

# Health Care Glossary

JANUARY 2014

**Accountable Care Organization (ACO)** is a group of health care providers (e.g. primary care physicians, specialists, hospitals and others) who agree to assume collective responsibility for the cost and quality of care of a group of patients and are paid in a way that incentivizes improved quality and efficiency of health care.

**Ambulatory Care** is medical care that does not require an overnight stay in a hospital. Ambulatory Care can be provided in physicians' offices, clinics, emergency departments, outpatient surgery centers, as well as hospital settings that do not involve a patient being admitted for an overnight stay.

**Benchmark (benchmarking)** is a way for hospitals and doctors to compare data on quality of care, both internally and against data from other hospitals and doctors, to identify best practices of care and improve quality.

**Best practices** are the most up-to-date treatments for patients, which result in the best patient health and minimize patient risk of death or complications.

**Center for Medicare and Medicaid Innovation (CMMI)** is a new division within CMS, created by the health reform law, charged with testing new payment and health care service delivery models in Medicare and Medicaid. The Center will rapidly test, evaluate, and then bring to scale new payment and health care delivery strategies that could improve quality and encourage better coordinated, more patient-centered care.

**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. Marilyn Tavenner is currently the Administrator for the agency.

**Chronic care model** is a model of care that advocates for more productive interactions between patients and care teams. The model elements include:

- ▶ systems that provide access to data that helps doctors and patients coordinate their care (such as reminders about needed services);
- ▶ support for doctors and patients in making decisions about treatment plans that are based on the best available scientific evidence;
- ▶ support for patients to become empowered and effective in managing their own health and health care (such as working together with doctors to set manageable goals, create treatment plans, and solve any problems along the way);

- ▶ working with community organizations to help meet the needs of patients (such as connecting them to nutrition, exercise, or disease management classes that might be offered by local senior centers);
- ▶ health system leaders that work to create a culture around continually improving the safety, coordination and quality of care (such as processes to ensure patient have regular follow up from their care team, and that the care that is provided fits with patients' needs and preferences.)

**Chronic disease/condition** is a sickness that is long-lasting or recurrent. 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 evidence that help physicians and their patients make decisions about appropriate health care for specific medical conditions. Clinical practice guidelines identify and evaluate the most current information about prevention, diagnosis, prognosis, therapy, risk/benefit and cost effectiveness.

**Cognitive Impairments** are difficulties with memory, thinking, speech, or another mental function, caused by illness or injury, which may affect daily life.

**Comparative effectiveness research** compares multiple medications or treatments to determine which is most effective for different types of patients.

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

**Consumer/Patient/Beneficiary** refers to an individual who has significant personal or family experience with the health care system, either as an individual receiving care (such as someone covered by Medicare – a beneficiary) or as a caregiver.

**Consumer Advocate (also called consumer representative)** refers to individuals who work at nonprofit, mission-oriented organizations that represent a specific constituency of consumers or patients. What distinguishes consumer advocates is their primary emphasis on the needs and interests of consumers and patients. Another important characteristic of consumer advocates is they typically do not have a financial stake in the health care system. Examples of consumer advocacy organizations include AARP, YWCA and faith-based organizations.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS or CAHPS Hospital Survey)** are surveys that ask consumers and patients to report on and evaluate their experiences with health care. The H-CAHPS survey focuses specially on hospital care, while CAHPS focuses on care in non-hospital settings (physician offices, nursing homes, etc.). These comprehensive and evolving set of standardized surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The results of CAHPS and H-CAHPS surveys are publically reported to allow valid comparisons to be made across all settings.

**Collaborative Consumer Engagement** is the act of working in partnership with consumers, consumer advocates, patients and their families/caregivers to improve the health care delivery system.

**Coordination of Care** ensures that patients and all members of a patient's care team have access to and take into consideration all required information on a patient's conditions and treatments to ensure that the patient receives appropriate health care services.

**Cost** refers to the actual amount of money paid to a health care provider for a health care service.

**Cultural Competency** in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring the way care is delivered to meet patients' social, cultural, and linguistic needs.

**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 the U.S. government agency that is responsible for protecting Americans' health and for providing essential human services, particularly for the most vulnerable. Secretary Kathleen Sebelius currently leads the agency.

**Effective Care** means health care services that are of proven value and have few, if any, significant tradeoffs. The benefits of the services so far outweigh the risks that all patients with specific medical needs should receive them. These services, such as beta-blockers for heart attack patients, are backed by medical theory and strong evidence of value, determined by clinical trials or other studies.

