

# Glossary for the Maternal Child Health Services Contract

Federal Fiscal Year (FFY) 2013-2014  
Contract Period October 1, 2012-September 30, 2014

1. **Adverse birth outcomes:** A group of conditions, including but not limited to, low birth weight, preterm births and infant mortality, and may be associated with such risk factors as late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, inadequate birth spacing, chronic diseases (i.e. diabetes, gum disease, obesity, etc.), maternal age, poor nutrition, and low socioeconomic status.
  2. **Amendment:** A written, official modification to the contract.
  3. **Authorization:** The name of a local public health agency (LPHA) Administrator, Director, or Designee (other duly authorized individual of the LPHA Contractor, or of the joint submission Contractor/Contracting Agency).
  4. **Best practices:** A best practice results from a rigorous process of peer review and evaluation that indicates effectiveness in improving public health outcomes for a target population. A best practice:
    - Has been reviewed and substantiated by experts in the public health field according to predetermined standards of empirical research;
    - Is replicable, and produces desirable results in a variety of settings.
    - Clearly links positive effects to the program/practice being evaluated and not to other external factors.
- Source:  
<http://www.amchp.org/programsandtopics/BestPractices/Pages/BestPracticeTerms.aspx>
5. **Children:** A child from birth (0) through the 21<sup>st</sup> year, who is not otherwise included in any other class of individuals.
  6. **Children with special health care needs:** All children with chronic conditions who require more than routine health care. The federal Maternal and Child Health Bureau's (MCHB) definition is as follows: "Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services at a type or amount beyond that required by children generally."
  7. **Clarification:** The Department reserves the right to request clarification of information submitted and to request additional information regarding the proposal.
  8. **Coalition:** A coalition is an alliance of individuals, groups, parties, or states that come together, join forces, or form partnerships usually for a specific or common purpose.
  9. **Community partners:** A person, in an agency or other entity outside the contractor's direct control, upon whom the contractor relies to build and sustain its service coordination system.
  10. **Compliance:** Conformity in fulfilling official requirements.
  11. **Cultural competence:** Refers to an ability to interact effectively with people of different cultures. Cultural competence comprises four components: (a) awareness of one's own cultural worldview, (b) attitude towards cultural differences, (c) knowledge of different cultural practices and worldviews, and (d)

cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures.

12. **Evaluation:** The systematic process of determining merit and significance of a program, course, or other initiative using criteria against a set of standards.
13. **Evidence-based public health:** The development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioral science theory and program planning models.  
*Source:*  
Brownson RC, Baker EA, Leet TL, Gillespie KN. *Evidence-Based Public Health*. New York: Oxford University Press; 2003
14. **Federal funding source:** Maternal Child Health (MCH) Services contract funds are made available through the Maternal and Child Health Services Title V Block Grant.
15. **Funding methodology:** Funding for each jurisdiction is based on the following formula: "A female/child poverty index is determined for each county in Missouri by the Bureau of Vital Statistics. The female/child poverty index is a composite of two (2) factors for each of the 118 jurisdictions: 1) Maternal-infant indicator (the unduplicated count of births to adolescents (age less than 18), infant and fetal deaths and low birth weight births) and 2) women and children in poverty (estimated population of women of childbearing age (15-44), males under age 18 and females under age 15 at 185% of the federal poverty level). The female/child poverty index for the MCH Services Contract in FFY 2013 is based upon the most current data available: 2006-2010 data for births, fetal and infant deaths, and the Census Bureau's most recent American Community Survey 2005-2009 poverty data. The base-funding amount of \$15,000 is multiplied by 118, and subtracted from the total funding amount for the contract. The difference is then multiplied by the female/child poverty index for each county, and added to the base-funding amount to arrive at the total award amount for each LPHA."
16. **Health disparities:** Differences between groups of people that can affect frequency and/or impact disease or adverse outcomes. Differences can include racial, ethnic, culture, gender, age, and disability diversity in a population.
17. **Health literacy:** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
18. **Interventions:** Actions taken on behalf of individuals, families, systems, and communities to improve or protect health status.
19. **Joint submission:** Agencies may work collectively in groups to address needs across a larger geographical area. In such cases, funding will be based on the total available to the geographical area working in such a collaborative relationship. Multi-geographical area proposals must address one selected priority health issue and must describe how this joint effort is to be delineated between all included jurisdictions. One of the partner LPHAs must be designated as lead and the lead agency will be the Contractor or Contracting Agency. Letters of agreement with the Contracting Agency are required. Letters of agreement between partner

