Health Care Glossary

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Accountable Care Organization (ACO)

- Is a group of health care providers (e.g. primary care doctors, specialists, hospitals, and others) who:
  - Agree to work together and take responsibility as a team for deciding how to provide the best care for patients at the lowest cost;
  - Are paid in ways that make them want to work even harder to provide excellent care while keeping costs down.

Ambulatory Care

- Is medical care that does not require an overnight stay in a hospital.
- This kind of care can be provided in the following places:
  - Doctors' offices,
  - Clinics,
  - Emergency departments,
  - Outpatient surgery centers; as well as
  - Hospital, but that does not involve a patient being staying overnight.
- Of interest: "Ambulatory" comes from the word "ambulate" which means to "walk" or "move about."

Benchmark (benchmarking)

- Is a way for hospitals and doctors to keep track of, and measure, how well they are doing at providing excellent care while keeping costs down.
- To do this, they gather information (data) over different periods of time. Then, they use this information to:
  - Measure how well they are doing from one period to the next.
  - Measure how well they are doing compared to other hospitals and doctors.
  - Find out what treatments work best and use that information to provide even better care. Treatments that work the best are often called "best practices."

Best practices

- Are the most up-to-date treatments for patients.
- These are also practices which result in the best patient health and lower patient risk of death or complications.

Centers for Medicare and Medicaid Services (CMS)

- Is the agency within the U.S. Department of Health and Human Services that administers:
  - Medicare,
  - Medicaid, and
  - the State Children's Health Insurance Program (SCHIP or CHIP).

Center for Medicare and Medicaid Innovation (CMMI)

- Is a new division within the Centers for Medicare and Medicaid Services (CMS), created by the health reform law, passed in 2010.
- It tests new ways of providing health care, and paying for health care, through the Medicare and Medicaid programs.
- The Center will test these new ways of providing and paying for health care to see which ones work best. The goal will be to improve the quality of care and to encourage care that is better coordinated and more patient-centered.
- Then the Center will test, or try out, new methods in a few places. If they work well, the Center will expand these methods to many more places.

Chronic care model

Is a way of providing care that encourages better and more helpful interactions between patients and their health care providers. This includes the following:

- **Improved coordination of patient care:** Uses systems and tools to give health care providers access to all the information they need to provide good care for a patient. For example, doctors might organize their practice to improve communication with other doctors' offices and use electronic medical records to get easy access to patients' health information. Using these systems and tools helps coordinate the different care that patients get and prevent medical errors. The goal is to provide the best care with the least confusion.
- **Better decision-making by doctors and patients:** Provides support for doctors and patients in making decisions together about treatment plans that are based on the best scientific research;
- **Patients to be involved in their own care:** Helps patients to become more empowered and effective in managing their own health and health care;
  - For example: Working together with doctors to 1) set manageable goals, 2) create treatment plans, and 3) solve any problems along the way.
- **Additional outside support to help patients manage their health:** Involves working with community organizations to help meet patients' needs;
  - For example: Connecting patients to nutrition, exercise, or disease management

programs that might be offered by local senior centers.

- **Leadership committed to continued improvements:** Health system leaders work to create a culture around continually improving the safety, coordination, and quality of care;
    - For example: Creating ways to be sure that 1) patients have regular follow up from their care team, and that 2) the care that is provided fits with patients' needs and preferences.

Chronic disease/condition

- Is a sickness that is long-lasting or that comes back or flares up, from time to time.
- Examples include: diabetes, asthma, heart disease, kidney disease, and chronic lung disease.

Clinical practice guidelines (also called clinical care guidelines)

- Are a set of recommendations, based on scientific research, that are used to identify and evaluate the most current information about the best way to care for patients. There are guidelines about how to do the following kinds of things:
    - prevent illness
    - identify illness
    - predict the course of an illness
    - treat illness
    - figure out risks and benefits
    - keep costs down
- These guidelines help doctors and their patients make decisions about appropriate health care for specific medical conditions.

Cognitive Impairments

- Are types of problems with the mind, which may affect daily life.
- They include having problems with the following:
    - Memory,
    - Thinking,
    - Speech, or
    - Another mental function.

