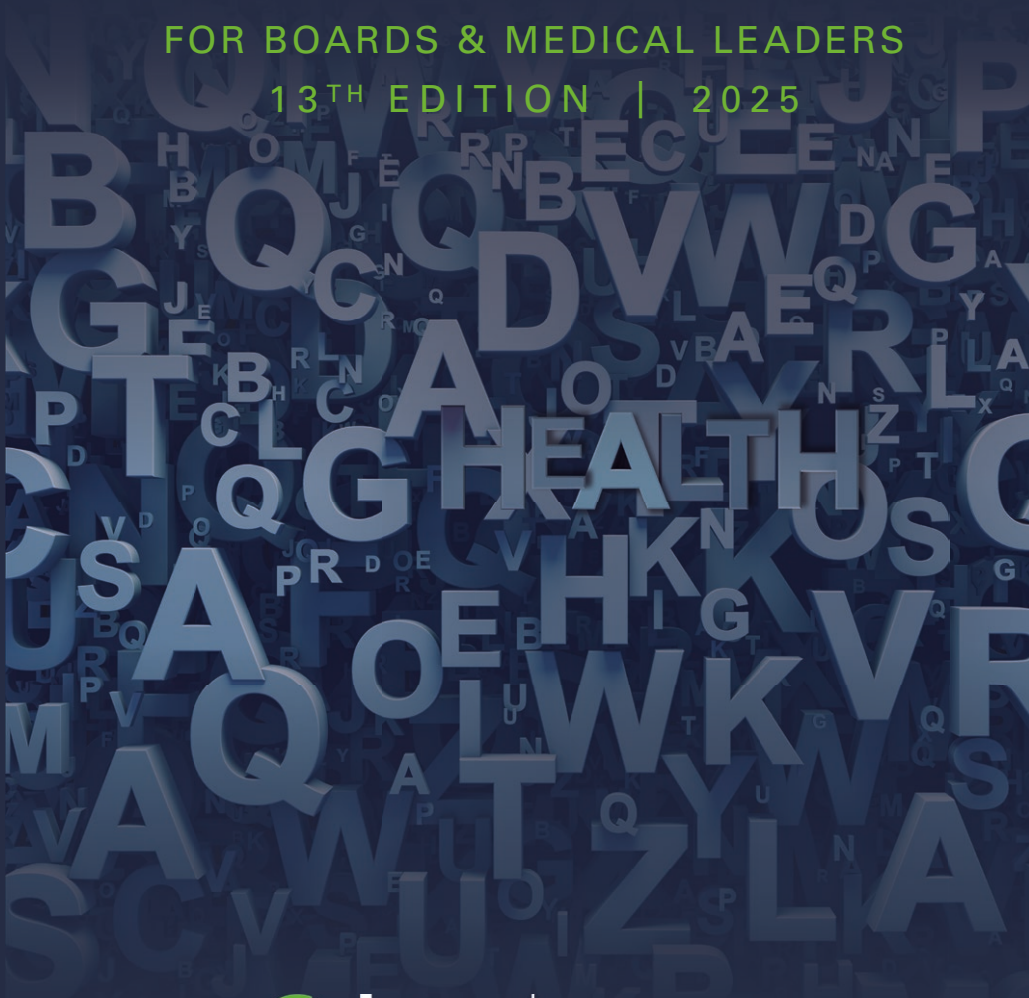
Healthcare Acronyms & Terms

FOR BOARDS & MEDICAL LEADERS

13TH EDITION | 2025



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Introduction

Welcome to the world of healthcare. Successful navigation through this complex world requires a cache of tools, first and foremost of which is a guide to the language, terminology, and jargon.

The 13th edition of *Healthcare Acronyms & Terms* provides new terms for a post-COVID healthcare industry. The most significant additions this year are related to the healthcare equity and disparity issues revealed by the COVID-19 pandemic and their implications on healthcare. In addition, many new terms emphasize technological advancements related to digital health and artificial intelligence, new financial and business disruptors in the sector, and greater emphasis on social and environmental responsibility.

This booklet both demystifies healthcare and updates the user's healthcare vocabulary. It actually serves two purposes: it is a starting place for those new to the industry and an extension for those who have been navigating the terminology landscape for a while. The Governance Institute publishes an update every two years to keep pace with new acronyms and terms that make it into boardrooms.

Acronyms

AAFP	American Academy of Family Physicians
AAHC	Association of Academic Health Centers
AAMC	Association of American Medical Colleges
AAPCC	Adjusted average per capita cost
AAPM	American Academy of Pain Medicine
AAPPO	American Association of Preferred Provider Organizations
AAPS	Association of American Physicians and Surgeons
AARP	American Association of Retired Persons
ABA	American Bar Association
ABHW	Association for Behavioral Health and Wellness
ABMS	American Board of Medical Specialties
ACA	Affordable Care Act (also known as the Patient Protection and Affordable Care Act, PPACA, and "Obamacare")
ACC	American College of Cardiology
ACCME	Accreditation Council for Continuing Medical Education
ACE	Acute care episodes
ACGME	Accreditation Council for Graduate Medical Education
ACH	Accountable Community for Health
ACHCA	American College of Health Care Administrators
ACHE	American College of Healthcare Executives
ACO	Accountable care organization
ACO REACH	Accountable Care Organization Realizing Equity, Access, and Community Health Model
ACOG	American College of Obstetricians and Gynecologists
ACP	American College of Physicians
ACPE	Accreditation Council for Pharmacy Education
ACPE	American College of Physician Executives
ACS	American Cancer Society
ACS	American College of Surgeons
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADC	Average daily census
ADE	Adverse drug event
ADL	Activities of daily living
ADR	Adverse drug reaction
ADS	Alternative delivery system
AFL-CIO	American Federation of Labor and Congress of Industrial Organizations
AFMR	American Federation for Medical Research
AG	Attorney General
AHA	American Heart Association

AHA	American Hospital Association
AHC	Accountable Health Communities Model
AHIMA	American Health Information Management Association
AHIP	America's Health Insurance Plans
AHLA	American Health Law Association
AHP	Allied health professional
AHP	Association for Healthcare Philanthropy
AHP	Association Health Plan
AHQA	American Health Quality Association
AHRQ	Agency for Healthcare Research and Quality
AHS	Academic health system
AHSR	Addiction Health Services Research
AI	Artificial intelligence
AIDS	Acquired immune deficiency syndrome
AIPBP	All-inclusive population-based payments
AKS	Anti-Kickback Statute
ALA	American Lung Association
ALM	Asset and liability management
ALOS	Average length of stay (see LOS)
ALR	Administrative loss ratio
AMA	American Medical Association
AMC	Academic medical center
AMGA	American Medical Group Association
AMI	Acute myocardial infarction (heart attack)
AMSA	American Medical Student Association
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
ANSI	American National Standards Institute
AOA	American Osteopathic Association
AONE	American Organization of Nurse Executives
A/P	Accounts payable
APA	American Psychiatric Association
APA	American Psychological Association
APC	Ambulatory payment classification
APHA	American Public Health Association
APM	Alternative Payment Model
APP	Advanced practice provider
APR	Accreditation Participation Requirements (from The Joint Commission)
APRN	Advanced Practice Registered Nurse
A/R	Accounts receivable

ARC	AIDS (acquired immune deficiency syndrome) related complex/condition
ARRA	American Recovery and Reinvestment Act of 2009
ARS	Auction-rate security
ASAE	American Society of Association Executives
ASC	Ambulatory surgery center
ASCA	Ambulatory Surgery Center Association
ASCO	American Society of Clinical Oncology
ASCP	American Society of Clinical Pathology
ASH	American Society of Hematology
ASIM	American Society of Internal Medicine
ASO	Administrative services only contract
ASTHO	Association of State and Territorial Health Officials
ATS	Alcohol Treatment Services
AV	Actuarial value
AWI	Adjusted wage index
B2B	Business-to-business
B2C	Business-to-consumer
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BC/BS	Blue Cross/Blue Shield
BHP	Basic Health Program
BIPOC	Black, Indigenous, and people of color
BLS	Basic life support
BME	Board of Medical Examiners
BMQA	Board of Medical Quality Assurance
BPCI	Bundled Payments for Care Improvement
BPCI-A	Bundled Payments for Care Improvement Advanced
Bx	Biopsy
CABG	Coronary artery bypass graft
CAE	Certified Association Executive
CAH	Critical access hospital
CAHPS®	Consumer Assessment of Healthcare Providers and Systems (formerly Consumer Assessment of Health Plans Study; see also HCAHPS®)
CAPC	Center to Advance Palliative Care
CAPP	Council of Accountable Physician Practices
CARA	Comprehensive Addiction and Recovery Act
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CAT	Computerized axial tomography
CBO	Community-based organization
CBO	Congressional Budget Office

CC	Complications and co-morbidities (see MCC)
CCIIO	Center for Consumer Information and Insurance Oversight
CCM	Chronic care management
CCR	Cost coverage ratio or cost to charge ratio
CCTP	Community-Based Care Transitions Program
CCU	Cardiac care unit
CCU	Critical care unit (also intensive care unit, or ICU)
CD&I	Culture, diversity, and inclusion
CDC	Centers for Disease Control and Prevention
CDHP	Consumer-driven health plan
CDS	Clinical Documentation Specialist
CDSS	Clinical decision support system
CE	Continuing education
CEC	Comprehensive ESRD Care
CEHRT	Certified EHR technology
CER	Comparative effectiveness research
CfC	Conditions for Coverage (CMS)
CFO	Chief Financial Officer
CFRE	Certified Fund Raising Executive
CGO	Chief Governance Officer
CHA	Catholic Health Association
CHC	Community health center
CHF	Congestive heart failure
CHIP	Children's Health Insurance Program
CHIP	Community health improvement plan
CHNA	Community health needs assessment
CHOW	Change of ownership
CHQPR	Center for Healthcare Quality and Payment Reform
CHRO	Chief Human Resource Officer
CHW	Community health worker
CI	Clinical integration
CIA	Confidentiality, integrity, and availability
CIA	Corporate integrity agreement
CIN	Clinically integrated network
CIO	Chief Information Officer
CIO	Chief Innovation Officer
CISA	Cybersecurity and Infrastructure Security Agency
CISO	Chief Information Security Officer
CJR	Comprehensive Care for Joint Replacement
CLABSI	Central line-associated bloodstream infection
CM	Case manager
CME	Continuing medical education

CMI	Case mix index
CMMI	Center for Medicare and Medicaid Innovation
CMO	Chief Medical Officer
CMP	Civil monetary penalty
CMS	Centers for Medicare and Medicaid Services
CMWF	The Commonwealth Fund
CNO	Chief Nursing Officer
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COE	Center of excellence
COI	Conflict of interest
COLA	Cost of living adjustment
CON	Certificate of need
CO-OP	Consumer Operated and Oriented Plan
CoP	Conditions of Participation (Medicare)
COPD	Chronic obstructive pulmonary disease
COS	Chief of Staff
COTH	Council of Teaching Hospitals
COVID-19	Coronavirus Disease 2019 (aka SARS-CoV-2)
CPA	Certified Public Accountant
CPC+	Comprehensive Primary Care Plus
CPG	Clinical practice guidelines
CPHQ	Certified Professional in Healthcare Quality
CPI	Consumer Price Index
CPIA	Clinical practice improvement activities
CPOE	Computer physician (or provider) order entry
CPR	Cardiopulmonary resuscitation
CPT	Current procedural terminology
CQI	Continuous quality improvement
CQM	Clinical quality measure
CQO	Chief Quality Officer
CQS	Comprehensive quality strategy
CQuIPS	Center for Quality Improvement and Patient Safety
CR	Cardiac rehabilitation
CR	Commercial reasonableness
CRM	Customer relationship management
CSR	Corporate social responsibility
CT	Computerized tomography
CVD	Cardiovascular disease
CXO	Chief Experience Officer
D&O	Directors and officers (insurance)
DCE	Direct contracting entities

DE&I	Diversity, equity, and inclusion
DEIB	Diversity, equity, inclusion, and belonging
DEIBA	Diversity, equity, inclusion, belonging, and accessibility
DGME	Direct graduate medical education
DHS	Designated healthcare services
DME	Durable medical equipment
D.N.	Doctorate of Nursing
DNA	Deoxyribonucleic acid
DNR	Do not resuscitate order
DNV	Det Norske Veritas (hospital accreditation; see also NIAHO)
D.O.	Doctor of Osteopathic Medicine
DOA	Dead on arrival
DOFR	Division of financial responsibility
DOH	Department of Health
DOJ	Department of Justice
DOL	Department of Labor
DRG	Diagnosis related group
Dr.P.H.	Doctor of Public Health
DSCR	Debt service coverage ratio
DSH	Disproportionate share hospital
DSRIP	Delivery System Reform Incentive Payment Programs
DTx	Digital therapeutics
DUR	Drug utilization review
Dx	Diagnosis
EAP	Employee Assistance Program
EBHR	Evidence-based hospital referral
EBM	Evidence-based medicine
EBRI	Employee Benefit Research Institute
ECF	Extended care facility
ECG	Electrocardiography (also EKG)
ECP	Essential community provider
eCQM	Electronic clinical quality measure
ECRM	Enterprise cyber risk management
ECU	Extended care unit
ED	Emergency department
EDI	Electronic data interchange
ED&I	Equality, diversity, and inclusion
EEG	Electroencephalography
EEO	Equal employment opportunity
EHB	Essential health benefits
EHR	Electronic health record
eICUs	Electronic intensive care units

EIDM	Enterprise Identity Management System
EKG	Electrocardiography (also ECG)
ELSI	Ethical, Legal, and Social Implications Research Program
ELTRR	Equitable Long-Term Recovery and Resilience
EMG	Electromyography
EMR	Electronic medical record
EMS	Emergency medical services
EMT	Emergency medical technician
EMTALA	Emergency Medical Treatment and Labor Act
ENT	Ear, nose, and throat
EOB	Explanation of benefits
EOC	Emergency operations center
EOC	Evidence of coverage
ePHI	Electronic protected health information
EPM	Episode payment model
EPO	Exclusive provider organization
EPs	Elements of performance
EPSDT	Early and periodic screening, diagnosis, and treatment
ER	Emergency room (also ED, emergency department)
ERISA	Employee Retirement Income Security Act
ERM	Enterprise risk management
ESG	Environmental, social, and governance
ESRD	End-stage renal disease
EUA	Emergency use authorization
F&A	Fraud and abuse
FACEP	Fellow, American College of Emergency Physicians
FACHE	Fellow, American College of Healthcare Executives
FACOG	Fellow, American College of Obstetricians and Gynecologists
FACP	Fellow, American College of Physicians
FACS	Fellow, American College of Surgeons
FAH	Federation of American Hospitals
FAP	Financial assistance/charity care policy
FASB	Financial Accounting Standards Board
FCA	False Claims Act
FDA	Food and Drug Administration
FEHBP	Federal Employee Health Benefits Plan
FEMA	Federal Emergency Management Agency
FFS	Fee-for-service
FICA	Federal Insurance Contributions Act
FMAP	Federal medical assistance percentage
FMV	Fair market value
FNP	Family Nurse Practitioner