LPHAs must be included as part of the proposal. The requirements for joint submission contract proposals as mentioned above, do not apply to local public health agencies of multiple geographic areas with combined governance (i.e. Columbia/Boone County, Phelps/Maries, and Tri-County [Worth, Gentry, DeKalb]).

20. **Life Course Perspective:** Life Course Perspective (LCP) offers a way of looking at an individual's health over their life span, not as disconnected stages (infancy, latency, adolescence, childbearing years) unrelated to each other, but as an integrated whole. It suggests that a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the span of a person's life and builds on recent social science and public health literature that suggests that each life stage influences the next.
21. **Legal electronic signature:** This is an original signature that was made digital by means of scanning a signed original document into a PDF version, or by inserting a scanned original signature into the section of the document in which it is required. A legal electronic signature is required on electronically submitted contract proposals, invoices, or amendment request letters for the contract.
22. **Match funding:** In order to receive federal Maternal and Child Health Services Title V Block Grant funds, the State of Missouri must match three non-federal dollars for every four federal dollars expended. The Department is not requiring a fixed amount of match, however, is asking for a commitment from each LPHA to make a good faith effort to help the state meet this obligation by reporting the local dollars spent on the MCH population. Reporting of local match dollars may be funds from any non-federal source, and should be clearly documented as efforts being made to improve the health of the MCH population. Any funds identified as match dollars may not be used as match for another funding source or reimbursed by other means. Match local funds expenditures may include the following:
  - Personnel salary costs
  - Fringe benefits paid to employees
  - Travel expenses, such as mileage, meals, and lodging for attendance at professional development related to the maternal and child health population
  - Purchase of equipment, excluding the purchase of major medical equipment, may include such items as audio-visual equipment, examination equipment, or other equipment purchased with local funds and used to support the maternal and child health population
  - Purchase of supplies, including office supplies and any materials purchased specifically for work with the maternal and child health population
  - Expenditures which exceeded contract funding and could not be applied to other sections
23. **Maternal and child health (MCH) activities:** Any combination of direct health care services, enabling services, population-based services, and infrastructure or resource building activities directed to improving the health of women of child-bearing age, pregnant women, mothers, infants, children, and adolescents; including those with special health care needs.

24. **Maternal and child health (MCH) issues:** Issues related to protecting, promoting and improving the health of women of child-bearing age, pregnant women, mothers, infants, children, and adolescents; including those with special health care needs.
25. **Maternal and child health (MCH) population:** Population which encompasses or influences target subpopulations of women of child-bearing age, pregnant women, mothers, infants, children, and adolescents; including those with special health care needs.
26. **Overweight/obese adults:** For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the “body mass index” (BMI). An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. BMI is used because it correlates with the amount of body fat. BMI does not directly measure body fat. As a result, some people, such as athletes, may have a BMI that identifies them as overweight even though they do not have excess body fat.
27. **Overweight/at-risk of overweight children/teens:** For children and teens, overweight and at-risk of overweight are determined by using weight and height to calculate the percentile range on a standard growth chart because they are age and sex specific. A child/teen in the 95<sup>th</sup> or greater percentile range would be in the overweight status category; a child/teen in the 85<sup>th</sup> to less than the 95<sup>th</sup> percentile would be in the at-risk of overweight status category. A healthy weight for a child/teen would be from the 5<sup>th</sup> to less than the 85<sup>th</sup> percentile range.

