Appendix A
Glossary:
Terms and Definitions

Anthropometric Assessment - Scientific and comparative measurements of the human body such as height, length, and weight, which are used in determining normal or abnormal patterns of growth.

Anticipatory guidance – Information provided to pregnant women, their families, and parents about what to expect in the current and next phase of pregnancy or infancy/childhood.

Assets - The strengths and resources available to the participant or family, which may enable them to offset the identified risk factor(s). Examples include family support, previous parenting experience, financial support, education, and adequate transportation.

At-risk – Participants who have factors in their lives that predispose them to risk for adverse outcomes. This is determined using research and statistics along with professional judgement.

Care coordination –The coordination, facilitation, and provision of care services identified through screening, evaluation of service need and assessment that are aimed at reducing participant risk and maximizing outcome. Care coordination services are the foundation for the delivery of Healthy Start services. Services provided to Healthy Start participants include those that:

1) Establish rapport and develop relationships with families (starting with initial contact);
2) Identify/evaluate/assess, in collaboration with families, their strengths, resources, needs and priorities;
3) Plan/problem solve with participants and families;
4) Address identified risks and needs;
5) Provide information, education and encouragement needed to inform and/or motivate families to take steps necessary to change situations placing them at risk;
6) Promote self-sufficiency and healthy outcomes (through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, enhancing parent-infant interaction, promoting continuation in health care; managing behavior concerns);
7) Make maximum use of community resources through information and referral;
8) Monitor the plan of care to assure that the multiple concerns of families are addressed;
9) Collaborate with other providers to assure continuity and coordination of care; and
10) Advocate on behalf of the participant, including communicating to providers and the community their strengths, needs and feelings.

Care coordinators - Health care providers, health-related professionals, or paraprofessionals working under the supervision of a professional who function in partnership with the participant or family for the provision of care coordination and other Healthy Start services.

Community resources – Supportive opportunities and services provided by others in the community that may complement or overlap those provided by Healthy Start. Examples include prenatal and primary care providers, postpartum home visitors, teen pregnancy programs, substance abuse treatment providers, Florida First Start, religious organizations, and neighborhood and community centers.

Concerns, priorities and resources - In the context of care coordination, concerns are the areas the participant/family identifies as needs, issues, problems to address as part of the family support plan process; priorities are the areas of concern that the participant/family decides to address first; and resources are the strengths, abilities, and formal and informal supports that can be mobilized to meet the participant's/family's concerns, needs, or goals.

Dietary Assessment - Process of evaluating the dietary intake of an individual through information that includes diet histories, food records and recalls, food preferences and eating patterns, use of nutrition supplements, use of medications, and all other data regarding the facilities for purchase, storage, and preparation of food.

Direct Service Encounter: Direct contact with a participant or a provider for that participant via the telephone or face-to-face communication.

Exclusive Breastfeeding – Breast milk only (no water, juice, semisolids or solids).

Family Support Plan – A written document that provides direction for care coordination based on the participant/family's concerns, priorities, and resources. A family support plan is not a plan of care. It is a participant centered plan that helps participants/families create and live their own goals/dreams.

Family Support Planning Process - The family support planning process is provided to families who are receiving ongoing care coordination services. This is a collaborative and interactive planning partnership between families and professionals. The Family Support Plan is developed by a team that consists of participants/parents of participants, the care coordinator and if available, other professionals involved in assessment, planning and service provision. The care coordinator acts as the single point of entry for the family to assist in the coordination of services. The Family Support Plan is written to document the family's concerns and priorities in their own words, formal and informal resource available to address those concerns and priorities, and who is responsible for what activities.

Health Management Component (HMC) - A uniform, computerized service reporting system that provides information about and documentation of services funded by the State of Florida, Department of Health.

Healthy Families Florida – Healthy Families Florida is a community-based, voluntary home visiting program designed to enable children to grow up healthy, safe, and

nurtured. The program promotes positive parenting and healthy child development, thereby preventing abuse and other poor childhood outcomes.

Healthy Start Coding – Designated codes recorded each time a Healthy Start funded service is provided to or on behalf of a Healthy Start participant. In the aggregate, these codes provide the opportunity to link intensity and duration of service delivery to outcomes in order to evaluate effective implementation and impact of Healthy Start services.

Healthy Start Encounter Form – The paper form used to register and account for all services delivered to Healthy Start participants.

Healthy Start Liaison – Department of Health and contract consultant staff who are identified as the contact person for a particular region and who have responsibility to participate in quality improvement activities for that region, as well as the provision of technical assistance as needed and requested.