FP	Family practice or practitioner
FPL	Federal poverty level
FQHC	Federally qualified health center
FQHMO	Federally qualified health maintenance organization
FSA	Flexible spending account
FTC	Federal Trade Commission
FTE	Full-time equivalent
FY	Fiscal year
FYE	Fiscal year end/ending
GAAP	Generally accepted accounting principles
GAO	Government Accountability Office (U.S.; formerly General Accounting Office)
GDP	Gross domestic product
GDPR	General Data Protection Regulation
GME	Graduate medical education
GNP	Gross national product
GP	General practitioner
GPDC	Global and Professional Direct Contracting
GPO	Group purchasing organization
GPWW	Group Practice Without Walls
GSA	Group service agreement
GSP	Governance Support Professional
GYN	Gynecology or gynecologist
HAC	Hospital-acquired condition
HCAHPS®	Hospital Consumer Assessment of Healthcare Providers and Systems (see also CAHPS®)
HCBS	Home and community-based services
HCC	Hierarchical condition category
HCERA	Health Care and Education Reconciliation Act of 2010
HCFAC	Health Care Fraud and Abuse Control
HCI	Hospital Care Intensity Index (The Dartmouth Atlas of Health Care)
HCL	Human-Centered Leader
HCQIA	Health Care Quality Improvement Act
HDHP	High-deductible health plan
HDL	High-density lipoprotein (“good cholesterol”)
HEDIS	Healthcare Effectiveness Data and Information Set
HFAP	Healthcare Facilities Accreditation Program
HFMA	Healthcare Financial Management Association
HGP	Human Genome Project
HHA	Home Health Agency
HHS	U.S. Department of Health and Human Services

HIE	Health Information Exchange
HIIN	Hospital Improvement Innovation Network
HIMSS	Healthcare Information and Management Systems Society
HIN	Health information network (also known as regional health information organization, or RHIO)
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPC	Health insurance purchasing cooperative
HIT	Health information technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HIV	Human immunodeficiency virus
HIX	Health insurance exchange
HLE	Health life expectancy
HMO	Health maintenance organization
HOPD	Hospital outpatient department
HPSA	Health professional shortage area
HQA	Hospital Quality Alliance
HQEP	Hospital Quality Efficiency Program
HQID	Hospital Quality Incentive Demonstration (CMS/Premier)
HRA	Health risk assessment
HRET	Health Research and Educational Trust
HRO	High-reliability organization
HRQOL	Health-related quality of life
HRRP	Hospital Readmission Reduction Program
HRSA	Health Resources and Services Administration
HRSNs	Health-related social needs
HSA	Health savings account
HSMR	Hospital standardized mortality rate
HU^{me}	Human Understanding Metric
HX	Human experience
ICD	Implantable cardioverter defibrillator
ICD-11	International Classification of Diseases, 11th Revision
ICU	Intensive care unit
IDN	Integrated delivery network
IDR	Independent dispute resolution
IDS	Integrated delivery system
IEC	Independent ethics committee (also called institutional review board, or IRB)
IHF	International Hospital Federation
IHI	Institute for Healthcare Improvement
IHS	Integrated health system
IIS	Immunization Information System

IM	Internal medicine
IME	Indirect medical education
INS	Immigration and Naturalization Service
IOM	Institute of Medicine
I/P	Inpatient
IPA	Independent practice association
IPCE	Interprofessional Continuing Education
IPPS	Inpatient prospective payment system
IQR	Hospital Inpatient Quality Reporting Program
IRB	Institutional review board (also called independent ethics committee, or IEC)
IRF	Inpatient rehabilitation facility
IRS	Internal Revenue Service
ISO	International Organization for Standardization* (See the entry in the terms section for more on ISO and the ISO 9000 family of standards.)
IT	Information technology (also called information systems, or IS)
JAMA	*Journal of the American Medical Association*
JC	Joint Commission
JEDI	Justice, equity, diversity, and inclusion
JOA	Joint operating agreement
JOC	Joint operating company
JV	Joint venture
KFF	Kaiser Family Foundation
KPIs	Key performance indicators
LGBTQ+	Lesbian, gay, bisexual, transgender, and queer; the "plus" represents an all-encompassing representation of sexual orientations and gender identities
LLC	Limited liability company
LLMs	Large language models
LOI	Letter of intent
LOS	Length of stay
LTAC	Long-term acute care
LTC	Long-term care
LTCF	Long-term care facility
LTD	Long-term disability
LTI	Long-term incentive
LTSS	Long-term services and supports

*Many people ask, “Shouldn’t it be IOS?” In fact, it is not an acronym. “ISO” is a word, derived from the Greek “iso-” that occurs in terms such as “isometric” (of equal measure or dimension). To avoid a plethora of acronyms resulting from the translation into different national languages of members; e.g., IOS in English, OIN in French (from Organisation internationale de normalisation), whatever the country, it is always ISO.

LUPA	Low utilization payment adjustment
LVN	Licensed vocational nurse
LWBS	Left without being seen
M&A	Mergers and acquisitions
MA	Medicare Advantage
MAC	Medicare administrative contractor
MACPAC	Medicaid and CHIP Payment Access Commission
MACRA	Medicare Access and CHIP Reauthorization Act
MAGI	Modified adjusted gross income
MAP	Medical audit program
MB	Market basket
MBCA	Model Business Corporation Act
MBWA	Management by walking around
MCC	Major complication and comorbidity (CMS diagnosis code; see CC)
MCO	Managed care organization
M.D.	Doctor of (Allopathic) Medicine
MEC	Medical executive committee
MedPAC	Medicare Payment Advisory Commission
MFCU	Medicaid Fraud Control Unit
MFS	Medicare fee schedule
MGCRB	Medicare Geographic Classification Review Board
MGMA	Medical Group Management Association
M.H.A.	Master of Health Administration
MI	Myocardial infarction (heart attack; also acute myocardial infarction, or AMI)
MIA	Medically indigent adult
MIPS	Merit-Based Incentive Payment System
MIS	Management information system
ML	Machine learning
MLR	Medical loss ratio
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMR	Measles, mumps, rubella (vaccine)
MMRCs	Maternal Mortality Review Committees
MOB	Medical office building
MOH	Ministry of Health
MOU	Memorandum of understanding
M.P.H.	Master of Public Health
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus aureus

MS-DRG	Medicare severity-diagnosis related group (formerly DRG; see entry in the terms section)
MSA	Metropolitan statistical area
MSG	Multi-specialty group
M.S.N.	Master of Science in Nursing
MSO	Management services organization
MSP	Medical services professional
MSP	Medicare secondary payer
MSPB	Medicare spending per beneficiary
MSSP	Medicare Shared Savings Program
MSW	Medical social worker
MU	Meaningful use
MUA	Medically underserved area
MVP	Minimum viable product
NACD	National Association of Corporate Directors
NACHGR	National Advisory Council for Human Genome Research
NAHMOR	National Association of HMO Regulators
NAHQ	National Association for Healthcare Quality
NAIC	National Association of Insurance Commissioners
NAMSS	National Association of Medical Staff Services
NAPH	National Association of Public Hospitals and Health Systems
NARHC	National Association of Rural Health Clinics
NAS	National Academy of Sciences
NASBA	National Association of State Boards of Accountancy
NBCH	National Business Coalition on Health
NBME	National Board of Medical Examiners
NCCIH	National Center for Complementary and Integrative Health
NCHS	National Center for Health Statistics
NCI	National Cancer Institute
NCID	National Center for Infectious Diseases
NCMHD	National Center on Minority Health and Health Disparities
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDNQI	National Database of Nursing Quality Indicators
NEJM	*New England Journal of Medicine*
NF	Nursing facility
NGACO	Next Generation Accountable Care Organization
NGO	Non-governmental organization
NHGRI	National Human Genome Research Institute
NHLBI	National Heart, Lung, and Blood Institute
NHS	National Health Service (United Kingdom)
NIA	National Institute on Aging

NIAHO	National Integrated Accreditation for Healthcare Organizations (see also DNV GL)
NIAMS	National Institutes of Arthritis and Musculoskeletal and Skin Diseases
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health
NIHCM	National Institute for Health Care Management
NIOSH	National Institute of Occupational Safety and Health
NIST	National Institute of Standards and Technology
NLM	National Library of Medicine
NLP	Natural language processing
NLRB	National Labor Relations Board
NLRN	Newly licensed registered nurse
NMR	Nuclear magnetic resonance
NOBC	Nurses on Boards Coalition
NP	Nurse practitioner
NPDB	National Practitioner Data Bank
NPI	National provider identifier
NPRM	Notice of proposed rule making
NPS	Net Promoter Score
NPSG	National Patient Safety Goal
NPV	Net present value
NQF	National Quality Forum
NQS	National Quality Strategy
NRC	National Research Corporation (now called NRC Health)
OB	Obstetrics or obstetrician
OB/GYN	Obstetrician and gynecologist
OCIO	U.S. Office of the Chief Information Officer; or Outsourced Chief Information Officer
OCM	Oncology care model
OCR	Office of Civil Rights (This office investigates HIPAA violations and mandates corrective action.)
O.D.	Doctor of Optometry
OIG	Office of the Inspector General
OIS	Office of Information Security of the U.S. Food and Drug Administration
OMAs	Open Meeting Acts
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
OON	Out-of-network
OOP	Out-of-pocket (payments)

O/P	Outpatient
OPC	Outpatient clinic
OPPS	Outpatient prospective payment system
OR	Operating room
OSG	Office of the Surgeon General
OSHA	Occupational Safety and Health Administration
OTC	Over the counter (drug)
P&L	Profit and loss
P2PHE	Pathways to Population Health Equity
P4P	Pay-for-performance
PA	Physician Assistant
PAC	Patient advisory council
PAC	Post-acute care
PBC	Provider-based clinic
PBP	Population-based payment
PB-RHC	Provider-based rural health clinic
PBT	Participating tax-exempt bond transaction
PCLC	Palliative Care Leadership Centers
PCMH	Patient-centered medical home
PCN	Primary care network
PCORI	Patient-Centered Outcomes Research Institute
PCP	Primary care physician (or provider)
PDA	Personal digital assistant
PDGM	Patient-Driven Groupings Model
PDMP	Prescription drug monitoring program
PE	Private equity
PET	Positron emission tomography
PEV	Physician enterprise value
PFAC	Patient and family advisory council
PFCC	Patient- and family-centered care
PFPM	Physician-focused payment model
PFS	Physician fee schedule
PGP	Personal gender pronoun (e.g. she, her, he, him, they, them)
Pharm.D.	Doctor of Pharmacy
Ph.D.	Doctor of Philosophy
PHE	Public health emergency
PHI	Protected health information
PHM	Population health management
PHO	Physician–hospital organization
PHR	Personal health record
PhRMA	Pharmaceutical Research and Manufacturers of America
PHS	Public health services

PICU	Pediatric intensive care unit
PMPM	Per member per month
PNA	Provider needs assessment
POA	Present on admission (indicates whether someone comes to the hospital with an existing condition)
POC	People of color
POC	Process of care
POS	Point of service
PP&E	Property, plant, and equipment
PPACA	Patient Protection and Affordable Care Act of 2010 (also referred to as the Affordable Care Act, ACA)
PPE	Personal protective equipment
PPI	Producer Price Index
PPO	Preferred provider organization
PPP	Paycheck Protection Program
PPS	Prospective payment system
PQCs	Perinatal Quality Collaboratives
PQI	Prevention Quality Indicator
PQRI	Physician Quality Reporting Initiative
PQRS	Physician Quality Reporting System
PRF	Provider Relief Fund (See CARES Act in the terms section.)
PRN	As (often as) or if necessary (from the Latin, *pro re nata,* for an occasion that has arisen, as circumstances require)
PRO	Peer review organization
PRRB	Provider Reimbursement Review Board
PSI	Patient safety indicators
PSNet	Patient Safety Network of the Agency for Healthcare Research and Quality (AHRQ)
PSO	Patient safety organization
PSQIA	Patient Safety and Quality Improvement Act
PSWP	Patient safety work product
PT	Physical therapy/therapist
PTAC	Physician-Focused Payment Model Technical Advisory Committee
PX	Patient experience
QA	Quality assurance
QC	Quality control
QCDR	Qualified clinical data registry
QHP	Qualified health plan
QI	Quality improvement
QIO	Quality improvement organization
QM	Quality management

QPA	Qualifying payment amount
QPP	Quality Payment Program
QPS	Quality and patient safety
QR	Quality review
QSEC	Quality, safety, and experience committee
RAC	Recovery audit contractor (Medicare)
RAF	Risk adjustment factor
RBRVS	Resource-based relative value scale
RCA	Root-cause analysis
RCM	Revenue cycle management
REAL	Race, ethnicity, ancestry, and language
REIT	Real estate investment trust
RFI	Request for information
RFP	Request for proposal
RHC	Rural health clinic
RHIO	Regional health information organization
RM	Risk management
RN	Registered nurse
ROA	Return on assets
ROE	Return on equity
ROI	Return on investment
RPA	Robotic process automation
RPM	Remote patient monitoring
RRC	Rural referral center
RRT	Rapid response team
RSV	Respiratory syncytial virus
RUG	Resource utilization group
RVU	Relative value unit
RWJF	Robert Wood Johnson Foundation
Rx	Prescription
S&P	Standard & Poor's
SAMHSA	Substance Abuse and Mental Health Services Administration
SARS	Severe acute respiratory syndrome
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2 (aka COVID-19)
SBC	Summary of benefits and coverage
SCH	Sole community hospital
SCHIP	State Children's Health Insurance Program
SDOH	Social determinants of health
SEC	Securities and Exchange Commission
SEIU	Service Employees International Union
SG	Surgeon General

SGR	Sustainable growth rate
SHCC	State/Statewide Health Coordinating Council
SHFFT	Surgical hip/femur fracture treatment
SHIP	State Health Insurance Assistance Program
SHOP	Small Business Health Options Program
SIBR	Structured interdisciplinary bedside rounds
SICU	Surgical intensive care unit
SNF	Skilled nursing facility
SOA	Sarbanes-Oxley Act of 2002 (also SOX)
SOAR	SSI/SSDI Outreach, Access, and Recovery (see SSI/SSDI)
SOGI	Sexual orientation and gender identity
SRA	Security risk analysis
SSI/SSDI	Supplemental Security Income/Social Security Disability Insurance
SSP	Shared Savings Program
STAC	Short-term acute care
STAT	Sooner than already there, or immediately (from the Latin *statim*)
STEEEP	Safe, timely, effective, efficient, equitable, patient-centered
SWOT	Strengths, weaknesses, opportunities, and threats
T&E	Travel & expense
TCC	Total cash compensation
TCJA	Tax Cuts and Jobs Act
TCM	Transitional care management
TIN	Taxpayer identification number
TPA	Third-party administrator
TQI/TQM	Total quality improvement/management
TRS	Total shareholder return
UBI	Unrelated business income
UBIT	Unrelated business income tax
UCR	Usual, customary, and reasonable (charges)
UM/UR	Utilization management/review
UPL	Upper payment limit
URAC	Utilization Review Accreditation Commission (now known as URAC)
URM	Underrepresented minorities
USPSTF	U.S. Preventative Services Task Force
VA	Veterans Administration/Affairs
VAERS	Vaccine Adverse Event Reporting System
VBC	Value-based contract
VBID	Value-Based Insurance Design
VBP	Value-based payment/purchasing

VCOH	Vital conditions of health
VISs	Vaccine Information Sheets
VNAA	Visiting Nurse Associations of America
VPMA	Vice President of Medical Affairs
WHI	Women's Health Initiative
WHO	World Health Organization
WIC	Women, Infants, and Children (a federal assistance program)
WIN	Well-Being in the Nation
WKKF	W.K. Kellogg Foundation
WNV	West Nile virus
YTD	Year-to-date

Glossary of Terms

21st Century Cures Act

Signed into law on December 13, 2016, by the United States Congress, it authorized $6.3 billion in funding for medical research and product development, opioid prevention and treatment, mental health services, health information technology, and medical device innovation.