Collaborative Consumer Engagement

- Is when health care providers work in partnership with consumers, consumer advocates, patients, and their families/caregivers.
- This is done to improve the health care delivery system and make sure it meets the needs of patients and their families/caregivers.

Comparative Effectiveness Research (CER)

- Is research that compares different medicines or treatments.
- It is done to figure out which medicines or treatments work the best for different types

of patients.

Co-morbidity

- Is the presence of one or more diseases in a patient, in addition to a previously diagnosed illness.
- For example: a patient may have both diabetes and heart disease.

Consumer/Patient/Beneficiary

- Refers to a person who has significant personal or family experience with the health care system.
    - It can refer to a person receiving care (such as someone covered by Medicare – a beneficiary).
    - It can also refer to a family caregiver.

Consumer Advocate (also called Consumer Representative)

- People who work for non-profit organizations and represent the needs and interests of certain groups of consumers or patients. For example, American Cancer Society consumer advocates represent the concerns of cancer patients. These advocates help make sure that consumers and patients have a voice in the health care system.
- Examples of consumer advocacy organizations include: AARP, American Cancer Society, March of Dimes, and faith-based organizations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- Is a survey that asks consumers and patients to report on and evaluate their experiences with health care.
- It focuses on care in *non-hospital settings* (physician offices, nursing homes, etc.).
- It asks the same questions and is scored in the same way, wherever it is used. It continues to be improved, as needed.
- It asks questions about how care is given. For example, it asks questions about how well health care providers talk with their patients and how easily patients can get the health services they need.
- The CAHPS survey is done every year. The results are sometimes reported to the public.

Consumer Assessment of Healthcare Providers and Systems (H-CAHPS or CAHPS Hospital Survey)

- Is a survey that asks consumers and patients to report on and evaluate their experiences with health care.

- Unlike the CAHPS survey, this survey focuses on *hospital care*.
- It asks the same questions and is scored in the same way, wherever it is used. It continues to be improved, as needed.
- It asks questions about how care is given. For example, it asks questions about how well health care providers talk with their patients and how easily patients can get the health services they need.
- The H-CAHPS survey is done every year. The results are sometimes reported to the public.

Coordination of Care

- Ensures that patients and all members of a patient's care team have, and consider, all required information on a patient's conditions and treatments.
  - For example, a primary care doctor knows what medicines a patient has been prescribed by other doctors. He can look at the complete list of the patient's medicines to find and prevent dangerous drug interactions.
  - Or, a hospital lets a patient's primary care doctor know when the patient is leaving the hospital to go home. This helps make sure the primary care doctor can give the patient the best follow-up care needed.

Cost

- Refers to the amount of money paid to a health care provider for a health care service.

Cultural Competency (in health care)

- Describes the ability of health care systems to provide good care to patients with diverse values, beliefs, and behaviors.
- It includes the ability to customize the way care is delivered to meet patients' social, cultural, and language-related needs. This means taking the following kinds of things into consideration when making suggestions for treatment or preventive care:
  - Income
  - Living conditions
  - Daily lifestyle/schedule
  - Food preferences and diet
  - Education
  - Reading skills
  - Health beliefs
  - Main language spoken

Delivery System

- Refers to the way medical care is organized and provided to patients.
- This includes the care, products, and services patients receive from doctors, hospitals, and other professionals.

Department of Health and Human Services (HHS or DHHS)

- Is a U.S. government agency responsible for protecting Americans' health, in many

ways, and for providing essential human services, particularly for people who need the most help. This includes financial assistance for people with low incomes.

Effective Care

- Means providing treatments that research has shown work well. The benefits of using the treatment are much greater than any problems or risks that might come up from using the treatment.
    - For example, research shows that taking medicines known as beta-blockers can lower a patient's risk of heart attack. While some patients may experience side effects from taking beta-blockers, such as being tired and getting headaches, many patients decide that the benefits outweigh the risks. In other words, patients are often willing to put up with being tired and sometimes having headaches if it means they will be less likely to have a heart attack.
- These are services that are backed by medical theory and have strong evidence of value, determined by clinical trials or other research studies. They have been well-researched.

