

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 judgment.

Business Day – Monday through Friday, excluding weekends and holidays.

Calendar Day – Any day of the week, including weekends and holidays.

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 assessment);
- 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.

Coalition's Service Area – The geographical area represented by the coalition. This area shall consist of one or more counties and may include one or more services delivery catchment areas.

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, religious organizations, and neighborhood and community centers.

Comprehensive Prenatal and Infant Health Care – Those maternal and infant health care activities which are provided in the community to enable pregnant women to maintain good health and have positive birth outcomes and their infants to experience normal growth and development in the first year of life.

Concerns, Priorities and Resources – In the context of care coordination, concerns are the areas the participant/family identified 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 strength, abilities, and formal and informal supports that can be mobilized to meet the participant's/family's concerns, needs or goals.

Congenital disorder – A disorder existing before or at birth, regardless of cause, that is designated by the Department of Health.

Coordinated Intake and Referral – A system that connects pregnant women, interconception women and families of young children to services in an attempt to offset risk factors that may lead to poor pregnancy and infant outcomes.

Core Services Package – The minimum services which must be included in a community prenatal, newborn and infant health care service delivery plan and should include prenatal and postnatal care, outreach, prenatal risk assessment, home visiting, nutrition, case management, comprehensive infant health services, family planning, substance abuse treatment, and childbirth and parenting education and referrals to other programs for additional services as needed.

Decision Tree – A graph used to determine which home visiting program(s) for which a client is eligible. The Program Services Inventory is used to develop the decision tree. When a maternal-child program is added, removed or changes in a way that affects CI&R, the Program Services Inventory and Decision Tree must be updated.

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 Services – the professional and paraprofessional activities, including those provided by resource mothers and fathers, that entail a cost in time and effort spent in personal contact with consumers of prenatal and infant health care services. Such activities include, but are not limited to, routine prenatal care, health and social services, care coordination of clients, and outreach to specific individuals.

Enhanced services – Those services provided to participants that maximize access to and participation in comprehensive prenatal and infant health care such as breastfeeding education and support, childbirth education, nutritional counseling, psychosocial counseling, and tobacco cessation counseling. Healthy Start Coalitions have the authority to determine which specific enhanced services will have the greatest impact on pregnancy, health and developmental outcomes in their geographic regions.

Environmental Risk factor – A physical, social, or economic factor in an individual's environment which places him or her at risk for having or developing a health or health-related problem. These would be factors such as those delineated in Florida Statute 383.14.

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

Family – The participant and others who have an integral role in the care and support of the participant such as parents, spouses, non-custodial parents, legal guardians, significant others, siblings, grandparents, and foster parents.

Family Support Plan – The written guide resulting from a family-centered planning process jointly prepared by the participant or family and the Healthy Start worker. The plan is the basis for care coordination and identifies the specific concerns, needs, and priorities of the client or family, the resources available, and specifies service objectives that should lead to improved health outcomes. 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 Plan Process – The family support planning process is provided to families who are receiving the Healthy Start Program. 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 or participants, the Healthy Start worker and if available, other professionals involved in assessment, planning and service provision. The Healthy Start worker 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 resources available to address those concerns and priorities, and who is responsible for what activities.

Health Care Provider – Physicians, physician's assistants, certified nurse midwives, licensed midwives, advanced registered nurse practitioners, and registered nurses who are licensed in the state of Florida pursuant to Florida Statute Chapter 458 or 459, or Florida Statute Chapter 464 or 467, and are qualified to provide prenatal, intrapartum, postpartum, family planning, or pediatric health care.

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

Health Paraprofessionals – Non-professional personnel who function under the supervision of a care coordinator, health care provider, or other health-related professional and are trained to assist in providing direct services to Healthy Start participants within the parameters of specific locally approved written protocols. Health paraprofessionals include resource mothers, sisters, and fathers; health aides; parent educators; outreach childbirth educators; breastfeeding peer counselors; and other appropriately trained and professionally supervised individuals.

Health-Related Professionals – Registered nurses, registered or licensed dietitians, public health nutritionists, social workers, nutrition and health educators, and other health or human services professionals who function independently or with the care coordinator as part of the interdisciplinary team, and are qualified to provide or supervise the provision of Healthy Start services including care coordination and enhanced services to Healthy Start participants.

Healthy Start Child – A child, less than three years of age (0-36 months), 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 of Health’s risk screening instrument as defined in Florida Administrative Code 64C-7, or by risk assessments conducted subsequent to the initial screen and whose parent or family agrees to participate in Healthy Start.

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 the 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 Infant – An infant, less than twelve months of age, whose parent or family agrees to participate in Healthy Start and 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 of Health’s risk screening instrument as defined in Florida Administrative Code 64C-7.008(2), or as determined by factors other than the score at the time of screening or subsequent to the initial screen.

Healthy Start Liaison – Department of Health and contract consultant staff who are identified as the contact person for a particular region and who have the 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 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 of Health’s prenatal risk screening instrument or by risk assessments conducted subsequent to the initial intake (also known as the initial contact) or as determined by factors other than the score at the time of the initial screening;
- 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 of Health’s postnatal (infant) risk screening instrument, or by risk assessments conducted subsequent to the initial intake (also known as 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.

Healthy Start Participant and Participant – A Healthy Start pregnant (antepartum) or postpartum woman or a Healthy Start child as defined in this section.

Healthy Start Pregnant Woman – A pregnant woman who has agreed to participate in Healthy Start and may be at increased risk of pregnancy complications or poor birth outcome due to environmental, medical, nutritional, behavioral, or developmental risk factors as determined by the Department of Health's prenatal risk screening instrument as defined in Florida Administrative Code 64C-7.008(1), or as determined by factors other than the score at the time of screening or subsequent to the initial screen.