340B Drug Pricing Program

A federal government program started in 1992 that mandates drug manufacturers participating in Medicare to provide outpatient drugs to eligible covered entities and healthcare organizations at significantly reduced prices.

Access

The ability to obtain healthcare services, including cost, transportation, location, and hours of operation.

Accessibility

The term for making a facility usable by people with physical disabilities. Examples of accessibility include self-opening doors, elevators for multiple levels, raised lettering on signs, and entry ramps.

Accountable care organization (ACO)

A set of providers that have the ability to manage the full continuum of care for the patients within their provider network and that receive financial incentives to improve the quality and efficiency of care. These providers share in both incentive payments and penalties, thereby accepting joint responsibility for the quality and cost of healthcare services provided to patients. (Also see *ACO REACH Model.*)

Accountable Health Communities (AHC) Model

A model created by the Center for Medicare & Medicaid Innovation that addressed the gap between clinical care and community services in the healthcare delivery system. Over a five-year period through April 2022, the AHC model tested whether increased awareness of and access to services addressing health-related social needs impacted total healthcare costs and improved health and quality of care for Medicare and Medicaid beneficiaries in targeted communities.

Accreditation

A judgment made by a professional society or other recognized organization that a healthcare provider substantially meets appropriate standards of care.

Accretion

The growth or increase by gradual addition, in finance and general nomenclature.

Accrual accounting

Accounting method that recognizes revenues as services are rendered, independent of the time the cash is actually received.

ACE demonstration project

A three-year bundled payment demonstration project developed by CMS that encompassed five hospitals in the Southwest. The Medicare Acute Care Episode (ACE) demonstration project began in January 2009 and included paying bundled rates specifically for 28 cardiovascular and nine orthopedic DRGs, with other diseases also considered. ACE combined the Medicare Part A and Part B payments for hospitals and physicians into a single payment, which the providers shared. By sharing the payment and potential risk pool, physicians and hospitals worked together to ensure the most efficient care was delivered at the highest quality.

Acid test (quick ratio)

A financial ratio designed to measure the relationship between "quick" assets (cash, marketable securities, accounts receivable) to current liabilities; an important measure of liquidity.

ACO Investment Model

An initiative developed by the Center for Medicare & Medicaid Innovation for organizations participating as ACOs in the Medicare Shared Savings Program. Ending in 2017, this was a model of pre-paid shared savings that built on the experience with the Advance Payment ACO Model. This model tested the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. (Also see *accountable care organization.*)

ACO Realizing Equity, Access, and Community Health (ACO REACH)

An accountable care organization (ACO) model under the Centers for Medicare and Medicaid Services that equips healthcare providers with tools and resources to promote collaboration to improve the quality of care for patients with traditional Medicare. Unlike other ACO models, this model promotes health equity, policies to ensure provider involvement in leadership and governance, and greater monitoring and transparency.

Activities of daily living (ADL)

Basic tasks people perform every day to maintain their health, safety, and cleanliness.

Actuarial equivalent

Used to measure whether two or more health benefit plans have the same value.

Actuarial value

The percentage of total average costs for covered benefits that a health plan will cover. The Affordable Care Act established four levels of coverage based on the concept of actuarial value. As plans increase in actuarial value (bronze, silver, gold, and platinum) they cover a greater share of enrollees' medical expenses overall.

Actuary

An accredited insurance professional who calculates predictable health risks, rates, and premium costs.

Acute care

Health services designed to meet the needs of patients requiring short-term care for a period of 30 days or less.

Adjusted admissions

The sum of inpatient admissions and equivalent admissions based on the provision of outpatient services. Equivalent admissions are derived by multiplying inpatient admissions by the ratio of outpatient to inpatient revenue.

Adjusted average per capita cost (AAPCC)

An estimate of how much Medicare will spend in a year for an average beneficiary.

Administrative loss ratio (ALR)

The remaining overhead costs being spent on administrative overhead, after accounting for the medical loss ratio (MLR).

Admitting privileges

The authorization a board of directors gives to a provider, based on his or her license, education, training, and experience, to admit patients to a particular hospital to provide patient care.

Adverse selection

The tendency of people who are in poorer-than-average health to apply for insurance coverage.

Affordable Care Act (ACA)

See *Patient Protection and Affordable Care Act of 2010.*

Agency for Healthcare Research and Quality (AHRQ)

A government agency that supports and conducts research that evaluates the effectiveness, quality, and value of healthcare in everyday settings, uncovering the evidence and developing the knowledge and tools that yield measurable improvements in quality.

"All or none" measurement

Also called "perfect care," it means a patient must receive all the care (e.g., procedures and treatments) indicated in a specified protocol. If a patient receives all processes in a specific protocol, he/she has received "all;" if the patient receives anything less than all processes in the protocol, he/she has received "none."

Allowable charges (or costs)

The costs insurers will pay.

Alternative payment models (APMs)

Payment methods that offer incentives to providers for delivering high-quality, cost-efficient care. APMs can be applied to a population, a care episode, or a specific clinical condition. Examples include bundled payments, value-based care models, advanced APMs, and population -based payments.

Ambulatory care

Healthcare services that do not require overnight or inpatient care.

Ambulatory surgery center (ASC)

Outpatient center that provides surgical procedures that do not require an overnight stay.

American Osteopathic Association (AOA)

The primary certifying board for osteopathic physicians (D.O.s) and the accreditation agency for all osteopathic medical colleges and healthcare facilities. Through its Healthcare Facilities Accreditation Program (HFAP), it has deeming authority from CMS to conduct accreditation surveys of acute care hospitals (not only osteopathic hospitals). (See *Healthcare Facilities Accreditation Program*.)

American Recovery and Reinvestment Act of 2009 (ARRA)

Economic stimulus package created to increase jobs, spur economic activity and invest in long-term growth, and foster unprecedented levels of accountability and transparency in government spending. This act, also known as the Recovery Act, put a total of about $150 billion into healthcare in order to support comparative effectiveness research, accelerate the adoption of health information technology, promote prevention and wellness, strengthen scientific research and facilities, improve children and community services, and improve information technology security.

Anchor Institution

A place-based, mission-driven entity such (e.g., hospital, university, government agency) that leverages its economic power alongside human and intellectual resources to improve the long-term health and social welfare of their communities.

Anti-Kickback Statute (AKS)

A provision of the Social Security Act that forbids any knowing and willful conduct involving the solicitation, receipt, offer, or payment of any kind of remuneration in return for referring an individual for any Medicaid- or Medicare-covered item or service or for recommending or arranging the purchase, lease, or order of an item or service that may be wholly or partially paid for through the Medicare or Medicaid programs. Violation of the Anti-Kickback provision can result in a fine of up to $25,000 for each violation and/or imprisonment for up to five years. The law also mandates exclusion or suspension from government healthcare programs following a conviction under this statute. Note that the Anti-Kickback statute requires knowledge of wrongdoing whereas the Stark laws do not. (See *Stark law & regulations*.)

Anti-Kickback Statute safe harbors

Caveats that protect certain arrangements from prosecution under the Anti-Kickback Statute, and address a broad range of topics including: investments in underserved areas; practitioner recruitment in underserved areas; obstetrical malpractice insurance subsidies for underserved areas; sales of physician

practices to hospitals in underserved areas; investments in ambulatory surgical centers; investments in group practices; referral arrangements for specialty services; and cooperative hospital service organizations. (See *safe harbor*.)

Artificial Intelligence (AI)

The theory and development of computer systems able to perform tasks that normally require human intelligence, such as visual perception, speech recognition, decision making, and language translation.

Assisted living

Housing, supportive services, personalized assistance, and healthcare designed to respond to the unique needs of individuals who need assistance with activities of daily living.

Auction-rate security (ARS)

A debt instrument (corporate or municipal bond) with a long-term nominal maturity for which the interest rate is regularly reset through a dutch auction. It could also refer to a preferred stock for which the dividend is reset through the same process. In the dutch auction, broker-dealers submit bids on behalf of potential buyers and sellers of the bond. Based on the submitted bids, the auction agent will set the next interest rate as the lowest rate to match supply and demand. Since ARS holders do not have the right to put their securities back to the issuer, no bank liquidity facility is required.

Balanced Budget Act of 1997 (BBA or BBA 97)

Legislation that was part of a plan to balance the federal budget by 2002. It included $112 billion from slowing the growth of the Medicare program and $7 billion from changes to Medicaid, and provided Medicare beneficiaries with additional choices for care through private health plans. To control spending on services already paid prospectively, such as the services provided by hospital inpatient departments, the act reduced payment updates in relation to what they would have been. To control spending on services that had been reimbursed largely on the basis of costs or charges, such as those provided by hospital outpatient departments, skilled nursing facilities, and home health agencies, the act established new prospective payment systems. To control spending and to expand beneficiaries' choices of private health plans, the law also created the Medicare+Choice program, which allows new types of plans to participate, and established new payment rules that raised payments to plans in some areas, lowered them in others, and capped the growth in payments at less than the growth in fee-for-service spending.

Balanced Budget Refinement Act of 1999 (BBRA)

Legislation that restored some of the funding that was cut under the BBA, including modification of Medicare's payment rates for services including those furnished by hospitals, skilled nursing facilities, home health agencies, physicians, physical and speech therapists, occupational therapists, and managed care plans.

Balanced scorecard

A tool that translates an organization's mission and strategy into a comprehensive set of performance measures that provides the framework for a strategic measurement and management system. Developed in the early 1990s by Robert Kaplan and David Norton, it includes four perspectives: financial/stewardship, customer/stakeholder, internal process, and organizational capacity/learning and growth. Organizations must develop metrics, collect data, and analyze it relative to each of these perspectives.

Basic Health Program (BHP)

A health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Health Insurance Marketplace. The Basic Health Program gives states the ability to provide more affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and Children's Health Insurance Program levels.

Benchmark

A quantifiable measure that serves as a standard by which others may be measured or judged. Dashboards normally include benchmarks of competing organizations at a local, state, and nationwide basis, and also internal benchmarks showing the organization's improvement on its own. The caution about using healthcare benchmarks is that much so-called "benchmark" data available are essentially averages, and comparing your hospital to other average hospitals will not necessarily result in high or improved performance.

Beneficiary

A person who is entitled to services.

Benefits

Specific services members or policyholders are entitled to use in their health plan.

Best practices

Strategies and programs that have demonstrated superior performance in their clinical, operational (management), and/or governance processes and outcomes. Also referred to as "recommended practices."

Board certified

Describes a physician who is certified as a specialist in his or her area of practice; a physician who has met specific standards of knowledge and clinical skills within a specific field or specialty.

Bundled payment

Also known as "case rates" or "episode-based payment," this payment model makes a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings.

Bundled Payments for Care Improvement Advanced (BPCI-A)

A voluntary bundled payment model with two-sided risk that started in October 2018. It qualifies as an advanced alternative payment model (APM) under the MACRA law thereby allowing individual providers to potentially qualify for bonus payments by participating in the program. There is only one risk track and the episode is 90 days in duration. It includes 29 inpatient and three outpatient episodes, and payments are tied to performance on quality measures.

Bundled Payments for Care Improvement (BPCI) Initiative

A payment model where organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare. Research has shown that bundled payments can align incentives for providers allowing them to work closely together across all specialties and settings.

Bylaws

Rules adopted by an organization chiefly for the government of its members and the regulation of its affairs.

Capital expenditure

An expenditure that benefits more than one fiscal accounting period; a cost to acquire a long-term asset.

Capital structure (leverage)

Measures the extent to which debt financing is employed by a corporation; the mix of long-term debt and equity employed by a corporation for permanent, long-term financing needs.

Capitation

A method of payment for health services in which a provider is paid a fixed amount for each member/subscriber regardless of services provided to each patient. Also referred to as global payments.

Care continuum

In medicine, describes the delivery of healthcare over a period of time. In patients with a disease, this covers all phases of illness from diagnosis to cure, or depending on the illness, the end of life.

Care journey (also patient journey)

The ongoing sequence of care events which a patient follows form the point of access into the health system, continuing towards diagnosis and care and ending in outpatient care.

Carve-out benefits

High-cost or specialty services, such as mental health, substance abuse, vision, or dental, which are financed and managed separately from other covered health services. Also may refer to a population sub-group for whom separate healthcare arrangements are made.

Case management

A managed care technique in which a patient with a serious medical condition is assigned an individual who coordinates, manages, and monitors the patient's continuous, cost-effective treatment, sometimes outside a hospital setting.

Catastrophic processes

Processes in patient care that, if failed, cause direct fatal or almost fatal harm to the patient. For example, if a patient receives the wrong type of blood, that patient can be severely injured or can die within hours. (See also *non-catastrophic process*.)

Center for Consumer Information and Insurance Oversight (CCIIO)

A center created by CMS that helps implement many reforms of the Affordable Care Act. It is tasked with setting and enforcing standards for health insurance that promote fair and reasonable practices to ensure that affordable, quality health coverage is available to all Americans. The center also provides consumers with comprehensive information on coverage options currently available so they may make informed choices on the best health insurance for their family.