Episodes of Care

- Refers to a series of encounters or visits to health care facilities to treat a specific health condition, within a specific period of time.
- Thinking of care in this way is useful for measuring both the quality of care received and the efficiency of care provided.

Electronic Health/Medical Record (EHR or EMR)

- Generally, it is a medical record kept on a computer, instead of in a paper chart.
- Specifically, it is medical software with the electronic history of a patient's medical care.
- Using electronic records has a number of advantages:
    - It makes the health care system more efficient.
    - It allows for better coordination of care. Each provider can now see what another provider has done, so they can work better together to care for each patient.
    - It also gives patients the chance to look at and control their own medical records.

Evidence-based Medicine

- Involves making medical decisions based on information and practices that have been carefully researched, written about, and proven to work.
- Is the use of the most up-to-date, best available scientific research and practices with proven effectiveness in daily medical decision-making.
- It includes individual clinical practice decisions by well-trained, experienced health care clinicians.
- Evidence, or proof, is central to developing performance measures (deciding how to best treat for the most common and expensive health conditions).

Family Caregiver

- Is a family member or friend who cares for and supports a patient with a chronic health condition or an illness.

Federally Qualified Health Center (FQHC)

- Is a health organization that offers primary care and preventive health services to all patients, regardless of their ability to pay for care.
- An FQHC may be a public or private nonprofit organization.
- It must also meet specific criteria to receive government funding. This includes having a Community Governing Board, with more than half of the Board members (at least 51%) being made up of people who use the health center's services.

Fee-For-Service

- Is a way of paying for care provided by doctors , hospitals, or other health care providers.
- With this approach, patients or a third party (such as a health plan) pay for:
    - Each office visit or health care service a patient receives; or
    - Each health care service a patient receives.

Functional Status

- Refers to a person's ability to do normal activities of daily living (ADLs).
- These are activities that people engage in to meet basic needs, fulfill usual roles, and maintain health and well-being.
    - For example, getting dressed, bathing, and using the bathroom are ADLs.
- A decrease in functional status is measured by a person's inability to do ADLs over a period of time.

Health Care Acquired Condition/Hospital Acquired Infection (HAC or HAI)

- Is an illness or infection that a patient didn't have when he/she checked into the hospital.
- Instead, it is passed on to them as a result of contaminated medical equipment or germs from:
    - Other patients,
    - Doctors, or
    - Staff

Health Disparities

- Are differences in how health care is delivered and how easy it is for patients to get

based on factors such as:

- Race,
- Ethnicity, (people's national or cultural background),
- Language,
- Geography, (where people live)
- Gender, (whether they are male or female)
- Sexual orientation, (whether they are lesbian, gay, bisexual, or transgender)
- Education, and/or
- Income

- One of the goals of health care quality improvement efforts is to find where unfair and unjust health care practices exist and get rid of them. One method used to identify these unfair practices is stratifying quality data. This means separating the data by R/E/L/G, which means:
  - Race,
  - Ethnicity,
  - Language, and
  - Gender

Health Information Technology (Health IT or HIT)

- Is a term that refers to the use of electronic medical (or health) records, instead of paper records.
- It uses computers, software programs, electronic devices, and the Internet to securely manage information about patients' health in a secure way. This includes:
  - Storing information,
  - Retrieving information,
  - Updating information, and
  - Transmitting information

Health Literacy

- Is the degree to which individuals are able to get, process, and understand basic health information and services needed to make appropriate health decisions.
- Health literacy is not simply the ability to read.
- It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations.
- For example: Health literacy allows people to understand instructions on medicine bottles and doctors' forms, as well as talk about health needs and concerns with a doctor or nurse.

Health/Disease Registries

- Are lists of people diagnosed with a specific disease.
    - For example: A diabetes registry lists people with diabetes.
- Health/disease registries are used for purposes such as research, public health, or quality improvement.

Hospital Discharge

- Is the way that a patient is released from the hospital by health care professionals.
- After a hospital discharge, a patient may be going home or to another health care setting, such as a rehabilitation center or nursing home.