**Episodes of Care** refers to a series of encounters or visits to health care facilities to treat a health condition. Thinking of care in this holistic way is useful for measuring both the quality of care received and the efficiency of the care provided.

**Electronic Health/Medical Record (EHR or EMR)** is medical software that contains the electronic history of a patient's medical care. The use of electronic records makes the health care system more efficient, allows for better coordination of care and provides patients the opportunity to view and control their own medical records.

**Evidence-Based Medicine** is the use of the most current, best available scientific research and practices with proven effectiveness in daily medical decision-making, including individual clinical practice decisions by well-trained, experienced clinicians. Evidence is central to developing performance measures for the most common and costly 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.

**Functional Status** refers to an individual's ability to do normal daily activities to meet basic needs, fulfill usual roles, and maintain health and well-being. Testing a patient's functional status is an important part of care for the elderly. Decrease in functional status is measured by a person's loss of independence in activities of daily living (ADLs) over a period of time.

**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 and must meet specific criteria, including 51% consumer representation in governance, to receive government funding.

**Fee-For-Service** is an approach to payment for care under which patients or a third party (such as a health plan) pay physicians, hospitals or other health care providers for each office visit or health care service a patient receives.

**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 – that is passed on to him/her as a result of contaminated medical equipment or germs from other patients, doctors, or staff.

**Health Disparities** are differences in the delivery of health care, access to health care services and medical outcomes based on ethnicity, geography, gender, sexual orientation, and other factors that do not include socioeconomic status or insurance coverage. One of the goals of health care quality improvement efforts is stratifying quality data by **race/ethnicity/language (R/E/L)** in order to better understand where inequities exist and eliminate them.

**Health Information Technology (Health IT or HIT)** is a term that refers to the use of electronic medical (or health) records, as well as computers, software programs, electronic devices and the Internet to securely store, retrieve, update and transmit information about patients' health.

**Health Literacy** is the degree to which individuals are able to obtain, 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 prescription drug 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, such as diabetes.

**Hospital Discharge** is the process by which a patient is released from the hospital by health care professionals.

**Hospital Readmission** occurs when a patient is readmitted to the same hospital after discharge. Readmissions rates, usually within a certain time period (7-60 days), are viewed as an indicator of the quality of care delivered to patients, with low readmissions rates associated with better care.

**Inpatient Care** is the delivery of health care services to a person who has been admitted to a hospital or other health facility for a period of at least 24 hours.

**Intervention** includes any type of treatment, preventive care or test a person could take or receive to improve his/her health or help with a particular problem. Intervention can also be used to describe a way of improving quality of care.

**Meaningful Engagement** is a set of practices established to activate stakeholders in all aspects of a project's design, governance, implementation and evaluation. This is a term often used with respect to multi-stakeholder bodies.

**Meaningful Use** is a federal program that gives health care providers funding for health information technology (HIT) adoption. Providers need to show they are using "certified electronic health record technology" in ways that improve the quality of care, individual access to health information and the health of populations.

**Medical Error** is a mistake that harms a patient. Adverse drug events, hospital-acquired infections and wrong-site surgeries are examples of preventable medical errors.

**Medication Management** includes activities to ensure the safe and effective use of prescription and over-the-counter drugs. This includes helping patients keep track of the prescription and over-the-counter drugs they are taking, and when, so that they are taken properly and don't cause a bad reaction or side effect.

**Misuse (of care)** occurs when an appropriate process of care has been selected, but a preventable complication occurs and the patient does not receive the full potential benefit of the service. Avoidable complications of surgery or medication use are misuse problems. Giving a patient penicillin for strep throat, despite a known allergy to that antibiotic, is an example of misuse.

**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 unnecessary care or circumstances where the potential for harm exceeds the potential for benefit. Prescribing an antibiotic for a viral infection like a cold, for which antibiotics are ineffective, is overuse. Overuse can also apply to repeated diagnostic tests and surgical procedures.

**Patient Activation Measure (PAM)** is a series of tools to measure how likely a patient is to be an informed, active participant in his/her own health care. Physicians sometimes use

PAM to identify a patient's stage of activation, and then work with that patient to individualize their care plans.

