Healthcare Glossary Of Terms

Along with the changes in healthcare delivery has come a new vocabulary. In searching for health services to provide to your residents, it is of value to be familiar with this terminology.

Terms	Acronym	Definitions
Accountable Care Organization	ACO	Are groups of physicians, hospitals and other health care providers, who come together voluntarily to give coordinated, high-quality care to a group of patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and medical records.
Admission, Discharge & Transfer	ADT	An ADT feed is one way an application or a provider can get demographics and medical records information from a clinic or hospital information system (HIS).
Behavioral Health Organization	BHO	Service and care management organizations specializing in the care of mental illness substance abuse and behavioral health.
Bundle Payment Care Initiative	BPCI	Experimental payment program supported by Centers for Medicare and Medicaid Services for reimbursement of certain services delivered to Medicare patients. Composed of four alternative payment and risk sharing models, all based upon fixed episode of care based payments and care quality metrics.
Clinical Event Notification	CEN	Automated alert programs distributing notifications upon initiation or change in care status or attributed patients or beneficiary populations.
Certified Home Health Agency	CHHA	Certified home health agencies provide skilled nursing, physical, speech, occupational, social work and home health aide service to patients in their home that is reimbursed by Medicare.
Clinically Integrated Network	CIN	Contractual collaboration of hospitals, health systems and provider groups to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control cost and ensure quality.
Care Management	CM	A set of evidence-based, integrated clinical care activities that are tailored to the individual patient, and that ensure each patient has his or her own coordinated plan of care and services.
Centers for Medicare & Medicaid Services	CMS	An agency within the U.S. Department of Health and Human Services that is responsible for administration of several key federal health care programs.
Clinical Protocol & Quality Assurance	CPQA	The Committee within CHS that is the governing body for reviewing & approving clinical protocol, quality and compliance related activities and programs.
Care Transition Notifications	CTN	Real-time alerts to clinicians and care managers any time an attributed patient is admitted, discharged or transferred to a new care setting. CTNs enable real-time clinical and operational management of the patient.
Date Of Service	DOS	Refers to the exact date a patient received medical services. Dates of service are extremely important when dealing with medical billing.
Data Share Preferences	DSP	Process of informing Medicare attributed patients that the practice is a participant in an ACO and providing patients with the option to share their claims information.
Delivery System Reform Incentive Payment Program	DSRIP	Program that will fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over five years. Up to $6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health.
Evidence-Based Guidelines	EBG	A systemically developed statement to assist practitioner and patient decisions about the appropriate health care for specific clinical circumstances.

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Terms	Acronym	Definitions
Evidence-Based Measures	EBM	Metrics that are utilized to determine a patient's health outcome based on scientific evidence. This information is shown through results, such as claims, test, survey and labs.
Electronic Medical Records/ Electronic Health Records	EMR/EHR	Systems that store health records, forms and data in an electronic format.
Fee For Service	FFS	When services are unbundled and paid for separately. In health care, it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.
Healthcare Effectiveness Data & Information Set	HEDIS	Tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and services.
Home Health Aide	HHA	Home health aides deliver personal care to patients at home. They are typically for patients who need help or cannot perform daily household functions.
Health Insurance Portability & Accountability Act	HIPPA	A set of rules and standards created to help protect a patient's personal information. It permits disclosure of health information needed for patient care and other purpose.
Health Maintenance Organization	HMO	Health insurance policy type that arranges managed care for providers on a prepaid basis. Most HMO policies do not allow a member to go outside of their network.
Integrated Delivery Network	IDN	Network of facilities and providers that cooperate to offer a continuum of care to a specific geographic area or market.
Managed Long-Term Care	MLTC	A system that streamlines the delivery of long-term services to people who are Medicaid eligible and chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the New York State Department of Health. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen.
Medicare Shared Savings Program	MSSP	Designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee for Service beneficiaries and reduce unnecessary costs.
Occupational Therapy	OT	Form of therapy used to help rehabilitate performance of activities required in daily life.
Patient Centered Medical Home	PCMH	A care delivery model where patient treatment is coordinated through primary care physicians to ensure that a patient receives the necessary care. In order for a practice to achieve PCMH, they must encompass five functions: comprehensive care, patient centered, coordinated care, accessible services, quality & safety.
Preferred Provider Organization	PPO	A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals and providers outside of the network for an additional cost.
Physical Therapy	PT	Form of therapy used to rehabilitate a patient through exercise and other physical measures.
Quality, Utilization, Admission, Cost	QUAC	A score generated for physicians in the network. Quality refers to patient compliance among five measures based on evidence based guidelines. Utilization is broken into two sections: ED utilization measures the number of ED visits among attributed patients and DU measures how frequently providers are referring to within the CHS Physician Partners. Admissions is broken into two sections: number of admissions and readmissions for attributed patients. Cost shows the amount of risk adjusted per member per month for the provider's attributed patients.
Skilled Nurse Facility	SNF	Facilities that provide round-the-clock nursing care and significant assistance with activities of daily of care and decreasing costs.
Shared Savings Program	SSP	Programs designed to facilitate coordination and cooperation among providers to improve the quality of care and decreasing cost.
Transition Of Care	TOC	The movement of a patient from one setting of care to another.
Value-Based Payment	VBP	The payment made by Medicare with the value-based modified adjustment applied.