tools*

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<tr>
<td>DAST-10</td>
<td>10 items/approximately 3-5 mins/self report <a href="http://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf">http://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf</a></td>
<td>41%-95% sensitive 68%-99% specific</td>
<td>drugs</td>
<td>Adults and adolescents in primary care. Not validated for prenatal patients.</td>
<td>No</td>
<td>Free</td>
</tr>
</tbody>
</table>

Comprehensive Process within which screening can be embedded is SBIRT. In Louisville OB providers and delivering hospitals may access SBIRT from trained Peer Recovery Coaches by contacting Centerstone KY. Providers wishing to build internal capacity for SBIRT can access web based training at no cost through SAMHSA funded web based tools, training and information:


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<th>Cost</th>
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</thead>
<tbody>
<tr>
<td>SBIRT</td>
<td>Screening, brief intervention, referral to treatment: 1-3 questions <a href="http://www.integration.samhsa.gov/clinical-practice/sbirt#why">http://www.integration.samhsa.gov/clinical-practice/sbirt#why</a> Select validated screen: SAMSHA recommends AUDIT, ASSIST or DAST-10</td>
<td>41%-95% sensitive 68%-99% specific</td>
<td>ETOH and drugs</td>
<td>Primary care and specialty</td>
<td>Webinar</td>
<td>Free</td>
</tr>
</tbody>
</table>

Abbreviations: ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test); AUDIT-C (Alcohol Use Disorders Identification Test); CRAFFT, T-ACE and TWEAK are acronyms based on their respective screening questions; TICS (Two-Item Conjoint Screening Tool); WHO (World Health Organization).


LOUISVILLE, KY
PLAN OF SAFE CARE COLLABORATIVE
RISK ASSESSMENT

MOTHER'S NAME __________________________ DOB:________________ RACE/ETHNICITY: ______
ADDRESS:______________________________________ ZIP:____________
INFANT'S NAME: ___________________________ DOB: _______________ DATE: __________________
MOTHER’s Primary Case Manager/Care Coordinator ________________________________________________
PHONE: __________ Agency_____________________________________________________________________
NAME OF HOSPITAL: _______________________ HOSPITAL RECORD #_____________________________
NAME OF INSURANCE CARRIER, MCO, or Coverage ______________________________________________
MCO Case manager _____________________________________________________________
NAME OF PERSON COMPLETING FORM: ________________________________________________________
TELEPHONE #____________ SIGNATURE:

LEVEL OF RISK: 1=Low Risk, 2= Intermediate, 3= High risk, 0= Unable to assess

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
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<th>EXPLANATION-MANDATORY FOR EACH FACTOR</th>
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<tbody>
<tr>
<td>1. INFANT WITHDRAWAL SYMPTOMS</td>
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<td>2. SPECIAL MEDICAL AND/OR PHYSICAL PROBLEMS</td>
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<tr>
<td>3. SPECIAL CARE NEEDS OF CHILD</td>
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<tr>
<td>4. DRUG/ALCOHOL USE</td>
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<tr>
<td>5. DRUG/ALCOHOL TREATMENT HISTORY</td>
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<tr>
<td>6. PREGNATAL CARE</td>
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<td>7. EMOTIONAL AND INTELLECTUAL ABILITIES</td>
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<tr>
<td>8. LEVEL OF COOPERATION</td>
<td></td>
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<tr>
<td>9. AWARENESS OF IMPACT OF DRUG/ALCOHOL USE ON FETUS/CHILD</td>
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<tr>
<td>10. RESPONSIVENESS TO INFANT, BONDING, PARENTING SKILLS</td>
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<tr>
<td>11. HISTORY OF FAMILY VIOLENCE</td>
<td></td>
<td>(INDICATE HOW INFORMATION WAS OBTAINED)</td>
</tr>
<tr>
<td>12. FATHER OR PARENT SUBSTITUTE IN HOME</td>
<td></td>
<td></td>
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<tr>
<td>13. STRENGTH OF FAMILY SUPPORT SYSTEMS</td>
<td></td>
<td></td>
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<tr>
<td>14. DRUG CRIMINAL ACTIVITY</td>
<td></td>
<td></td>
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<tr>
<td>15. SIBLINGS IN HOME AT RISK</td>
<td></td>
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<tr>
<td>16. KNOWN ENVIRONMENTAL RISK IN THE HOME</td>
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For Prenatal Omit: 1, 2, 3 and 10
Circle all that apply: Tox screen done Tox positive Type of drug(s)
Infant yes no yes no results not available ____________________________
Mother yes no yes no results not available ____________________________
Child Abuse Report Filed? yes no
Child Abuse Report Accepted? yes no If yes, attach to copy of 1116 P.C. form given to DCBS
Plan of Safe Care Developed? yes no