Center for Medicare and Medicaid Innovation (CMMI)

An office within the Centers for Medicare and Medicaid Services (CMS) that was created by the Affordable Care Act to research and test innovative payment and service delivery models in order to reduce the cost and improve the quality of care for patients. Also known as the CMS Innovation Center.

Center of Excellence (COE)

A specialized product line, such as cardiac services, developed by a provider in order to establish a recognized high-quality, high-volume, cost-effective clinical program.

Certificate of Authority (COA)

License issued by a state government to operate a health maintenance organization (HMO) within that state.

Certificate of Coverage

The legal description given to employees or beneficiaries about the benefits, providers, and general rules and regulations of a health plan.

Certificate of Need (CON)

Laws of certain states that require entities to seek prior approval from the state before expanding and/or offering new types of healthcare services.

ChatGPT

An artificial intelligence tool created by OpenAI in the form of a chatbot and virtual assistant. Based on large language models (LLMs), it uses machine learning algorithms to generate responses to user questions and search terms. It is designed to refine and direct provided answers towards a desired length, format, style, level of detail, and language using successive user replies as context.

Chief of Staff (COS)

The physician/doctor elected by the medical staff to represent it in a variety of settings including the organization's board meetings. It is not unusual for the Chief of Staff to be an *ex officio* member of the board (with or without vote as determined by the specific organization's bylaws). The COS is also the primary contact between the medical staff, management, and the board, and is responsible for seeing that any initiatives or responsibilities placed on the medical staff by the board are carried out. In non-clinical context, a COS is also the name of a role that supports and advises the CEO or other top executives and may be responsible for implementing and overseeing organization-wide initiatives and programs.

Children's Health Insurance Program (CHIP)

See *State Children's Health Insurance Program.*

Chronic Care Management (CCM)

Under Medicare Part B, one of multiple covered programs that allow a healthcare provider to manage and coordinate patient care between traditional office visits. It is a service that provides coverage for patients with two or more chronic conditions for a continuous relationship with their care team. Under CCM, the patient's care team can bill for time spent managing the patients' conditions. This includes formulating a comprehensive care plan, interactive remote communication and management (usually over the phone), medication management, and coordination of care between providers.

Churning

An unethical practice in a fee-for-service reimbursement environment in which providers see patients more often than is medically necessary in order to increase revenue. Insurance churning relates to instability of insurance coverage and frequent transitions between plans or between insured and uninsured status.

Civil Monetary Penalty Law (CMP)

Under this law, the Office of Inspector General (OIG) may bring administrative actions against providers who submit false or fraudulent claims to the United States or its agent for a medical item or service. Penalties for violation may include fines and/or termination from Medicare, Medicaid, or other state healthcare programs.

Clinical integration

An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians to control costs and ensure quality.

Clinical protocols or clinical practice guidelines (CPG)

A healthcare management tool that provides evidence-based recommendations for the diagnosis and/or treatment of specific conditions. These recommendations are often developed by professional associations or other groups representing providers in a certain specialty, and they may be endorsed by government agencies, accrediting bodies, and other organizations. (See also *evidence-based medicine.*)

Clinical quality measure (CQM)

Created by CMS, clinical quality measures help measure and track the quality of healthcare services provided by hospitals and providers. CQMs measure various aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of resources, care coordination, patient engagement, population and public health, and clinical guidelines. Providers are required to report CQMs to CMS as part of quality improvement and reimbursement programs.

Clinically integrated network (CIN)

A group of providers (physicians, hospitals, pharmacists, social workers, post-acute providers, etc.) that contract together to improve the quality and efficiency of care. Participants share clinical and financial information and work as a team to improve care coordination, utilize healthcare resources wisely, and develop policies and procedures to improve care delivery.

Coinsurance

The share of healthcare premiums that is paid by the insured.

Commercial reasonableness

Under the Stark Law and Anti-Kickback Statute, physician contracts must be consistent with "fair market value" and also be "commercially reasonable": the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS (designated healthcare services) referrals.

Community health improvement plan (CHIP)

A long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. A plan is typically updated every three to five years. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources.

Community health needs assessment (CHNA)

A comprehensive profile of community health that encompasses the demographics of the community, special healthcare needs and targeted populations within the community, barriers to projected future needs, and other factors.

Community hospital

Non-federal, typically not-for-profit acute care general and specialty hospital that provide facilities and services to the general public.

Comparative effectiveness research (CER)

A field of research that analyzes and compares the harms and benefits of existing healthcare interventions and strategies for preventing, diagnosing, treating, and monitoring the health conditions of a specific group of patients in order to determine the best treatment methods.

Compliance plan

A program set up by a healthcare provider to ensure compliance with regulations, including regarding coding and billing, to prevent fraud and abuse.

Comprehensive Accreditation Manual for Hospitals

A resource for hospitals provided by accrediting body The Joint Commission, which includes hospital elements of performance for hospital standards, National Patient Safety Goals, and Accreditation Participation Requirements (APRs). (See also, The Joint Commission.)

Comprehensive Addiction and Recovery Act (CARA)

Signed into law on July 22, 2016, it enhanced grant programs that help coordinate efforts to address the opioid epidemic, including expanding prevention and education efforts and promoting treatment and recovery programs.

Comprehensive Care for Joint Replacement (CJR) Model

A model created by CMS aimed to support better and more efficient care for beneficiaries undergoing hip and knee replacements from surgery through recovery. This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care.

Comprehensive ESRD Care (CEC) Model

A model the Center for Medicare & Medicaid Innovation designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). The model builds on experience from the Pioneer ACO Model, Next Generation ACO Model, and the Medicare Shared Savings Program to test accountable care organizations for ESRD beneficiaries. This model ended March 31, 2021. (Also see *accountable care organization*.)

Computerized physician/provider order entry (CPOE)

An electronic system that healthcare professionals can use to enter drug and test orders. These systems have access to a patient's medical information and have built-in safeguards that screen for potential medical errors, including dosing mistakes, drug interactions, and allergic reactions. While initially expensive, CPOE has been shown to improve quality and lower operating costs by significantly reducing medical error rates.

Conditions of Participation (CoP)

Developed by CMS, Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) are the minimum health and safety standards that healthcare providers and suppliers must meet in order to be Medicare and Medicaid certified. These standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS meet or exceed the Medicare standards set forth in the CoPs/CfCs.

Conflict of interest (COI)

A situation in which someone in a position of trust, such as a lawyer, insurance adjuster, a politician, executive or director of a corporation/non-profit organization, or a medical research scientist or physician, has competing professional or personal interests that may impair his/her ability to fulfill duties to the corporation or organization impartially. A conflict of interest can exist even if no unethical or improper act results from it.

The non-profit board's obligations with respect to conflict of interest arise within the context of the fiduciary duty of loyalty, which legally obligates a director to exercise his/her powers in good faith and in the best interests of the organization, as opposed to his/her own interests or the interests of another entity.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A law that gives individuals and their families the right to choose to continue group coverage for up to 18 months under certain circumstances (e.g., loss of job, reduction in number of hours worked). Individuals choosing this option are typically required to pay the full costs of coverage.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

A public-private initiative (with CMS and AHRQ) to develop standardized surveys of patients' experiences with ambulatory and facility-level care. The program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with healthcare. CAHPS originally stood for the Consumer Assessment of Health Plans Study, but as the products have evolved beyond health plans, the name has evolved as well to capture the full range of survey products and tools. (See also *Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS®*.)

Consumer-centered care/patient-centered care

Care that puts the consumer first—their cultural traditions, personal preferences and values, family situations, and lifestyles. Consumer-centered hospitals and health systems look to their consumers and their families for feedback and engage consumers at every level of care design and implementation. It puts responsibility for important aspects of self-care and monitoring in patients' hands—along with the education and support they need to carry out that responsibility. It ensures that transitions between providers, departments, and healthcare settings are respectful, coordinated, and efficient. Consumer-centered care is also one of the overreaching goals of health advocacy, in addition to safer medical systems, and greater patient involvement in healthcare delivery and design.

Consumer-directed/driven healthcare

A term describing a broad movement to give consumers more control over—and accountability for—healthcare decisions, including lifestyle choices, health coverage, provider choice, and use of services. Purchasers moving toward consumer-directed healthcare often give employees/beneficiaries a greater financial stake in healthcare decisions and provide them with information on the relative costs and quality of providers or plans to help guide these decisions.

Consumer Operated and Oriented Plan (CO-OP)

A program created by the Affordable Care Act that allows for the development of qualified non-profit health plans selling essential health benefit plans through state exchanges.

Continuous quality improvement (CQI)

A continuing process of and systematic approach to identifying problems in healthcare delivery, and testing and monitoring methods and solutions for constant improvement; scientific methods are often employed to improve work processes, eliminate wastes, etc., in order to meet and exceed consumer needs and expectations (also called total quality management, or TQM).

Controlled competitive process

A process to support non-profit organizations seeking to be acquired that provides a framework through which to solicit and objectively evaluate proposals in a reasonable, free-market environment, eliciting high value and fair terms that are agreeable to external stakeholders.

Coordination of benefits (COB)

Agreement between health plans and insurers to make certain that the same services are not paid for more than once.

Copayment

The money patients pay for their share of a specific healthcare service in addition to what insurance covers.

Coronavirus Aid, Relief, and Economic Security (CARES) Act

An act passed by Congress on March 27, 2020 consisting of over $2 trillion in economic relief intended to protect Americans from the public health and economic impacts of COVID-19. It included assistance for workers and families, small businesses, and state/local/tribal governments.

Corporate social responsibility (CSR)

A business model that helps a company or healthcare organization be socially accountable to itself, its stakeholders, and the public. CSR initiatives seek to make a positive impact on employees, local communities, and the environment. It is the way through which a company achieves a balance of economic, environmental, and social imperatives.

Cost-benefit analysis

A method of comparing the monetary costs of a project to the benefits.

Cost center

A business or organizational unit of activity that incurs expenses.

Cost coverage ratio (CCR)

The standard for evaluating the appropriate rate and thus the success of a managed care contracting effort. The cost coverage ratio is calculated by dividing the net revenue from a specific health plan by the fully allocated expenses associated with delivering that care to that plan's patients.

Cost-effectiveness analysis

A method of measuring and comparing benefits and total costs (direct, indirect, and intangible) of a project or program to the benefits and total costs of another project or program.

Cost-shifting

The practice of increasing reimbursement from one payer source to subsidize inadequately reimbursed services rendered to other payers' patients.

Credentialing

The review process of evaluating a healthcare provider to determine whether the provider meets certain standards of knowledge and clinical skill, including a review of licensure, board certification, malpractice insurance and history, and the like.

Critical access hospital (CAH)

A designation by Medicare that is reserved for hospitals meeting certain criteria related to access to services. CAHs are typically small, inpatient facilities that represent the only source of inpatient and/or emergency care in a defined geographic (often rural) area. CAHs are subject to additional regulations from Medicare. Often designated as sole community hospitals (SCHs; see separate entry), they are also typically eligible for upward adjustments in payments from Medicare.

Critical pathway

A healthcare management tool that suggests the best way (based upon scientific evidence) to treat a disease or use a healthcare procedure; designed to reduce variations in clinical practices, these tools typically map out day-by-day recommendations to guide a routine patient's hospital stay.

Current assets

Assets that are expected to be turned into cash within one year (e.g., accounts receivable).

Current liabilities

Obligations that will become due and payable with cash within one year.

Current ratio

A financial ratio designed to measure the relationship or balance between current assets and current liabilities; an important liquidity ratio.

Cybersecurity

The state of being protected against the criminal or unauthorized use of electronic data, or the measures taken to achieve this.

The Dartmouth Atlas of Health Care

Based at the Dartmouth Institute for Health Policy and Clinical Practice and supported by a coalition of funders led by the Robert Wood Johnson Foundation, the Dartmouth Atlas documented variations in how medical resources are distributed and used within the U.S. It used Medicare data to provide information and analyzed about national, regional, and local markets, as well as hospitals and physicians. As of June 2024, the Atlas is no longer being updated; however there remains a Web site archive that provides historical data.

Dashboard

A report that displays the state of the hospital at a glance, using standard visual symbols much like a car's dashboard. In essence, the dashboard shows key indicators related to various aspects of the hospital, including financial, quality, and patient satisfaction measures. Most hospitals use more than one dashboard, showing differing levels of detail for the board and management team. They are also referred to as "executive dashboards" or "charts of key performance indicators."

Debt capacity

The total amount of debt a business can incur and repay according to the terms of a debt agreement.

Debt-to-capital/capitalization ratio

This ratio is calculated by taking the company's interest-bearing debt, both short- and long-term liabilities and dividing it by the total capital.

Deductible

The level of out-of-pocket expenditures that a policyholder is responsible for paying each year before insurance coverage begins. Deductibles can range from just a few hundred dollars to $5,000 or more. Insurance plans with low deductibles tend to be more expensive. High-deductible plans can be combined with a health savings account or HSA (see separate entry).

Deficit Reduction Act of 2005 (DRA)

Legislation that saves nearly $40 billion over five years from mandatory spending programs through slowing the growth in spending for Medicare and Medicaid, changing student loan formulas, and other measures. For Medicare, it requires a payment adjustment in Medicare diagnosis related group (DRG) payment for certain hospital-acquired conditions (applies to IPPS hospitals only). CMS has titled the program, "Hospital-Acquired Conditions and Present on Admission Indicator Reporting." Starting in 2007, hospitals were required to submit data on specified quality measures or have their annual market basket update reduced by two percentage points.

Section 5001(c) of the DRA required the Secretary to identify, by October 1, 2007, at least two conditions that for discharges occurring on or after October 1, 2008, IPPS hospitals will not receive additional payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as though the secondary diagnosis were not present. Section 5001(c) provides that CMS can revise the list of conditions from time to time, as long as it contains at least two conditions.

Defined contribution plan

The term "defined contribution" (DC) is used to describe a wide variety of approaches to the provision of health benefits, all of which have in common a shift in responsibility for payment and selection of healthcare services from employers to employees. DC-type benefits have existed as cafeteria plans since the 1980s. A cafeteria plan gives each employee the opportunity to determine the allocation of his or her total compensation (within employer-defined limits) among various employee benefits (primarily retirement and health).

Definitive agreement

A document defining the final terms of an agreement between buyer and seller, typically of a company's assets or stock.

Demand-side disruption

Market disruption affecting the demand side of consumer goods and services, such as a recession or economic downturn lowering consumer purchasing power.

Derivative

A financial instrument whose values depend on the value of other underlying financial instruments. The main types of derivatives are futures, forwards, options, and swaps.

The main use of derivatives is to reduce risk for one party. The diverse range of potential underlying assets and pay-off alternatives leads to a wide range of derivatives contracts available to be traded in the market. Derivatives can be based on different types of assets such as commodities, equities (stocks), residential mortgages, commercial real estate loans, bonds, interest rates, exchange rates, or indexes (such as a stock market index, consumer price index, or other derivatives). Their performance can determine both the amount and the timing of the pay-offs. Unregulated credit derivatives have become an increasingly large part of the derivative market.