Source:

<http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm>

28. **Preconception health:** Preconception health is a woman’s health before she becomes pregnant. It focuses on the conditions and risk factors that could affect a woman if she becomes pregnant. Preconception health applies to women who have never been pregnant, and also to women who could become pregnant again. Preconception health looks at factors that can affect a fetus or infant. These include factors such as taking prescription drugs or drinking alcohol. The key to promoting preconception health is to combine the best medical care, healthy behaviors, strong support, and safe environments at home and at work.
29. **Preventive services:** Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.
30. **Protective factors:** Conditions in families and communities that, when present, increase the health and well-being of children and families. They are attributes that serve as buffers or coping strategies that strengthen all families and communities. Examples include caregiver education in addressing childhood obesity, or family connectedness or higher self-esteem in the prevention of teen pregnancy or tobacco use.
31. **Risk factors:** Characteristics, variables and/or conditions present in individuals or groups that increase the likelihood of that individual or group developing a disorder or adverse outcome. A number of social-emotional factors, social norms, and peer practices are identified as risk factors for harmful health practices. Examples include poverty and substance abuse in the incidence of teen pregnancy.

32. **Service coordination:** A collaborative process that addresses the health needs of a population through identification, assessment, referral, assurance, education, and evaluation, using communications and available resources to promote quality and improved outcomes.
33. **Social determinants of health:** The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.
34. **Spectrum of Prevention:** The Spectrum of Prevention is a systematic tool that promotes a multifaceted range of activities for effective prevention. The Spectrum identifies multiple levels of intervention and helps people move beyond the perception that prevention is merely education. The Spectrum is a framework for a more comprehensive understanding of prevention that includes six levels for strategy development. These levels are complementary, and when used together produce a synergy that results in greater effectiveness than would be possible by implementing any single activity or linear initiative. At each level, the most important activities related to prevention objectives should be identified. As these activities are identified they will lead to interrelated actions at other levels of the Spectrum.  
*Source:* [www.preventioninstitute.org](http://www.preventioninstitute.org)
35. **Strategies:** Refers to a plan of action designed to achieve a particular goal. Activities include Campaigns and Promotions, Individual Education, Group Education, Supportive Relationships, Provider Education, and Environment and Policies and are intended to address change in behavior, knowledge, attitudes, skills, beliefs and/or social support.
36. **Subcontract:** The contractor may subcontract funds to another agency for contract activities as stated under 9.0 Special Provisions.
37. **Supplanting:** Utilizing funds from the MCH Services contract to fund activities currently being funded from another local, state or federal source. However, the funding from this contract may be used to increase or expand MCH Services program activities.
38. **System:** A perceived whole whose elements combine because they continually affect each other over time and operate toward a common purpose.
39. **System outcome(s):** Benefits for participants or public following performance of the plan of work in a contract. For the Maternal Child Health Services Contract this means measures of change for each level of the Spectrum of Prevention, due no later than September 30, 2014, as included in the approved work plan. The system outcome(s) are a specific result that a contractor will commit to achieve within the contract period. Attainment can be verified through documentation provided by the contractor at the end of the contract period.
40. **Target population:** People or entities that interact with an organization's service coordination system. This interaction is intended to result in a change in condition.

- 41. Ten Essential MCH Services:** 1) Assess and monitor maternal and child health status to identify and address problems; 2) Diagnose and investigate health problems and hazards affecting women, children, and youth; 3) Inform and educate the public and families about maternal and child health issues; 4) Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems; 5) Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and families; 6) Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being; 7) Link women, children, and youth to health and other community and family support services, and assure access to comprehensive, quality systems of care; 8) Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs; 9) Evaluate effectiveness, accessibility, and quality of personal health and population-based maternal and child health services; 10) Conduct research and support demonstrations to gain new insights and innovative solutions to maternal and child health related problems.
- 42. Verify/Verifying:** Establishing that something represented to happen, does in fact take place.