Healthy Start services – Those services provided to participants that maximize access to and participation in comprehensive prenatal and infant health care such as client and participant identification (case finding), care coordination, childbirth education, parenting education and support, nutritional counseling, psychosocial counseling, smoking cessation counseling, breastfeeding education and support, and other services that optimize health and developmental outcomes and improve access to care. Home visiting is a strategy for providing Healthy Start services. In addition to the home, Healthy Start services can also be provided in the neighborhood, school, workplace, or clinic; wherever the concerns, priorities, and resources of the participant or family can best be met. Healthy Start Coalitions have the responsibility to assess the maternal and infant health needs and services necessary to have the greatest impact on pregnancy, health and developmental outcomes in their geographic regions.

Healthy Start woman and Healthy Start mother – means a woman in the antepartum or postpartum period who has increased risk of poor birth outcome due to environmental, medical, nutritional, behavioral or developmental risk factors or a woman in the postpartum period who has delivered an infant and agreed to participate in the Healthy Start Program.

Hereditary Disorder – A particular disorder designated by the Department of Health in accordance with Florida Administrative Code Rule 64C-7.008, that is genetically inherited from parent to offspring.

Home Visitation Advisory Committee – A committee made up of representatives of all maternal-child home visiting programs participating in CI&R. The purpose of the committee is to monitor the results of CI&R including the strengths, needs for improvement and, when applicable, adding new maternal-child programs to CI&R.

Home Visiting – 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.

Infant – A newborn child through 12 months of age.

Infant Risk Screening –The use of selected risk factors to identify infants at increased risk for mortality and morbidity, as designated in accordance with Florida Administrative Code Rule 64C-7.011.

Initial Assessment – 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.

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.

Initial Intake – Interchangeable with the term Initial Contact. See Initial Contact.

Interconception Woman – a Healthy Start participant who is past eight weeks postpartum and has no baby for services to be coded to either through a loss (miscarriage, stillbirth, infant death) or placed out of the home (adoption, removed by DCF).

Low Birth Weight – A birth weight of less than 2500 grams.

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 goals of improving clinical outcomes and the quality of life for patients and saving health care dollars.

Miscarriage – A spontaneous loss of a fetus before the 20th week of pregnancy.

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 eliminated food substances.

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 systemic, 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).

Postnatal Risk Screening – See Infant Risk Screening.

Prenatal and Infant Health Care Coalition and Coalition – An alliance of private and public individuals or groups organized to assess needs, prepare plans, build community support, and ensure that services are sufficient, within available resources, to promote and support the health and well-being of pregnant women and their infants.

Prenatal and Infant Health Care Service Delivery Plan – The written document adopted by the Coalition which establishes outcome and process objectives, priority service needs and priority target groups, and programmatic strategies for the coalitions service area, and which describes the provider network which will ensure early and continuous prenatal and infant care for all persons in need in the service area.

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 health care 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.

Prenatal Risk Screening –The use of selected risk factors to identify pregnant women at increased risk for pregnancy complications or adverse outcomes, as designated in accordance with Florida Administrative Code Rule 64C-7.011.

Preterm Birth – A birth occurring before 37 weeks gestation.

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. The priority target population can either be a region of the coalition’s catchment area, such as by census tract or zip code, or can be a specific group of individuals with common characteristics such as repeat teen pregnancies.

Program Component – A two-digit number that identifies the program to which service and time are being coded. The program components that identify services and time are being provided to Healthy Start participants are 22, 26, 27, 30, 31, and 32.

Program Services Inventory – A document that shows every home visiting program participating in CI&R, a description of the services of each of those programs, eligibility criteria, and capacity. The Program Services Inventory is used to develop the decision tree. When a maternal-child program is added, removed or changes in a way that affects CI&R, the Program Services Inventory and Decision Tree must be updated.

Prospective Coalition – A group of individuals or organizations who have demonstrated their interest in forming a coalition by submitting a letter of intent to form a coalition.

Provider – A county health department, a private practitioner, a hospital, a community health center, a birthing center or any other entity which provides prenatal or infant health care services.

Quality Assurance System – A continuous process for internal and external evaluation to obtain and report information about the structure, process and outcome of the prenatal and infant care delivery networks. The process evaluates the extent to which administration, staff and public health services are in compliance with pre-established standards, and meets the needs of the women and infants served.

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 in 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 factor – An element associated with an increased risk of pregnancy complications or infant mortality and morbidity.

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 instrument designed to identify pregnant women and infants who are most likely to be at risk for poor health outcomes.

Risk Screening Instrument – A tool developed by the Department of Health containing selected risk factors in accordance with Florida Administrative Code Rule 64C-7.011.

Scoring Mechanism – A method used to ascertain potential risk based on the risk factors contained on the risk screening instrument.

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

Service Code – a four-digit number that identifies the type of service provided.

Services Delivery Catchment Area – A geographical area which includes a logical network of prenatal, labor and delivery, postpartum and infant health care providers which can be reasonably accessed by clients.

Service Relationships – 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.

Stillbirth – The loss of a fetus after 20 weeks of pregnancy.

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

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.

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 services.

Tracking – 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 services. Tracking activities include the following: establishing a way for service providers to notify the care coordinator of missed appointments and incomplete referrals; communicating with providers, participants or families according to a locally agreed upon periodicity schedule regarding receipt of services; and considering change in the intensity of care coordination or care coordination closure if the participants' care coordination needs change.

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.