Diagnosis related group (DRG)

See *Medicare severity-diagnosis related group (MS-DRG)*.

Digital health

A term encompassing all digital care programs; the convergence of digital technologies with health, healthcare, living, and society to enhance the efficiency of healthcare delivery and make medicine more personalized and precise. It encompasses mobile health, telehealth/telemedicine, virtual care, artificial intelligence/machine learning, and data analytics.

Direct graduate medical education (DGME) payments

The payments hospitals receive from Medicare/Medicaid based on the amount of medical school graduates being trained.

Direct-to-employer plan

A health insurance plan in which an employer establishes a contract directly with a care provider in order to reduce costs.

Disabling guidelines

Guidelines stipulating the situations in which a director is no longer fit to serve on the board. These usually include conflicts that are so significant that an individual should not be elected to the board, or should be asked to resign if they occur during a director's term (e.g., repeated, intentional failure to disclose a conflict of interest; a single but significant, intentional failure to disclose a conflict of interest; intentional violation of the organization's confidentiality policy or code of conduct, etc.).

Discounted fee-for-service

A discounted payment method based upon a negotiated amount or percentage that is agreed upon between a provider and a health plan.

Disproportionate share hospital (DSH) payments

A Medicare payment system that provides additional Part A payments to hospitals that treat a relatively high proportion of low-income persons (as compared to other hospitals).

Division of financial responsibility (DOFR)

A part of the contract between two or more partners (for example, payers, providers, IPAs, MSOs, medical foundations) that outlines who pays for which health services under a risk arrangement.

DNA sequencing

The relative ordering of base pairs in DNA, a gene, a chromosome, or an entire genome.

Dodd-Frank Wall Street Reform and Consumer Protection Act

A federal statute signed into law by President Barack Obama on July 21, 2010. Passed as a response to the 2008–2010 recession, it is the most sweeping change to financial regulation in the U.S. since the Great Depression, and affects almost every aspect of the financial services industry.

While Dodd-Frank specifically targets for-profit corporations, many of the provisions have impacted non-profit governance, including risk management, executive compensation, stakeholders' rights, and board qualifications to govern.

Duty of care

The obligation of directors to exercise proper diligence of care in their decision-making process, meaning the directors acted in "good faith," with a level of care that an ordinarily prudent person would exercise in like circumstances, and in a manner that they reasonably believe is in the best interest of the organization.

Duty of loyalty

Requires directors to discharge their duties unselfishly, in a manner designed to benefit only the organization and not the directors personally. It is the duty most focused upon by regulators because it is a duty affected by self-dealing, related party transactions, and other arrangements that may result in improper personal benefits to individuals. It incorporates a duty to disclose situations that may present a potential for conflict with the organization's mission, as well as a duty to avoid competition with and appropriation of the assets of the organization.

Duty of obedience

Requires that directors be faithful to the underlying charitable purposes and goals of the non-profit organization they serve, as set forth in the organization's governing documents. It presumes that the mission of the organization, and the means to achieve it, are inseparable.

Early and periodic screening, diagnosis, and treatment (EPSDT)

A federal requirement that state Medicaid programs cover a comprehensive set of preventive services and early assessment of the health needs of Medicaid-eligible children. Any medically necessary treatment that results from the provision of EPSDT-mandated services must also be covered, even if that service is not typically covered by the Medicaid program.

Economic credentialing

A term that refers to a hospital's use of economic factors (e.g., costs, utilization) in addition to quality-related criteria in determining whether to grant or extend privileges to a physician to practice in the hospital. (See also *credentialing*.)

Economies of scale

Rewards of efficiency and cost savings that are the outcome of mass production.

Emergency Medical Treatment and Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. For information on recent updates to EMTALA, visit www.cms.hhs.gov.

Emergency operations center (EOC)

During a disaster response, a central emergency operations center coordinates emergency information and resources.

Employee engagement

The strength of the mental and emotional connection employees feel toward their places of work. NRC Health research and others have shown that employee engagement has a direct positive correlation with patient experience.

Employer pay-or-play

A mandate of the Affordable Care Act, as of January 1, 2015, requires employers with more than 50 employees to offer and pay for health benefits for their full-time workers or pay a $2,000 per employee tax penalty if they do not offer health insurance (as amended by the reconciliation bill).

Encounter

The recording of a medically related service or visit rendered by a provider to a health plan enrollee.

Endemic

A disease outbreak that is consistently present but limited to a particular region, making the disease spread and rates predictable. Malaria, for example, is considered endemic in certain countries and regions.

Enterprise cyber risk management (ECRM)

A risk management program (to manage the possibility of loss or harm) specifically focused on the risks related to information assets such as PHI, systems, and devices.

Enterprise risk management (ERM)

The methods and processes used by organizations to manage risks and seize opportunities related to the achievement of their objectives. ERM provides a framework for risk management, which typically involves identifying particular events or circumstances relevant to the organization's objectives (risks and opportunities), assessing them in terms of likelihood and magnitude of impact, determining a response strategy, and monitoring progress. By identifying and proactively addressing risks and opportunities, corporations can protect and create value for their stakeholders, including owners, employees, customers, regulators, and society overall.

Environmental, social, and governance (ESG)

A broad range of qualitative and quantitative considerations that relate to the sustainability of an organization and to the broader impact on society of its operations, investments, and activities. Examples include a company's carbon footprint, or the accountability of a company's management or a nation's government.

Epidemic

An unexpected increase in the number of disease cases in a specific geographical area.

Episode of care

All services provided to a patient for a specific medical problem or condition during a set time period.

Equity joint venture

A joint venture between a hospital and a group of physicians in which a separate legal structure is created that is for-profit (i.e., not required to comply with tax rules that apply to tax-exempt organizations). It normally takes the form of a limited liability corporation (LLC), or similar entity, such as a limited liability partnership, general partnership, or limited partnership. Both the sponsoring hospital/health system and the physician investors are "members" of the LLC. The capital structure of the LLC consists of equity contributed by the hospital/health system and physician investors, and debt.

Essential health benefits

A set of healthcare service categories that must be covered by certain health plans. The Affordable Care Act ensures health plans offered in the individual and small group markets offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services.

Ethical, Legal, and Social Implications Program (ELSI)

A component of the Human Genome Project; currently studies the ethical, legal, and social issues surrounding the availability of genetic information. The world's largest bioethics program, it researches the implications of the use of genetic information on privacy and confidentiality, psychological impact and stigmatization, reproductive issues, clinical issues, conceptual and philosophical issues, health and environmental issues, and commercialization of products.

Evidence-based hospital referral (EBHR)

The practice of referring patients to hospitals that have a proven track record in producing high-quality outcomes in a given procedure or diagnosis. When outcomes data are missing (as is often the case), EBHR involves referring patients to high-volume centers for those select procedures and diagnoses (e.g., CABG surgery) where there is a proven correlation between high volume and high quality.

Evidence-based medicine (EBM)

A term that refers to that portion of the practice of medicine that is based upon established scientific findings as derived from clinical research studies. Most clinical guidelines, protocols, and care paths are based upon this type of evidence.

Evidence of coverage (EOC)

A certificate, agreement, contract, or letter of entitlement issued to a subscriber or enrollee establishing coverage to which the subscriber or enrollee is entitled.

Exclusive provider organization (EPO)

A type of managed care plan in which a member must remain within the provider network to receive benefits.

Ex-officio

Originating from the Latin meaning "from the office," refers to board members who are a part of their board due to holding another office or position of relevance.

Experience rating

An insurance method of setting premium rates based on the actual healthcare costs of a group or groups.

Explanation of benefits (EOB)

A statement to a member or covered insured explaining how and why a claim was or was not paid.

False Claims Act (FCA)

The criminal False Claims Act makes it illegal to present a claim upon or against the United States that the claimant knows to be false, fictitious, or fraudulent. The civil False Claims Act provides that any person who knowingly presents or causes to be presented to the U.S. government a false or fraudulent claim for payment or approval; knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government; or conspires to defraud the government by getting a false or fraudulent claim allowed or paid violates the act. The act also has *qui tam* provisions (see *qui tam action*). Under the civil provisions of the FCA, a defendant can be assessed a penalty of $11,000 per claim, plus three times the damages incurred by the federal government in its prosecution and investigation of the case. The criminal provisions provide for a fine of up to $50,000 as well as jail terms and exclusion from participation in Federal healthcare programs. The False Claims Act dates back to the Civil War era when suppliers of the Union Army were selling defective goods to the federal government.

Federal Emergency Management Agency (FEMA)

Agency of the U.S. government tasked with disaster mitigation, preparedness, response, and recovery planning. FEMA also initiates proactive mitigation activities, trains first responders, and manages the National Flood Insurance Program. In 2003, it became part of the U.S. Department of Homeland Security.

Federal Employee Health Benefits Plan (FEHBP)

The program that covers the nation's nine million active federal employees, retirees, and dependents. Those covered under this plan typically have a broad choice of health plans, with the federal government paying a largely fixed amount of money towards coverage. Thus, FEHBP enrollees who choose higher-priced plans bear much of the incremental financial costs of these plans.

Federal Insurance Contribution Act (FICA)

A United States payroll tax that requires employees and employers to pay into Social Security and Medicare.

Federal medical assistance percentage (FMAP)

The federal government's share of a state's expenditures for certain medical and social service programs, such as Medicaid and the Children's Health Insurance Program.

Federal Plan for Equitable Long-Term Recovery and Resilience (ELTRR)

The U.S. Department of Health and Human Services developed this plan in 2022, which lays out an approach for federal agencies to cooperatively strengthen the vital conditions necessary for improving individual and community resilience and well-being nationwide. (See Vital Conditions of Health.)

Federal poverty level (FPL)

Income criteria determined by the U.S. Department of Health and Human Services that determines if a person is eligible for assistance through various federal programs.

Fee-for-service (FFS)

A traditional method of reimbursement to healthcare providers in which an insurance company pays hospitals and doctors according to the fees on a preset schedule.

Fiduciary

Of, relating to, or involving a confidence or trust. In healthcare, a director's fiduciary duty incorporates the three duties of care, obedience, and loyalty (see separate entries for those definitions). The fiduciary duty relates to all of a director's responsibilities to the organization's welfare, not just financial oversight.

Fixed costs

Costs that do not vary with the output or activity of an organization; the "cost of opening the doors" (e.g., rent, utilities).

Form 990

The IRS form that tax-exempt organizations are required to file in lieu of a tax return. Completed forms are available to the public and therefore can affect public perception of an organization. Schedule H of the Form 990 specifically refers to hospitals, and according to the IRS, "Schedule H must be completed by an organization that operates at least one facility that is, or is required to be, licensed, registered, or similarly recognized by a state as a hospital." Schedule H covers charity care and community benefit; joint ventures; and Medicare, bad debt, and other items. Organizations not required to file Form 990 might wish to use it for state reporting purposes.

For more information and to download a copy of the Form 990, visit www.irs.gov.

Formulary

The list of prescription medications that may be dispensed by participating pharmacies.

Foundation model

A hospital or healthcare system that acquires the assets of a medical group, manages all non-physician staff and facilities, and contracts with the medical group for professional services.

FTEs per adjusted admission

The number of full-time equivalent (FTE) staff divided by the number of adjusted admissions.

Full-time equivalent (FTE)

Refers to the number of annual paid hours for one full-time employee; used as shorthand for "a full-time employee."

Gainsharing

The direct payment by hospitals to physicians, based on reducing hospital costs and meeting quality of care improvement standards. In the past (ca. 1999), gainsharing arrangements were prohibited due to their conflict with the Civil Monetary Penalties Law; the Office of the Inspector General (OIG) did not previously support the concept of gainsharing because of this violation but has since provided eight specific safe guards.

Consult your attorney or legal counsel before entering into any gainsharing arrangement.

Gatekeeper

A healthcare professional who controls a patient's access to healthcare and coordinates, manages, and authorizes all healthcare services provided to a patient; common model of managed care plans.

Gene therapy

The injection of healthy genes into a patient to cure or treat a hereditary disease or illness.

Generative AI

Machine learning artificial intelligence that goes beyond prediction to create new data based on learning patterns. It can generate images, texts, or other content. Healthcare uses include generating synthetic medical images and personalized treatment plans. (See predictive AI.)

Generative Dialogue

Generative dialogue is a process that allows boards to move away from fact-based discussion or a question-and-answer format. When engaging in a generative dialogue, the focus is on a future state or what could be. The goal is not to find a solution or come to a decision about an issue, but to envision a range of possibilities or end states where all ideas are considered.

Genetics

The study of the patterns of inheritance of specific traits.

Genetic testing

The process of testing a certain population of people for the purpose of detecting genetic susceptibility or predisposition to or determination of a condition or disease.

Genomics

The study of all the genetic material within the chromosomes of a particular organism.

Global and Professional Direct Contracting (GPDC) Model

A voluntary, accountable care organization (ACO) model designed to put patients at the center of their care. Building upon lessons-learned from initiatives involving Medicare ACOs, such as the Medicare Shared Savings Program and the Next Generation ACO Model, this model provided greater individualized attention to a beneficiary's specific healthcare needs within original Medicare, and changes financial incentives to reward high-quality care. It is being transitioned/updated into the ACO REACH Model. (See *ACO REACH Model.*)

Global payments

See *capitation*.

Government Accountability Office (GAO)

An independent, nonpartisan agency that investigates how the federal government spends taxpayer dollars. GAO gathers information to help Congress determine how well executive branch agencies are doing their jobs. GAO's work routinely answers such basic questions as whether government programs are meeting their objectives or providing good service to the public. Ultimately, GAO ensures that government is accountable to the American people. (Previously known as the General Accounting Office, the name was changed in 2004 to better reflect its activities.)

Grandfathered health plan

A health benefit plan or health insurance policy that was created on or before March 23, 2010—the date of enactment for the Affordable Care Act. Grandfathered plans are exempted from many changes required under the ACA. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers.

Group model

A type of HMO that contracts with physician groups for healthcare services for its health maintenance organization (HMO) enrollees at a negotiated fixed or capitated rate; in exchange, the HMO usually provides the facility, staff, and administrative support for the physician group.

Group practice

Three or more physicians formally organized to deliver patient care, make common use of facilities, equipment, and staff, and share income by a prearranged formula; can have a single-specialty or multi-specialty focus.

Group Practice Without Walls (GPWW)

A group practice in which the provider members come together legally but continue to practice autonomously in private offices scattered throughout the service area. Also called clinic without walls.

Health alliance

A conglomerate of business and consumers formed to negotiate prices for health benefits with HMOs or networks of physicians, hospitals, insurers, and other healthcare providers.