**Patient- and Family-Centered Care** is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients and families. It is based on the core concepts of 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 between patients, families, health care practitioners, and health care leaders in policy and program development, implementation, and evaluation, facility design, professional education, and delivery of care

**Patient-Centered Medical Home (PCMH)** is not an institution, but a way of delivering outpatient care that emphasizes readily accessible, comprehensive, coordinated care, and active involvement of the patient and family in health care decisions. In a medical home, the primary-care doctor operates as a “home base” for patients, overseeing all aspects of patients’ health and coordinates care with any specialists involved in the patient’s care.

**Patient Experience Data (also called Patient Satisfaction Data)** is information that reflects quality from the perspective of patients by capturing observations and opinions about what happened during the process of health care delivery. Patient experience data include various indicators of patient-centered care, including access (whether patients obtain appropriate care in a timely manner), communication skills, customer service, and helpfulness of office staff and information resources. 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 engage 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, family members, consumer advocates, and community members, as well as health care clinicians 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 quality of care, reforming the payment system, protecting patients’ rights, and reforming health insurance.

**Pay-for-Performance (P4P)** is a way of paying hospitals and physicians based on whether they meet specific health care quality objectives. The goal is to reward providers for the quality—not the quantity—of care they deliver.

**Payers** are the entities that pay for medical treatments. Examples include health plans, HMOs, self-insured employers and uninsured patients.

**Payment Reform** seeks to improve ways of reimbursing providers based on value instead of volume (as opposed to the fee-for-service method of payment).

**Preventive Care** is health care services that prevent disease or its consequences. It includes primary prevention to keep people from getting sick (such as immunizations), secondary prevention to detect early disease (such as mammograms) and 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).

**Price Transparency** is making the charges of a given health care service at different facilities available to the public.

**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, including primary care physicians, 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 used to motivate specific provider behavior within the health care system. Examples of incentives include monetary rewards for providers who provide high quality care.

**Public Reporting** makes information about hospital, physician and physician group performance available for consumers and others. The expectation is that a public report of local hospitals'/physicians' performance will motivate and improve performance and allow consumers to choose providers based on performance.

**Purchasers** are the entities that not only pay the premium for health care costs, but also control the premium dollar before paying it to the provider. Employers and state governments that provide health insurance to their employees are examples of purchasers.

**Quality (of care)** is the right care, at the right time, for the right reason, ideally 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, including the number, cost and intensity of services provided.

**Risk Adjustment** in health care refers to the use of factors such as severity of illness or age to estimate the risk involved in a patient undergoing a particular intervention. Adjusting

for risk when reporting performance measures allows for comparison of performance and quality across organizations and communities.

**Self-Management** is the ability of individuals to manage their health problems or conditions on a day-to-day basis. It is a skill that enables individuals and their families to use existing health services, as well as make choices about health care providers, medication, diet, exercise and other lifestyle issues that protect or damage health.

**Shared Decision-Making (SDM)** is a process in which patients and their doctors make medical decisions together, while taking into account clinical guidelines and the patient's preferences, life situation, needs, and values.

**Shared Savings** is a way of encouraging hospitals and physicians to reduce health care spending (while maintaining high levels of quality and safety) by offering them a percentage of any net savings they generate as a result of their efforts. The goal is to reward 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, such as patients, providers, employers and health plans.

**Transparency** is the process of collecting and reporting health care cost, performance and quality data in a way that can be accessed by the public and 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, such as from a hospital to a nursing facility, or to home.

**Underuse (of care)** refers to the failure to provide a health care service when it would have produced a good result for a patient. Examples include failure to give preventive services to eligible patients (e.g., mammograms, flu shots for elderly patients, screening for hypertension) and proven medications for chronic illnesses (steroid inhalers for people with asthma; aspirin, beta-blockers for patients who have suffered a heart attack).

**Value-Based Purchasing** refers to the concept of health care purchasers (i.e. employers) holding health care providers accountable for both cost and quality of care. Value-Based purchasing brings together information on the quality of health care, including patient outcomes and health status, with 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.

**(Unwarranted) Variation** refers to differences in the use of health care services that cannot be explained by differences in patient illness or patient preferences. Variation may occur because of differences in the degree to which providers follow clinical guidelines (meaning that the quality of care provided to patients is better or worse depending on how well a clinician follows these guidelines), as well as differences in the amount of service (such as tests, surgeries, etc.) delivered to different populations. Research on variations has shown that people living in areas where cost of care is higher and where use of services is higher



do not have longer life expectancy than those in areas where cost of care is lower. More care is not necessarily better care.

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