Hospital Readmission

- Happens when a patient is readmitted to a hospital after being released.
- Readmissions rates, usually within a certain time period (7 to 60 days), are viewed as one way of telling how well patients are being cared for.
- Low readmissions rates tend to mean that patients are getting better care and do not need to return to the hospital because of more health problems.

Inpatient Care

- Is giving health care services to a person who has been admitted to a hospital or other health facility for at least 24 hours.

Intervention

- Something that is done to improve a patient's health or help with a particular problem.
- This includes any type of treatment, preventive care, or test a person could take or receive.

Meaningful Engagement

- Is a way to actively involve different groups of people in all aspects of a project's design, governance, implementation, and evaluation.
- This is a term often used when describing groups that include patients, providers, and employers.

Meaningful Use

- Is a federal program that gives health care providers money to help them start using health information technology (HIT).
- Providers need to show they are using "certified electronic health record technology" in ways that:
    - Improve the quality of care,
    - Improve patients' access to health information, and

- Improve the health of populations.

Medical Error

- Is a mistake that harms a patient.
- Examples of preventable medical errors include: Adverse drug events, hospital-acquired infections, and surgeries on the wrong part of the body.

Medication Management

- Includes activities to ensure the safe and effective use of prescription and over-the-counter medicines.
- This includes helping patients keep track of:
  - Which prescription and over-the-counter medicines they are taking, and
  - When they are taking them.
- This is done so that people take medicines in the right ways and don't have a bad reaction or side effects.

Misuse (of care)

- Occurs when these things take place:
  - An appropriate process of care has been selected,
  - But a preventable complication occurs, and
  - The patient does not receive the full benefit of the health care service.
- Avoidable complications of surgery or medicine use are misuse problems.
  - For example: Giving a patient penicillin for strep throat, despite a known allergy to that antibiotic.

Outcome

- Refers to a patient's health—whether it improves, declines, or stays the same—after an encounter with the health care system.

Outpatient Care

- Is medical or surgical care that does not include an overnight hospital stay.

Overuse (of care)

- Describes either of these things:
  - Unnecessary care; or
  - Times when care is given and the chance of causing harm is greater than the possibility of benefit.
- For example: Prescribing an antibiotic for a viral infection like a cold, when antibiotics

do not work.

- Overuse can also happen when medical tests and surgical procedures are unnecessarily run more than once.

Patient Activation Measure (PAM)

- Is a way to measure how likely a patient is to be an informed, active participant in his/her own healthcare.
- Doctors sometimes use PAM to figure out how ready a patient is to change his or her behavior.
- Doctors then work with that patient on his or her care plan.

Patient- and Family-Centered Care (PFCC)

- Is a way of going about the planning, delivery, and evaluation of health care.
- It is based on partnerships among health care providers, patients, and families that are good for everyone involved.
- It is based on the following core concepts:
    - **Dignity and respect** for patient and family perspectives and choices;
    - **Sharing** complete and unbiased information with patients and families in ways that are affirming and useful;
    - **Participation** in care and decision-making at the level patients and families choose; and
    - **Collaboration** among patients, families, health care practitioners, and health care leaders in: 1) policy and program development, implementation, and evaluation, 2) facility design, 3) professional education, and 4) delivery of care.

Patient Centered Medical Home (PCMH)

- Is not an institution or a place.
- Instead, it is a way of delivering outpatient care that emphasizes:
    - Care that is easy to access, is comprehensive and well-coordinated; and
    - Active involvement of the patient and family in health care decisions.
- In a medical home, the primary-care doctor acts as a "home base" for patients.
    - That doctor is chosen by the patient and becomes the patient's personal physician.
    - The doctor (along with nurses, medical assistants, and others in the office who are part of the "care team") oversees all aspects of patients' health and coordinates care with any specialists or other providers involved in the patient's care.
    - Patients do not need a referral from their primary care doctor to see other doctors. This is because the primary care doctor serves more as a manager than a "gatekeeper" of each patient's care.