Health Care and Education Reconciliation Act of 2010 (HCERA)

This legislation, signed into effect on March 30, 2010, combines revised portions of the Affordable Care Act with the Student Aid and Fiscal Responsibility Act (SAFRA), which amends the Higher Education Act of 1965 (HEA).

Health Care Fraud and Abuse Control (HCFAC)

A program established by the Health Insurance Portability and Accountability Act of 1996 that funds efforts to coordinate federal, state, and local law enforcement efforts to prevent healthcare fraud and abuse.

Health Care Quality Improvement Act (HCQIA)

Passed by Congress in 1986, this legislation provides healthcare organizations and their peer review bodies immunity from monetary damages as a result of "adverse professional review actions" that relate to the competence or professional conduct of an affected physician or dentist. The act has established standards for due process when restricting or terminating a physician's privileges. It does not prevent other types of legal action (e.g. injunctions or restraining orders) and it does not convey protection of peer review documents from discovery in legal proceedings. HCQIA also created the National Practitioner Data Bank (NPDB), a system for reporting physicians whose competency has been judged inadequate.

Most medical staff "fair hearing plans" are written to comply with the due process requirements of HCQIA. HCQIA immunity applies to every jurisdiction in the United States.

Health disparities

Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment.

Health equity

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

Health information network

See *regional health information organization*.

Health Information Technology for Economic and Clinical Health Act (HITECH)

Legislation signed into law on February 12, 2009 as part of the American Recovery and Reinvestment Act of 2009. HITECH was meant to promote the adoption of electronic health records and supporting technology in the United States.

Health Insurance Marketplace

Set up in accordance with the Affordable Care Act, the Health Insurance Marketplace is a resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal law that addresses: 1) health coverage for workers and their families when they change or lose jobs; 2) reduction in fraud and abuse by giving government more flexibility in pursuing organizations suspected of fraud; and 3) administrative simplification, to standardize the electronic environment for the most common healthcare back-office functions; it includes security and privacy standards.

Health maintenance organization (HMO)

An organization that provides and organizes a wide array of comprehensive healthcare services for its members within three constraints: 1) the use of a primary care provider to coordinate patient care; 2) the use of specific providers and facilities; and 3) a fixed-fee structure.

Health savings account (HSA)

Formerly known as medical savings accounts (MSAs) or Archer MSAs, these accounts are available to individuals with high-deductible health insurance plans (and to companies that offer their employees such plans). Under an HSA, individuals (or companies on behalf of their employees) can set aside tax-free savings to cover out-of-pocket health-related expenditures, including expenses sometimes not covered by insurance, such as dental and eye care.

Health system

A corporate body that owns and/or manages hospitals and other health-related subsidiaries.

Healthcare Effectiveness Data and Information Set (HEDIS)

A standard set of performance measures developed in 1991 to measure the quality and performance of health plans by focusing on four aspects of healthcare: quality, access and patient satisfaction, membership and utilization, and finance; HEDIS is sponsored and coordinated by the National Committee for Quality Assurance (NCQA), and has been updated several times since its inception.

Healthcare Facilities Accreditation Program (HFAP)

Founded by the American Osteopathic Association in 1945, HFAP has deeming authority from CMS to conduct accreditation surveys of acute care hospitals under the Medicare Conditions of Participation. The program is a recognized alternative to accreditation by CMS or The Joint Commission.

Healthy People 2030

A set of formal goals and objectives for the nation's health status established by the federal government. It is updated every decade.

Hierarchical condition category coding (HCC)

A risk-adjustment model originally designed to estimate future healthcare costs for patients. The Centers for Medicare & Medicaid Services (CMS) HCC model was initiated in 2004, but is becoming increasingly prevalent as the environment shifts to value-based payment models.

Hierarchical condition category relies on ICD-10 coding to assign risk scores to patients. Each HCC is mapped to an ICD-10 code. Along with demographic factors (such as age and gender), insurance companies use HCC coding to assign patients a risk adjustment factor (RAF) score. Using algorithms, insurances can use a patient's RAF score to predict costs.

High-reliability organization (HRO)

Defined by the Patient Safety Network (PSNet) of the Agency for Health Research and Quality (AHRQ) as organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures. The principles of high reliability go beyond standardization of care, cultivating resilience by relentlessly prioritizing safety over other performance pressures.

High-risk pool

State programs that provide coverage to individuals who are considered uninsurable, usually due to a pre-existing condition, and are unable to purchase private insurance. The Affordable Care Act called for the establishment of a temporary high-risk pool in every state. These pools, which existed alongside state high-risk pools already in operation, went into effect June 21, 2010, and ended on January 1, 2014, when coverage became available to high-risk individuals through state health insurance exchanges.

Home healthcare

Any of a variety of services (e.g., nursing, physical therapy, social services) provided in an individual's home. (See Hospital at Home.)

Horizontal integration

A comparative strategy used by some hospitals or other organizations to control the geographical area of healthcare services by integrating the services of two or more similar (horizontal) healthcare facilities.

Hospice care

Programs providing palliative care, including pain relief, and supportive services that address the emotional, social, financial, and legal needs of terminally ill patients and their families. Hospice care can be provided in a hospice facility, hospital, home, or other setting.

Hospital at Home

A care model that enables some patients who need acute-level care to receive care in their homes rather than in a hospital. This delivery model has been shown to reduce costs, improve outcomes, and enhance patient experience.

Hospital Care Intensity Index (HCI)

A measurement used by the Dartmouth Atlas of Health Care that reflects both the amount of time spent in the hospital and the intensity of physician services delivered in the hospital. Data is presented by state and individual hospital, for the purpose of determining the propensity of states, regions, and hospitals to rely on the acute care hospital in managing chronic illness.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS® or Hospital CAHPS®)

A nationally standardized survey developed by CMS and AHRQ that asks consumers and patients to report on and evaluate their experiences with care provided in hospitals. Questions include the communication skills of providers and the accessibility of services.

The Affordable Care Act includes HCAHPS among the measures to be used to calculate value-based incentive payments in the hospital value-based purchasing program, which began with discharges in October 2012. (See also *Consumer Assessment of Healthcare Providers and Systems, or CAHPS®*.)

Hospital Inpatient Quality Reporting Program (also known as IQR)

This program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, which authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates.

The Hospital IQR program is intended to equip consumers with quality of care information to make more informed decisions about healthcare options. It is also intended to encourage hospitals and clinicians to improve the quality of inpatient care provided to all patients. Eligible hospitals that do not participate in the IQR program will receive an annual market basket update with a 2.0 percentage point reduction. The hospital quality of care measures and additional information are available on the CMS Hospital Compare Web site, www.medicare.gov/hospitalcompare.

Hospitalist

A physician who specializes in caring for patients in the hospital and generally only practice in acute care settings. Most are board-certified in internal medicine, family practice, or pediatrics; some have additional certification in specialties such as pulmonology, cardiology, or critical care medicine.

Hospital Quality Alliance/Hospital Compare Web Site

The Hospital Quality Alliance: Improving Care Through Information is a public/private collaboration to improve quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. It was created through the efforts of the Centers for Medicare and Medicaid Services (CMS) and organizations that represent hospitals, doctors, employers, accrediting organizations, other federal agencies and the public.

The quality measures reported through this program relate to heart attack, heart failure, pneumonia, and surgical infection prevention. It also provides patient perspectives on care they received while in the hospital; and information on how many Medicare patients were admitted to the hospital for certain illnesses, and what Medicare pays for services associated with them. It allows consumers to compare hospitals based on the experiences of Medicare patients who participate in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®), in addition to data on process of care and outcome measures. Go to www.hospitalcompare.hhs.gov for a complete list of measures.

Hospital standardized mortality rate (HSMR)

Developed by Sir Brian Jarman at the Imperial College in the United Kingdom, the HSMR is based on diagnoses groups that account for 80 percent of all deaths in acute care hospitals and is adjusted for other factors affecting mortality (e.g., age, sex, and mix of diagnoses). Mortality rates are calculated for each hospital and stratified by variables of interest (e.g., age, sex, and length of stay) for each of the selected diagnosis groups. The HSMR is a ratio of observed to expected deaths multiplied by 100. A ratio equal to 100 suggests that there is no difference between the hospital's mortality rate and the average national rate, greater than 100 suggests that the hospital's mortality rate is higher than the average national rate, and less than 100 suggests that the hospital's mortality rate is lower than the average national rate.

Human Genome Project (HGP)

A national effort sponsored by the National Institutes of Health and the Department of Energy to create an ordered set of DNA segments and to develop new computational methods for analyzing genetic map and DNA sequencing data. The project ended in 2003 with the completion of the human genetic sequence. An important feature of the project was the federal government's transfer of technology to the private sector through licensing technologies to private companies and awarding grants for innovative research. The project continues to catalyze the multibillion-dollar U.S. biotechnology industry and foster the development of new medical applications.

Human Understanding

The practice of intentionally developing a deeper understanding of a person's behaviors, preferences, wants, and needs, in order to build an ongoing relationship. In healthcare, this translates to the ability to treat every patient as an individual, every time.

Human Understanding Metric (HU^{me})

A measurement incorporated into patient experience surveys fielded by NRC Health that calculates patients' answers to the question, "Did everyone treat you as a unique person?" This metric has a statistically significant positive relationship with net promoter score (NPS).

Incidence

The number of new cases of a disease or condition in a defined population within a specific period of time.

Indemnity insurance

Traditional type of insurance coverage whereby insured individuals are reimbursed for covered medical expenses after they have been incurred; payments are made to the insured or directly to the provider.

Independent director

An independent director has no direct or indirect, material conflict of interest with the corporation. An independent director has no conflicts or has a conflict of such insignificance *(de minimis)* that it would not be perceived to exert an influence on the director's judgment. What constitutes a *de minimis* and material conflict, respectively, must be defined precisely and in quantifiable terms.

Independent ethics committee (IEC)

See *institutional review board*.

Independent practice association (IPA)

A group of independent physicians who have formed an association as a separate legal entity for contracting purposes; IPA physician providers retain their individual practices and see fee-for-service patients as well as those enrolled in HMOs.

Indirect medical education (IME) payments

Additional payments by Medicare to teaching facilities to compensate them for the additional costs of educating residents and treating sicker patient populations.

Individual mandate

A requirement that all individuals purchase health insurance or pay a penalty. This was included in the Affordable Care Act but was repealed in December 2017 through separate tax legislation passed by Congress.

Institute for Healthcare Improvement (IHI)

A not-for-profit organization focusing on the improvement of healthcare throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI was the force behind the 100,000 Lives and 5 Million Lives Campaigns. IHI's goal is to help accelerate change in healthcare by cultivating promising concepts for improving patient care and turning those ideas into action.

Institute of Medicine (IOM)

The Institute of Medicine serves as advisor to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public. Two groundbreaking reports from the IOM have spurred national movement in improving quality: *To Err is Human* (1999), and *Crossing the Quality Chasm* (2001).

Institutional review board (IRB)

An independent body constituted of medical/scientific professionals and non-medical/non-scientific members, whose responsibility it is to ensure the protection of the rights, safety, and well-being of human subjects involved in a trial and to provide public assurance of that protection by, among other things,

reviewing and approving/providing favorable opinion on the trial protocol, the suitability of the investigator(s), facilities, and the methods and material to be used in obtaining and documenting informed consent of the trial subjects.

Integrated delivery network (IDN)

See *clinically integrated network.*

Intensivist

A physician specifically trained to care for critically ill patients in intensive care units (ICUs).

Intermediate sanctions

A term used in regulations enacted by the IRS that is applied to non-profit organizations who engage in transactions that inure to the benefit of a disqualified person within the organization. These regulations allow the IRS to penalize the organization and the disqualified person receiving the benefit. Intermediate sanctions may be imposed either in addition to or instead of revocation of the exempt status of the organization. (See also *inurement*.)

International Classification of Diseases (ICD-10, ICD-11)

The international standard diagnostic classification for all epidemiological, clinical, and health management purposes. It is used to classify diseases and other health problems in relation to other factors, such as the symptoms, abnormal findings, social circumstances, and external causes, and it is used for many types of health and vital records. The International Classification of Diseases is published periodically by the World Health Organization and also provides national mortality and morbidity statistics.

International Organization for Standardization (ISO)

ISO is a network of the national standards institutes of 157 countries. It is a non-governmental organization but it acts as a bridging organization in which a consensus can be reached on solutions that meet both the requirements of business and the broader needs of society, such as the needs of stakeholder groups like consumers and users. The ISO 9000 family of standards (9001–9004) is primarily concerned with quality management—specifically what organizations do to fulfill the customer's quality requirements and applicable regulatory requirements, while aiming to enhance customer satisfaction and achieve continual improvement of performance in pursuit of these objectives. Some healthcare organizations use ISO 9000 in lieu of accreditation by The Joint Commission.

Inurement/private inurement

Rules of the Internal Revenue Service Code that prohibit any portion of the value of the tax-exempt organization from benefiting an individual. Inurement occurs when a tax-exempt organization compensates an individual at a level that is higher than a reasonable market level of compensation. In the case of a purchase or sale of a physician practice, inurement may occur if the physician sells his or her practice for more than fair market value or acquires or re-acquires a practice for less than fair market value. Hospitals that violate these rules risk losing their tax-exempt status.

The Joint Commission

A national organization that evaluates and monitors the quality of care provided in hospitals, healthcare organizations, and agencies based on established standards. CMS grants deemed status for participation in Medicare when healthcare organizations are accredited by The Joint Commission. Formerly known as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

Joint venture

The typical healthcare joint venture between a hospital and physicians consists of an outpatient facility that offers the technical component of healthcare services. Physicians credentialed to perform services at the facility (typically not limited to investors) perform the professional component of these services. Examples are ambulatory surgical centers, imaging centers, and diagnostic cardiac catheterization laboratories. They are normally structured as limited liability companies in order to afford the physician investors protection from double taxation while limiting the parties' risk of personal liability. According to IRS guidelines, in order for a tax-exempt organization's participation in a joint venture with non-exempt participants to be considered an activity related to its exempt purpose, the exempt organization must be able to exercise sufficient control over the venture to ensure that it is operated in an exempt manner. (See also *equity joint venture, "under arrangements" joint venture, participating tax-exempt bond transactions*, and *gainsharing*.)

Large language models (LLMs)

AI systems capable of language generation by analyzing extensive amounts of text data. Examples include artificial neural networks and ChatGPT.

Latinx

A gender-neutral term used to replace Latino or Latina when referring to a person of Latin-American descent.

The Leapfrog Group

An initiative driven by organizations that buy healthcare that are working to initiate breakthrough improvements in the safety, quality, and affordability of healthcare for Americans. Its hospital survey uses national performance measures to evaluate individual hospitals on safety, quality, and efficiency, selected with guidance from scientific advisors at the Armstrong Institute for Patient Safety at Johns Hopkins Medicine and Leapfrog's volunteer expert panels.