Healthy Start Participant – May include:

- A child up to age three who may be at increased risk for impairment in health, intellect, or functional ability due to environmental, medical, nutritional, behavioral, or developmental risk factors as determined by the department's postnatal (infant) risk screening instrument, or by risk assessments conducted subsequent to the initial contact or as determined by factors other than the score at the time of screening or subsequent to the initial screen;

- A pregnant woman, who has an increased risk of pregnancy complications or poor birth outcomes due to environmental, medical, nutritional, behavioral, or developmental risk factors as determined by the department's prenatal risk screening instrument or by risk assessments conducted subsequent to the initial contact or as determined by factors other than the score at the time of screening or subsequent to the initial screen;

- A non-pregnant woman who has risk factors that may lead to a poor subsequent pregnancy outcome, but has no infant to code services to due to pregnancy loss, miscarriage, fetal death, infant death, or an infant who was adopted or removed from the home. Women are eligible for Healthy Start services during the interconception period up to three years post delivery.

Home visiting – is a mechanism for providing care coordination and other Healthy Start services in a location that best meets the concerns, priorities and resources of the participant and family. It is a place of service or a strategy for service delivery. Home visiting is a term used for any non-clinic location the participant or family considers appropriate.

Individualized Plan of Care – a written plan of the interventions needed based on the evaluation of the Healthy Start participant's risks and needs, and the plan for the next encounter.

Initial assessment - is a face-to-face assessment of participant risks and service needs. This assessment is completed by a face-to-face evaluation in collaboration with the participant and family if appropriate. This face-to-face assessment is usually done after the Initial Contact.

Initial contact - The legislatively mandated point-of-entry into Healthy Start care coordination. The initial contact is an evaluation of service needs as outlined in chapter 4. The initial contact may be accomplished by telephone contact or through a face-to-face encounter. It also may be done simultaneously during a face-to-face Initial Assessment.

Leveling - An approach to care coordination and caseload management whereby participants are assigned a level of service delivery that corresponds to the intensity and duration of service required to address the participant's risks and need for services. Levels are fluid they are not static. A participant is designated a level E during the initial attempt to contact, however, a participant/family can change between levels whenever risk and service needs change. The standardized level definitions are:

Level P Participants without a completed initial contact.

Level E Participants require only the service components of an Initial Contact. Education, counseling and referral to community resources are given as needed.

Level 1 Participants typically function fairly independently, but may not have adequate knowledge about community services or may have additional barriers accessing, participating in or coordinating services for themselves or their child. Participants require short term follow-up on the ability to successfully access services. Participants do not stay in this level longer than 4 months before a determination is made to close to HS services or re-level to a higher level if services continue to be necessary. Education, counseling and referrals to community resources given as needed.

Level 2 Participants typically function fairly independently, but may not have adequate knowledge about community services or may have additional barriers accessing, participating in or coordinating services for themselves or their child. Education, counseling and referrals to community resources given as needed.

Level 3 Participants / families are experiencing multiple concerns and need frequent service coordination. Safety concerns and crisis intervention are often characteristics of participants in this level. Education, counseling and referrals to community resources given as needed.

Medical Nutrition Therapy - Evaluation of patient's health history, social status, and nutrient intake. On the basis of the assessment, a nutrition care plan is developed and implemented with the goals of improving clinical outcomes and the quality of life for patients and saving health care dollars.

NCHS - National Centers for Health Statistics, Centers for Disease Control and Prevention.

Nutrition - The science of food (nutrients and other substances therein), its action, interaction, and balance in relation to health, disease, and process by which an individual intakes, digests, transports, utilizes, and eliminates food substances.

Nutrition Assessment - The process of evaluating the nutrition status of an individual using medical, socioeconomic and dietary histories, anthropometric measurements, laboratory tests, and physical assessment values.

Nutrition Care Plan - The documentation of nutrition services and follow-up plans provided to a client.

Nutrition Counseling - The process of guidance and advisement based upon the dietary assessment.

Ongoing care coordination - A process by which families are assisted with locating, coordinating and monitoring needed services and learning what they can to maximize their health and well-being. Activities range from tracking to intensive coordination of services addressing complex problems, using a family support plan and reevaluating the Individualized Plan of Care and the participant's level.

Outreach - A systematic, family-centered, community-based activity that promotes improved pregnancies and infant health outcomes through public awareness, education and access to services. This includes participant identification and education, provider recruitment and retention, and community education. All these efforts are designed to increase participant, provider and community awareness in an effort to link pregnant women and infants to needed services, and/or make these services more accessible.

Paraprofessional – A non-professional who functions under the supervision of a health care provider or health-related professional, who is trained to assist in providing direct services to Healthy Start participants within the parameters of approved written protocols. Paraprofessionals who function as care coordinators may not assume the role of lead care coordinator or interdisciplinary team leader. Health paraprofessionals include resource mothers, sisters, and fathers; trained health aides; family support workers, parent educators; outreach childbirth educators; breastfeeding peer counselors; and other appropriately trained and professionally supervised individuals. Paraprofessionals who are indigenous to the region or culture they are serving often bring a unique community knowledge and understanding of the local system of care to the programs they work with.