Overall Level of Risk/Intensity of Case Management Recommended – Low Medium High
*Primary Case Manager after discharge ____________________________ Phone: __________________

*Primary Case Manager responsible for ensuring Plan of Safe Care recommendations are followed-up upon and provides Case Management based upon level of risk (at a minimum) in accordance with Louisville POSC Case Management Collaborative Guidelines.

<table>
<thead>
<tr>
<th>Case Management Intensity Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>Contact Weekly Birth – 3 months</td>
</tr>
<tr>
<td>Contact Monthly 4-12 months</td>
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<tr>
<td>Contact by phone first 6 months</td>
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<tr>
<td>Contact by mail (electronic or paper) 7 – 12 months</td>
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<tr>
<td>FACTOR</td>
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<tr>
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</tr>
<tr>
<td>1. Infant’s Withdrawal Symptoms</td>
</tr>
<tr>
<td>2. Special Medical &amp;/Or Physical Problems</td>
</tr>
<tr>
<td>3. Special Care Needs</td>
</tr>
<tr>
<td>4. Drug/Alcohol Use</td>
</tr>
<tr>
<td>5. Drug/Alcohol treatment History</td>
</tr>
<tr>
<td>6. Prenatal Care</td>
</tr>
<tr>
<td>7. Emotional And Intellectual Abilities</td>
</tr>
<tr>
<td>8. Level Of Cooperation</td>
</tr>
<tr>
<td>9. Awareness Of Impact Of Drug/Alcohol Use On Child</td>
</tr>
<tr>
<td>10. Responsiveness To Infant, Bonding, Parenting Skills</td>
</tr>
<tr>
<td>11. History Of Family Violence</td>
</tr>
<tr>
<td>12. Father Or Parent Substitute In Home</td>
</tr>
<tr>
<td>13. Strength Of Family Support Systems</td>
</tr>
<tr>
<td>14. Drug/Criminal Activity</td>
</tr>
<tr>
<td>15. Siblings In Home At Risk</td>
</tr>
<tr>
<td>16. Known Environmental Risk In The Home</td>
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<tr>
<td>Service</td>
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<tr>
<td><strong>Medical/Health</strong></td>
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<tr>
<td>PCP (Mother)</td>
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<tr>
<td>PCP (Infant)</td>
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<tr>
<td>OB PN Care</td>
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<tr>
<td>High Risk Infant Follow-up</td>
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<tr>
<td>Home Health</td>
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<tr>
<td>WIC Program</td>
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<tr>
<td>Family Planning</td>
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<tr>
<td>SUD/OTP</td>
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<tr>
<td>Mental Health</td>
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<tr>
<td><strong>Financial</strong></td>
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<td>KTAP</td>
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<td>SNAP</td>
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<tr>
<td>Housing Assistance (Sec. 8)</td>
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<tr>
<td>Food Pantry</td>
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<tr>
<td><strong>Early Childhood/Parenting</strong></td>
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<tr>
<td>HANDS</td>
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<tr>
<td>3 C's (child care subsidy)</td>
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<tr>
<td>Child Care</td>
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<tr>
<td>EHS/HS</td>
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<tr>
<td>First Steps (Part C)</td>
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<tr>
<td><strong>Social Services</strong></td>
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<tr>
<td>Employment/Training</td>
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<tr>
<td>Technical School</td>
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<tr>
<td>Adoption</td>
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<tr>
<td>Domestic Violence Center</td>
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<td>Other</td>
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