Length of stay (LOS)

The period of hospitalization as measured in days billed.

Leverage

See *capital structure.*

Liquidity

Financial ratios that measure the ability of a corporation to meet its short-term liabilities as they come due.

Long-term care

Housing, healthcare, and other support services provided on a long-term basis to individuals who are aged, chronically ill, or disabled. This type of care is often provided in nursing homes.

Machine learning

The use and development of computer systems that are able to learn and adapt without following explicit instructions, by using algorithms and statistical models to analyze and draw inferences from patterns in data. It is considered a subset of, or one type of, artificial intelligence (AI).

Magnet Recognition Program®

A designation through the American Nurses Credentialing Center that recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice. It is considered the highest recognition hospitals and health systems can receive for quality nursing care.

Managed care

An organized system of managing and financing the delivery of healthcare services to control the cost and quality of, and access to, services provided to plan members; includes a full range of integrated healthcare services, facilities, and products in which a patient's access is coordinated and managed by a primary care provider (gatekeeper); objectives are to contain costs, coordinate, and control patient utilization of services and resources, and to ensure favorable outcomes.

Managed competition

An economic theory/mechanism designed to blend government regulation with competition in the marketplace; employers would join large purchasing cooperatives to buy healthcare services from a network of providers in order to compete for consumers based on price, quality, and a standardized package of benefits.

Management by walking around (MBWA)

An approach in which a member of a hospital management team regularly walks through offices, lab areas, patient rooms, and so forth, to talk to employees, patients, and families to find out about any issues or problems and receive feedback.

Management services organization (MSO)

An organization that provides administrative and practice-management services to medical groups that are typically owned by physicians; commonly furnishes sites, facilities, equipment, and administrative staff and services, allowing physicians to concentrate on practicing medicine.

Marginal cost

The cost of producing an extra unit of product; a key consideration in pricing and in calculating cost implications of business expansion or contraction.

Market basket (MB)

A measure of all the goods and services that a hospital must buy to provide care. The market basket measures a fixed set of goods and services for the hospital and compares it with how much those same items would cost at a later or earlier time.

Means test

An annual income and assets test to determine if a person or family qualifies for public support.

Medicaid

A federal program that is jointly managed by federal and state governments and designed to provide healthcare services for the poor (i.e., those persons who, regardless of age, have insufficient income and assets to pay the costs themselves); it has become a major source of funding for nursing home care for the elderly.

Medicaid and CHIP Payment and Access Commission (MACPAC)

A commission established by the Children's Health Insurance Program Reauthorization Act of 2009 to review Medicaid and State Children's Health Insurance Program (CHIP) access and payment policies and to advise Congress on a wide range of Medicaid and CHIP issues.

Medical foundation

A tax-exempt, physician-sponsored organization that acquires the business and clinical assets of a physician group and manages the business.

Medical loss ratio (MLR)

The ratio of money paid out by an insurer for claims, divided by premiums collected for a particular type of insurance policy. The Affordable Care Act requires health insurance issuers to submit data on MLRs and to issue rebates to enrollees if this percentage does not meet the minimum standards. MLR requires insurance companies to spend at least 80 or 85 percent of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases.

Medically indigent

A term used in the healthcare sector to describe those who do not have and cannot afford insurance coverage.

Medicare

A federally administered health insurance program for persons 65 years of age and older and certain disabled persons under the age of 65; Medicare eligibility is not based on disability, income, or asset requirements. Medicare Part A covers hospital, inpatient costs, and prescription drugs patients receive in the hospital, and is financed entirely through taxes; Medicare Part B covers outpatient/ambulatory care and is financed by taxes and individual payments toward the Part B premium. A supplemental private plan (Part C or Medicare Advantage),

and prescription drug benefit (Part D) were added later. Because Parts B, C, and D require premium contributions from individuals, they are voluntary—i.e., Medicare beneficiaries can choose whether or not to participate.

Medicare Access and CHIP Reauthorization Act (MACRA)

Bipartisan federal legislation passed by Congress and signed by President Obama on April 15, 2015. MACRA replaces the Medicare Part B sustainable growth rate (SGR), the fee-for-service adjustment method used since 1997 to reimburse physicians for Medicare services. MACRA creates two new payment formula options for physicians and other clinicians: the Merit-Based Incentive Payment System (MIPS) and eligible advanced Alternative Payment Models (APMs).

Medicare Advantage (MA)

Private health plans that have contracted with Medicare to provide members with their Medicare Part A and Part B benefits. This plan was established as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and replaced the Medicare+Choice program.

Medicare donut hole

The uncovered portion of a Medicare beneficiaries' Part D prescription drug benefit plan that leaves them financially obligated for the cost of covered prescription drugs once a certain level of expenditures is reached during an enrollment year. The Affordable Care Act shrank the donut hole by reducing beneficiary copayments each year.

Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

Legislation passed by Congress in 2003 and signed into law by the President in 2004 that initially offers a prescription discount card (at a nominal fee) to Medicare beneficiaries. Beginning in 2006, MMA made available a prescription drug benefit to Medicare enrollees who enroll in the plan and pay a premium. The law also includes other changes designed to modernize the Medicare program.

Medicare severity-diagnosis related group (MS-DRG)

The Medicare severity-diagnosis related group replaces the former DRG program, which was phased in over 2008–2009. According to CMS, 745 MS-DRGs replaced the former 538 DRGs, with three severity levels based on complications or co-morbidities (CCs): 1) with major CCs; 2) with CCs; and 3) with no CCs.

Medicare Shared Savings Program (MSSP)

A program established by CMS that allows healthcare providers to join together in accountable care organizations (ACOs) to integrate and coordinate services in return for a share of any savings to the Medicare program. Medicare Shared Savings Program ACOs will be rewarded for lowering growth in Medicare costs while meeting performance standards on quality of care and putting patients first.

Medicare wage index

An index used to adjust Medicare DRG payments to providers based on variations in labor costs between rural and metropolitan areas and across metropolitan areas.

Medigap

Supplemental health insurance sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. There are 12 different standardized Medigap policies (plans A through L), and Medigap policies must be clearly identified as "Medicare Supplement Insurance." Each plan has a different set of basic and extra benefits.

Merger

Union of two or more organizations by the transfer of all assets to one organization that continues to exist while the other(s) is (are) dissolved.

Merit-Based Incentive Payment System (MIPS)

A merit-based payment model under the CMS Quality Payment Program (QPP) for physicians that began in 2019 and puts a portion of an eligible clinician's payments at risk. Metrics categories for performance include cost, quality, promoting interoperability, and improvement activities; these categories are weighted differently for small practices vs. larger practices. (Also see *Quality Payment Program.*)

Mid-level practitioner

Nurses, physician assistants, midwives, and other non-physicians who can deliver medical care under the sponsorship of a practicing physician.

Minimum viable product (MVP)

A version of a product with just enough features to be usable by early customers who can then provide feedback for future product development.

Mobile health

A term used for the practice of medicine and public health supported by mobile devices such as smart phones, tablets, computers, and personal digital assistants (PDAs), and wearable devices such as smart watches, for health services, information, and data collection.

Morbidity

The frequency and severity of sickness and accidents in a defined class, area, or population.

Mortality

Incidence of death in a defined population.

Multi-hospital system

Two or more hospitals owned, leased, contract managed, or sponsored by a central organization.

Multi-specialty group

A group of physicians representing two or more medical specialties who work together in a group practice setting and generally share profits, equipment, facilities, personnel, and office expenses.

National Committee for Quality Assurance (NCQA)

A national organization that conducts quality-focused reviews of HMOs and other managed care plans.

National Integrated Accreditation for Healthcare Organizations (NIAHO(R))

A hospital accreditation program of DNV GL (formerly called DNV Healthcare, Inc.). On September 30, 2008, the Centers for Medicare & Medicaid Services (CMS) approved DNV Healthcare, Inc. to become the first new hospital accreditation organization in more than 30 years (joining The Joint Commission and the American Osteopathic Association). DNV can deem hospitals in compliance with the Medicare Conditions of Participation. The program integrates ISO 9001 Quality Management System with the Medicare Conditions of Participation.

National Practitioner Data Bank (NPDB)

Established by HCQIA, this data bank serves as a clearinghouse of information for healthcare organizations throughout the nation. It has a number of reporting requirements that must be followed by healthcare entities that perform peer review. Healthcare bodies that do not make required reports to the NPDB forfeit the peer review immunities they would otherwise be entitled to under HCQIA.

National provider identifier (NPI)

A 10-digit, numeric identifier issued to healthcare providers by the Centers for Medicare and Medicaid Services and used for administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA).

National Quality Forum (NQF)

A private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. NQF's mission is to improve American healthcare through endorsement of consensus-based national standards for measurement and public reporting of healthcare performance, focusing on whether care is safe, timely, beneficial, patient-centered, equitable, and efficient.

Net Promoter Score® (NPS)

A simple, single, easy-to-calculate measure for tracking customer loyalty that is widely used and accepted in many industries. The score is calculated based on the HCAHPS question, *How likely would you be to recommend this facility to your family and friends?* NPS® is calculated by taking the percentage of respondents who answer 9 or 10 (people deemed to be "promoters" of the health system) and subtracting those who answer between 0 and 6 (known as "detractors").

Network

A group of providers that contract with a health plan or other insurer to provide a defined set of healthcare services to enrollees according to a predetermined (often discounted) fee schedule.

"Never events"

Preventable medical errors that result in serious consequences for the patient. Designated by CMS, the list includes certain hospital-acquired conditions "determined to be reasonably preventable. If a condition is not present upon admission, but is subsequently acquired during the hospital stay, Medicare will no longer pay the additional cost of the hospitalization." As of October 1, 2008, all of the identified conditions have payment implications when acquired during an inpatient stay. For more information, visit www.cms.hhs.gov.

Next Generation ACO Model

A model offered by the Center for Medicare & Medicaid Innovation for ACOs that are experienced in coordinating care for populations of patients. It allowed these provider groups to assume higher levels of financial risk and reward than under the Pioneer Model and Medicare Shared Savings Program. The program sunsetted at the end of 2020; ACOs are being redirected to the ACO REACH Model. (Also see *accountable care organization*.)

Niche provider

A provider that focuses on a specific market segment, such as a narrow set of medical services or conditions or a specific population.

No Surprises Act

Federal legislation passed in 2022 that aims to protect people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency and non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good-faith estimate from the provider.

Non-catastrophic process

A process in patient care in which its failure does not directly lead to death or severe injury within hours of the failure. For example, if healthcare workers fail to wash their hands, the patients they touch don't develop a devastating infection within minutes or hours, and most patients won't develop an infection at all. But non-catastrophic processes may still harm the patient. (See also *catastrophic processes*.)

Nurse practitioner (NP)

Nurse practitioners practice at an advanced level to provide care in a range of settings. NPs are responsible and accountable for health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases. They provide initial, ongoing, and comprehensive care to patients in family practice, pediatrics, internal medicine, geriatrics, and women's health.

Oncology Care Model (OCM)

A payment and delivery model developed by the Center for Medicare & Medicaid Innovation that aims to provide higher quality, more highly coordinated oncology care at the same or lower cost to Medicare. Under the OCM, physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. The practices participating in OCM have committed to providing enhanced services to Medicare beneficiaries, such as care coordination and navigation, and to using national treatment guidelines for care.

ORYX®

Introduced in February 1997, The Joint Commission's ORYX® initiative integrates outcomes and other performance measurement data into the accreditation process. ORYX measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts, which now include the standardized common measures referred to as "Hospital Quality Measures" from CMS. The same data set can be used to satisfy both CMS and Joint Commission requirements.

Outcomes

The measures of treatments and effectiveness in patient care in terms of cost, mortality, morbidity, health status, quality of life, functional status, and/or patient satisfaction.

Outlier patients

Patients who require hospital stays that are unusually long for their diagnosis. Typically a threshold length of stay (LOS) is established that defines when a patient in a certain diagnostic category becomes classified as an outlier.

Outlier payments

Additional reimbursement that Medicare and some insurers and health plans provide to hospitals to cover the additional costs of caring for outlier patients.

Outpatient prospective payment system (OPPS)

A system developed by the Centers for Medicare and Medicaid Services (CMS) to pay for most outpatient services at hospitals or community mental health centers under Medicare Part B.

Palliative care

Comprehensive, interdisciplinary care focusing primarily on promoting quality of life for people living with a serious, chronic, or terminal illness and for their families, assuring physical comfort and psychosocial support. It is appropriate at any age and at any stage in a serious illness and is provided alongside all other appropriate medical treatments.

Pandemic

An outbreak of a disease that becomes prevalent across a whole country, region, or the world.

Participating tax-exempt bond transaction (PBT)

An alternative to equity interests in structuring collaborative economic relationships with physicians. PBTs involve the sale of participating instruments to physician investors. Participating bonds pay investors based on the economic performance of the entity on whose behalf the bonds have been issued. These bonds are often subordinated obligations. As a result, the interest rate on these bonds is much higher than that available on traditional fixed-interest bonds. Because of the potential to yield high rates of tax-exempt interest, participating bonds have proven attractive alternatives to equity interests in structuring collaborative economic relationships with physicians.

Partnership for Patients

The Partnership for Patients was a public-private partnership working to improve the quality, safety, and affordability of healthcare for all Americans (this program was in place from 2011–2016). The Partnership for Patients aimed to engage 100 percent of the nation's acute care medical centers participating in making hospital care safer, more reliable, and less costly through the achievement of two goals: 1) making care safer by keeping patients from getting injured or sicker in the healthcare system, and 2) helping patients heal without complication by improving transitions from acute-care hospitals to other care settings.

Pathways to Population Health Equity (P2PHE)

A framework for public health practitioners to build a more prepared, resilient, and proactive public health system at every level. The development of the framework was facilitated by the Centers for Disease Control and Prevention (CDC), WE in the World, and the Association of State and Territorial Health Officials (ASTHO) to strategically advance health equity.

Pathways to Population Health (P2PH) Framework

A framework released jointly by the American Hospital Association/Health Research Education Trust, the Institute for Healthcare Improvement, the Network for Regional Healthcare Improvement, the Public Health Institute, and Stakeholder Health via 100 Million Healthier Lives with the support of the Robert Wood Johnson Foundation. Together with over 50 pioneer sponsors, they are engaging hundreds of healthcare organizations in a shared journey to population health with a focus on 1) speaking with a common voice and language; 2) breaking population health into simple, powerful portfolios of activity; and 3) developing tools and pathways to make the journey easier.