Patient Experience Data (also called Patient Satisfaction Data)

- These are measures of how patients evaluate their health care experiences.
- It does this by capturing the patient's observations and opinions about what happened during the process of health care delivery.
- Patient experience data is information on how well the patients' needs are met. It looks at the following parts of the patient experience:
  - **Access**. Can patients get care when they need it?
  - **Communication skills**. Is information provided to patients in a way they can understand?
  - **Respect**. Are patients treated with courtesy and respect?
  - **Support**. Do patients get the information and support they need to take care of their health conditions?
- The CAHPS survey (see above) is an example of a tool for measuring patient experience.

Patient and Family Advisory Councils (PFAC)

- Are a way to involve patients and families in policy and program decision-making in health care settings.
- These councils help design, implement, and evaluate changes in policies, programs, and practices that affect the care and services individuals and families receive.
- Councils generally include:
  - Patients and family members,
  - Community members,
  - Consumer advocates,
  - Doctors, nurses, and other health care providers, and
  - Administrative staff.
- PFACs may be referred to by many names such as Patient-Provider Councils, Patient Advisory Boards, Consumer Advisory Boards, etc.

Patient Protection and Affordable Care Act (also called the Affordable Care Act or ACA)

- Is the name of health reform legislation signed by President Obama in 2010.
- In addition to expanding access to health care, the law includes provisions aimed at:
  - Improving the quality of care,
  - Improving the payment system (the way health care is paid for),
  - Protecting patients' rights;
  - Changing health insurance.

Pay-for-Performance (P4P)

- Is a way of paying hospitals and doctors based on whether they meet specific health care quality goals.
- The goal is to reward providers for the quality—not the quantity—of care they deliver.

Payers

- Are the organizations or the people that pay for medical treatments.
- Examples include: Health plans, HMOs, self-insured employers, and uninsured patients.

Payment Reform

- Seeks to improve ways of reimbursing (paying) providers based on value instead of volume of the care they have provided.
- This is different from the fee-for-service method of payment. With that method, providers get paid regardless of the quality of the care that is given.

Premium

- Set amount of money that is paid to cover a patient's health insurance benefits.
- Premiums can be paid by employers, unions, employees, or shared by both the insured individual and their employer, for example.

Preventive Care

- Are health care services that prevent disease or its consequences.
- This includes:
    1. **Primary prevention:** to keep people from getting sick (such as immunizations),
    2. **Secondary prevention**: to detect early disease (such as mammograms) and,
    3. **Tertiary prevention:** to keep ill people, or those at high risk of disease, from getting sicker (such as helping someone with lung disease to quit smoking, or preventing complications from diabetes like foot or eye problems).

Price Transparency

- Is making the charges of a given health care service (such as an x-ray or MRI) at different facilities available to the public, so that those prices are "transparent" or easy to see.

Primary Care

- Is basic or general health care that helps patients and families to maintain and improve their health.
- It includes a range of prevention and wellness services, and treatment for common illnesses.
- Primary care is traditionally provided by doctors trained in:
    - Family practice,
    - Pediatrics,
    - Internal medicine; and occasionally

- Gynecology

Provider

- Refers to a professional who provides health services.
- This includes:
  - Primary care doctors and nurses,
  - Specialists (such as podiatrists or cardiologists); and
  - Other allied health professionals (such as physical therapists).
- Hospitals and long-term care facilities are also providers.

Provider Incentives

- Are steps taken to motivate specific provider behavior within the health care system.
- For example: Bonuses for providers who provide high quality care.

Public Reporting

- Makes information about hospital, physician, and physician group performance available to the public.
- The expectation is that a public report of local hospitals' or doctors' performance will:
  - Motivate and improve performance, and
  - Allow the public to choose providers based on performance.

Purchasers

- Are the organizations and people (often employers, unions, etc.) that do both of the following:
  - Decide on what benefits the insured person gets, including the amount of money given to him or her to cover health care expenses.
  - Work with groups that provide health insurance coverage to debate the cost of premiums (the portion of money the patient pays for his or her health care) and the overall cost of care.
- For example: Employers and state governments that provide health insurance to their employees are purchasers.