Payer of Last Resort - Entity that pays for services only after assuring that all other community or insurance resources have been exhausted.

Peer Review – The review of processes or materials by individuals involved in the development and/or use of said processes/materials who have equal standing with one another.

PEPW - See Presumptive Eligibility for Pregnant Women

Performance Measure – An indicator of how well we are doing in terms of quality performance related to service delivery (e.g., number of clients served) and health status (e.g., infant mortality rates).

Prenatal care - Prenatal care is the provision of medical, nutritional, psychosocial, and educational services to meet the needs of a pregnant woman and her family. Services include, but are not limited to, risk screening; pregnancy testing, diagnosis and treatment; radiology and laboratory tests; immunizations; health education; psychosocial counseling; adjunct services that provide supplemental nutritious foods and nutrition counseling and breastfeeding promotion and support; and care coordination with referral for needed services. Prenatal services are provided by healthcare providers and county health departments, and programs such as Special Supplemental Nutrition Program for Women, Infants and Children and Healthy Start.

Presumptive Eligibility for Pregnant Women - allows for early access to Medicaid for outpatient prenatal medical care. Provides Medicaid coverage for pregnant women for all her Medicaid billable services, except inpatient hospitalization and delivery.

Prioritization - A decision-making method whereby services are delivered based on order of importance or urgency (see triage).

Priority Target Group – The population of pregnant women or infants whom the coalition identifies as most in need of prenatal or infant care services because these groups are unable to access such services or have high rates of infant mortality, maternal death, low or very low birth weight or neonatal mortality, or other factors that contribute to adverse outcomes. This priority target population can either be a region of the coalition's catchment area, such as by census track or zip code, or can be a specific group of individuals with common characteristics such as repeat teen pregnancies.

Risk Appropriate Care - Risk appropriate care is the provision of supports and services that directly address identified risk factors that participants or families are unable to resolve without assistance. Risk appropriate care targets risk reduction services to improve outcomes. The concept of risk appropriate care implies that if the family is capable of resolving the risk factor or underlying situation without external intervention, then resources will not be used with that family but rather will be targeted to those most at need. Therefore it is an individualized approach to care meaning that all participants do not receive the same services. Healthy Start care coordination is based on the concept of risk appropriate care.

Risk Ratio – A statistical calculation for measuring the "degree of risk" associated with a specific factor. The risk ratio equals the occurrence of an adverse outcome in a population with a specific risk factor compared to the occurrence of that outcome in populations without the specific risk factor.

Risk Reduction Services - Services provided to participants that directly address risk factors or situations underlying risk factors, with the intent to minimize the impact of the risk situation. Risk appropriate care targets risk reduction services to improve outcomes. Examples in Healthy Start include: care coordination, psychosocial counseling, tobacco cessation, childbirth and parenting education, breastfeeding education and support.

Risk Screen – The Healthy Start instruments designed to identify pregnant women and infants who are most likely to be at risk for poor health outcomes.

Screening – The process of identifying pregnant women and infants who are most likely to be at risk for poor health outcomes.

Service relationship - The combination and agreements of all providers involved in Healthy Start, from the coalition to the county health departments, to private providers.

Simplified Eligibility - Provides expedited Medicaid prenatal care coverage for eligible pregnant women. The Medicaid eligibility for pregnant women is processes utilizing different verification requirements, and can be completed in a shorter time frame. Provides Medicaid coverage for pregnant women for all her Medicaid billable services.

Sixth Omnibus Budget Reconciliation Act - Provides funding for women identified as eligible for health care services based on their pregnancy.

SOBRA – see Sixth Omnibus Budget Reconciliation Act

Special Group Code - The special group field on the demographic section of the encounter form is used to track the provision of services to substance exposed infants or to substance abusing pregnant women.

Substance Abuse - The problematic use of alcohol, tobacco and illicit drugs.

Tracking - Those activities related to following up on referrals or the receipt of other services to determine whether Healthy Start participants are able to access or continue participation in services.

Target population - Based on an extensive needs assessment, the coalition defined population for which service delivery is focused. Those determined to be at highest risk and most in need and who will derive the most benefit from services.

Targeting - The practice of delivering services to participants determined to be at highest risk and need, who are most likely to benefit from services.

Transition – The movement or change from one set of services (or needs) to another, whether or not Healthy Start services have been completely discontinued. As the needs and eligibility of Healthy Start participant's change, the intensity of a particular program's involvement may also change. Smooth transition of care ensures continuity of services and results from formalizing relationships through interagency agreements within a community's programs to minimize both the interruption and the duplication of services.

Triage - A decision-making method whereby scarce service delivery resources are allocated based on who is most able to derive benefit from them. Related to prioritization.

WIC - Special Supplemental Nutrition Program for Women, Infants, and Children authorized by Section 17 of the Child Nutrition Act of 1966 as amended and funded through the United States Department of Agriculture.