Quality (of care)

- Is the right care, at the right time, for the right reason.
- Ideally, it is also at the right cost.

Quality/Performance Measures

- Are ways to evaluate the care provided by doctors and hospitals, based on accepted national guidelines.

- These measures evaluate:
    - Access to medical care,
    - The way care is given,
    - Patient results after treatment (outcomes),
    - Patient experiences with care, and
    - Use of medical services.

Resource Use

- Is the amount of health care services used for a patient.
- This includes:
    - How many services were provided,
    - How much of each service was provided, and
    - How much those services cost.

Risk Adjustment

- In health care, this means taking certain factors into consideration in order to estimate the risk involved in a patient getting a particular intervention.
- For example:
    - **Age** can play a role in estimating the risk of getting some treatments. A younger person may recover more easily than an older person.
    - **Severity of disease** can play a role, as well. Someone with early stage cancer may recover more easily than someone in a later stage of the same cancer.
- If these factors are not taken into consideration, it is hard to make fair comparisons. Organizations adjust for risk when reporting their performance measures - meaning how well they are providing care for patients.
- Reporting on performance measures allows them to see how they are doing in comparison with other organizations and communities.

Self-Management

- Is the ability of individuals to take care of health problems or conditions on a day-to-day basis.
- It is a skill that allows individuals and their families to use existing health services.
- It also helps patients make choices about:
    - Health care providers,
    - Medicines, and
    - Diet, exercise, and other lifestyle choices that protect or damage health.

Shared Decision-Making (SDM)

- Is a process in which patients and their doctors make medical decisions together.
- This is done while taking into account:
    - Medical recommendations, and
    - The patient's preferences, life situation, needs, and values.

Shared Savings

- Is a way of encouraging hospitals and doctors to lower health care spending, while keeping high levels of quality and safety.
- This is done by giving hospitals and doctors a percentage of any net savings they generate as a result of their efforts.
- The goal is to reward health care providers for the quality, safety, and cost-effectiveness – not the quantity – of care they deliver.

Stakeholder

- Refers to any person, group, or organization that can affect or be affected by the health care system.
- It includes:
    - Patients,
    - Providers,
    - Employers, and
    - Health plans.

Transparency

- Is the process of gathering and reporting data about health care in a way that can be accessed by the public. Making data "transparent" means making it easier for people to see.
- This includes data on:
    - Cost,
    - Performance, and
    - Quality.
- It is intended to improve the quality of health care and ultimately improve the health care system as a whole.

Transition of Care

- Refers to the movement of a patient from one health care setting to another.
- For example: The movement of a patient from a hospital to a nursing facility, or from a nursing facility to home.

Underuse (of care)

- Happens when a health care service is *not* provided to a patient, but could have led to a good result.
- For example:
  - **Failure to give preventive services to eligible patients** (such as mammograms, flu shots for elderly patients, screening for hypertension), and
  - **Failure to give trusted medicines for chronic illnesses** (such as steroid inhalers for people with asthma or aspirin and beta-blockers for patients who have suffered a heart attack).

Value-based Purchasing

- Refers to the concept of health care purchasers (i.e. employers or government programs like Medicare) holding health care providers accountable for both cost and quality of care.
- Value-based purchasing brings together two types of information that purchasers use to decide whom to pay to provide care for their employees. This includes:
  1. Information on the quality of health care, including patient outcomes and health status, and
  2. Information on cost of care.
- It focuses on managing the use of the health care system to:
  - Reduce inappropriate care, and
  - To identify and reward the best-performing providers.

Variation

- Refers to differences in the use of health care services that c*annot* be explained by:
  - Differences in patient illness, or
  - Differences in patient preferences.
- Instead, this variation *may* be explained by:
  - Differences in the ways providers follow medical recommendations (meaning that the quality of care provided to patients is better or worse depending on how well a clinician follows these recommendations),
  - Differences in the amount of service delivered to different populations (such as tests, surgeries, etc.).
- Research on variations has shown that people living in areas where the cost of care is higher, and where use of services is higher, do *not* have longer life expectancy than those in areas where the cost of care is lower. In other words, more care is *not* necessarily better care.