Patient advisory council (PAC)/Patient and family advisory council (PFAC)

A representative group of patients and caregivers (or, in the case of PFACs, patients, families, and caregivers) who meet regularly with clinic or hospital staff to help improve clinic or hospital performance. They are distinct from "community advisory boards," which are often patient-dominated boards of directors required for all Federally Qualified Health Centers (FQHCs). While FQHC boards typically focus on community relations and healthcare leadership, PACs provide two-way communication between the clinic or hospital and its patients about daily operations.

Patient- and family-centered care

An approach to the planning, delivery, and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients, and families. It redefines the relationships in healthcare by placing an emphasis on collaborating with people of all ages, at all levels of care, in all care settings. Patients and families define their "family" and determine how they will participate in care and decision making.

Patient and family engagement

A component of patient- and family-centered care that creates an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care.

Patient-centered care

See *consumer-centered care*.

Patient-centered medical home (PCMH)

A solution for primary care coordination (to address primary care physician shortages and the growing prevalence of chronic diseases). Enabled under the Tax Relief and Health Care Reform Act of 2006 and was demonstrated in Medicare pilot programs. The patient-centered medical home has significant implications for primary care delivery and compensation, chronic care management, evidence-based medicine, personal health records, and related initiatives. It changed the current reimbursement structure by providing reimbursement in the form of a "care management fee" to a physician practice or hospital for the services of a "personal physician." The patient-centered medical home includes five main characteristics: comprehensive care, patient-centered, coordinated care, accessible services, quality and safety.

Patient-Centered Outcomes Research Institute (PCORI)

Established by legislation under the Affordable Care Act, the PCORI is an independent, non-profit organization overseen by a board of governors made up of directors from AHRQ and NIH along with 19 other appointed members, including three from the patient/consumer community. The PCORI is charged with identifying research priorities based on certain factors and authorized to commission a wide variety of different types of comparative effectiveness research studies with respect to the relative health outcomes, clinical effectiveness, and appropriateness of medical treatments and services.

Patient-Driven Groupings Model (PDGM)

This patient-centered payment model from Medicare/CMS places home health periods of care into more meaningful payment categories while eliminating the use of therapy service thresholds for adjusting payment for home health episodes.

Patient Protection and Affordable Care Act of 2010 (PPACA or ACA)

A federal statute that was signed into law by President Barack Obama on March 23, 2010. Along with the Health Care and Education Reconciliation Act of 2010 (HCERA, signed into law on March 30, 2010), provisions of the legislation include: increasing health insurance coverage, expanding Medicaid eligibility, improving quality and efficiency of medical care services, subsidizing insurance premiums,

prohibiting denial of coverage/claims based on pre-existing conditions, providing incentives for businesses to provide healthcare benefits, and supporting healthcare workers through a new workforce training and education infrastructure.

Patient Safety and Quality Improvement Act (PSQIA)

As of July 29, 2005, the act was designed to create a national patient safety center to address medical errors within the healthcare system. It establishes patient safety organizations (PSOs) to which providers (individuals and entities) can voluntarily report medical errors and patient safety information. The PSOs will then take the information, analyze it, and provide feedback. (See *patient safety work product*.)

Patient Safety Network (PSNet)

A division of the Agency for Health Research and Quality (AHRQ) that serves as a national Web-based resource containing the most up to date news and essential information on patient safety.

Patient safety work product (PSWP)

Data, reports, records, memoranda, analyses (including root-cause analyses), and written or oral statements that are collected or developed for reporting to a patient safety organization (PSO) and that are, in fact, reported to a PSO.

PSWPs do not include patient medical records, billing or discharge information, or any other original patient or provider record. Information that is collected, maintained, or developed separately, or exists separately from a patient safety evaluation system is not protected under PSQIA. (See *Patient Safety and Quality Improvement Act*.)

Patient's Bill of Rights

A policy issued on July 22, 2010, by the Departments of Health and Human Services, Labor and Treasury that helps children (and eventually all Americans) with pre-existing conditions gain coverage and keep it, protect all Americans' choice of doctors, and end lifetime limits on the care consumers may receive. These new protections create an important foundation of patients' rights in the private health insurance market that puts Americans in charge of their own health.

Pay-for-performance

A payment system that links compensation to quality goals, and providers under this arrangement are rewarded for an improvement in the quality of healthcare services. Using a set of clinical performance standards, hospitals collect data to measure adherence to the standards. The hospital and the payer establish an agreed-upon performance baseline. The payer agrees to financially reward overachievers with higher reimbursements, and also penalize under-performers with lower reimbursements. CMS has engaged in pilot programs to demonstrate how this type of payment system would function.

Paycheck Protection Program

A federal program in which loans were provided to small businesses to be used for payroll costs, mortgage interest, rent, and utilities, to help sustain businesses financially due to impacts from the COVID-19 pandemic.

Payer (payor)

Any agency, insurer, or health plan (including the federal government) that pays for healthcare services and is responsible for reimbursing providers for the provision of those services.

Payment-to-cost ratio

The level of hospital payment divided by costs. A ratio of 1 indicates, for example, that payments are equal to 100 percent of costs.

Per case reimbursement

A payment method in which a health plan or insurer reimburses a hospital a flat amount for the patient's entire stay, with the amount typically varying by diagnosis or DRG.

Per diem reimbursement

A payment method in which a health plan or insurer reimburses a hospital a flat amount for each day the patient is in the hospital.

Per member per month (PMPM)

The amount of money a health plan or provider receives per person every month under capitated payment arrangements; may relate to either revenues or costs.

Pharmacogenetics

The study of the effect of genetic inheritance on individual response to drugs.

Physician assistant (PA)

A specially trained and licensed health professional who performs certain medical procedures in collaboration with or under indirect supervision of a physician. This includes diagnosing illness, developing treatment plans, coordinating care, and prescribing medications. PAs are nationally certified and state licensed to practice medicine, and often serve as a patient's principal healthcare provider.

Physician extender

Health professional, such as a nurse or health educator, who works with patients in order to make the patient's time with the physician more efficient and productive.

Physician–hospital organization (PHO)

A contractual organization of a hospital and its medical staff developed for the purpose of contracting directly with employers and managed care organizations, and the opportunity to better market physician–hospital services and achieve administrative efficiencies. PHOs can be "closed" (i.e., the hospital works only with select physicians who are typically chosen based on cost-effectiveness and/or high quality) or "open" (i.e., the hospital works with all members of the medical staff who wish to participate).

Physician Quality Reporting System (PQRS)

A voluntary reporting program created by the 2006 Tax Relief and Health Care Act that physicians use to report data on quality performance measures for services provided to Medicare beneficiaries. Those who satisfactorily report this data are offered payment incentives.

Picker Dimensions of Patient-Centered Care

Eight dimensions of care identified in 1987 through research by the Picker Institute and Harvard Medical School. The research involved reviewing relevant literature and conducting diverse focus groups of patients, physicians and other hospital staff, and family members, regarding their healthcare experiences, to determine what matters most to patients. The eight dimensions (in brief) are: respect for patients' values, preferences, and needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; continuity and transition; and access to care.

Point of service (POS)

An option given to members of HMOs and PPOs to see physicians or use facilities outside the specific network of physicians or hospitals outlined in their plans. Members can choose to go outside the network at the time they need service, but they typically absorb higher out-of-pocket expenses (e.g., through higher coinsurance) if they do so.

Policy

A statement of intent that guides and constrains further decision making and action, and limits subsequent choices.

Population health

The distribution of health outcomes within a population, the health determinants that influence distribution, and the policies and interventions that impact the determinants. Population health spans wellness and health promotion, management of chronic disease, care of the frail and elderly, and palliative care for those at the end of life. Population health approaches address the broader landscape of healthcare consumers to preserve wellness and minimize the impact of illness.

Predictive AI

Artificial intelligence that uses historical data to predict future outcomes, aiding decision making. It is trained on large datasets to recognize patterns. Healthcare applications include predicting patient readmissions and aiding in disease diagnosis and treatment planning.

Preferred provider organization (PPO)

A health plan that contracts with independent providers at a discount for services; physicians receive reduced rates in return for larger patient volumes. PPO members can typically choose to go to non-network providers, but they will face higher out-of-pocket expenses if they do.

Prevalence

The number of cases of a disease or condition existing in a given population during a specific period of time or at a particular moment in time.

Preventive care

Healthcare that emphasizes the early detection and treatment of diseases. Preventive care is intended to keep people healthier for longer, thus reducing healthcare costs over the long term.

Primary care

Basic medical care, including preventive services, provided on a regular basis to individuals, typically in a doctor's office.

Primary prevention

Care provided to prevent the initial onset of a disease or condition, such as physicians encouraging patients to exercise and eat right or counseling smokers to quit.

Private equity (PE)

Investment partnerships that pool money from groups of investors and buy and manage companies before selling them. They do not hold stakes in publicly-traded companies. In healthcare, PE firms have greatly increased their involvement over the past two decades, purchasing struggling hospitals and more often, physician groups. Money-making strategies through these purchases typically include merging multiple practices, reducing staff, closing portions of a hospital or healthcare practice's operations, focusing on growing a specific aspect of a healthcare practice's offerings, and renegotiating reimbursement rates with insurers.

Private inurement

See *inurement*.

Process-of-care measures

The measures of timely and effective care that show the percentage of patients who receive treatments known to get the best results for certain common, serious medical conditions or surgical procedures, and how quickly hospitals treat patients who come to the hospital with certain medical emergencies. The measures only apply to patients for whom the recommended treatment would be appropriate.

Program integrity

A program under CMS to ensure that Medicare pays the right amount for care provided, and only pays legitimate providers, for covered, reasonable, and necessary services to eligible beneficiaries while taking aggressive actions to eliminate fraud, waste, and abuse.

Public health

Public health is the science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and

responding to infectious diseases. Overall, public health is concerned with protecting the health of entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world.

Public reporting (in healthcare)

Due to increased government scrutiny of not-for-profit healthcare organizations, many states require mandatory reporting of hospital data, both quality and financial. The reported data include defined performance measures for clinical processes, clinical outcomes, cost, and administrative actions, as well as publication of provider performance results.

Purchaser

Those entities, including public and private employers, the federal government, and state governments, that pay insurers and health plans directly for health coverage on behalf of employees and/or eligible beneficiaries.

Quadruple Aim

An informal addition to the Institute for Healthcare Improvement's (IHI) Triple Aim; the fourth aim is employee wellness/attaining joy in work. (See Triple Aim.)

Qualified health plan

An insurance plan that is certified by a state or federal exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements outlined in the Affordable Care Act.

Quality

The degree to which health services for individuals and populations include the following six dimensions, from the Institute of Medicine (IOM): 1) safety, or freedom from accidental harm, 2) effectiveness, or evidence-based care, 3) patient-centeredness, 4) timeliness, or care that ensures prompt access to appointments, diagnosis, and treatment, 5) efficiency, or care delivered with optimal use of resources, and 6) equitable care, that doesn't vary due to personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status.

Quality assurance (QA)

A process that objectively and systematically measures, evaluates, and monitors the level of patient care being provided by physicians, hospitals, or other healthcare providers and organizations to ensure that patients are receiving the best and most appropriate care possible.

Quality improvement organization (QIO)

A group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs work under the direction of the Centers for Medicare & Medicaid Services to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.

Quality Payment Program (QPP)

An approach to payment created under the MACRA legislation that replaces the sustainable growth rate (SGR) and rewards the delivery of high-quality patient care through two tracks: the Merit-Based Incentive Payment System (MIPS) and eligible advanced Alternative Payment Models (APMs). Clinicians participating in an advanced APM may earn an incentive payment for participating in an innovative payment model, and clinicians participating in MIPS will earn a performance-based payment adjustment.

Quaternary care

The most highly specialized hospital services, available only in select facilities staffed by highly trained specialists. Examples include organ transplants, including heart, lung, and kidney transplants.

***Qui tam* action**

An abbreviation of the Latin phrase *qui tam pro domino rege quam pro si ipso in hac parte sequitur,* which means, "He who brings the action for the King as well as for himself." *Qui tam* provisions of a statute allow a private person to bring a civil action on behalf of both the United States and himself, and to share in part of the monetary recovery. The individual bringing the *qui tam* action can receive between 15 percent and 25 percent of whatever is recovered from the lawsuit, with the remainder going to the government. (See *False Claims Act*.)

Rapid response team (RRT)

A team of clinicians who bring critical care expertise to the bedside, and can be called by any hospital staff at the first sign of patient decline. Also known as a medical emergency team, or MET.

Recovery audit contractor (RAC)

A private firm hired and paid by CMS to audit the claims of providers that participate in fee-for-service Medicare, including hospitals, skilled nursing facilities, physicians, durable medical equipment (DME) suppliers, and labs. The RACs are tasked with identifying provider billing in violation of Medicare policy (both underpayments and overpayments) and recoup overpayments and refund underpayments under Part A or B of the Medicare program. However, RACs collect overpayments from providers before proving that the billing was indeed "improper," and providers have to appeal to have the funds returned, even if they have billed correctly. RACs also have the ability to deny claims in process if they have not yet been paid. The RAC permanent program began implementation in 2008 and became nationwide in 2010.

Recovery care center

A facility that provides routine outpatient surgery and low-risk surgical procedures that require only a brief inpatient stay, usually two days or less.

Regional health information organization (RHIO)

An organization that facilitates the exchange of electronic health records (sometimes referred to as a health information network or HIN).

Reliability

Reliability in healthcare is "failure-free operation over time from the viewpoint of the patient." (As defined by Roger Resar, M.D. and his colleagues at IHI.)

Resource allocation

In strategic planning, a resource-allocation decision is a plan for using available resources to achieve goals for the future. It is the process of allocating resources among the various projects or business units.

Resource-based relative value scale (RBRVS)

A fee schedule developed by the CMS to provide a more equitable physician reimbursement system for use by Medicare recipients; based on providers' training and skills rather than fees charged.

Return on assets (ROA)

See *return on investment.*

Return on equity (ROE)

After-tax earnings of a corporation divided by its stockholders' equity; stockholders' equity is determined by deducting total liabilities and intangible assets from total assets; often considered to be the most important of profitability ratios; objective is to realize ROE of at least 15 percent in order to provide for dividends and fund future growth.

Return on investment (ROI) (also called return on assets)

After-tax income for a specified period of time divided by total assets; a financial tool to measure and relate a corporation's earnings to its total asset base.

Risk management

A program of activities to identify, evaluate, and take corrective action against risks that may lead to patient or employee injury and/or property loss or damage with resulting financial loss or legal liability.

Root-cause analysis (RCA)

A problem solving method aimed at identifying the root causes of problems or events. The practice is predicated on the belief that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is hoped that the likelihood of problem recurrence will be minimized. However, it is recognized that complete prevention of recurrence by a single intervention is not always possible. Thus, it is often considered to be an iterative process, and is frequently viewed as a tool of continuous improvement.

Safe harbor

Regulatory or statutory provisions that shield certain designated payment arrangements from criminal prosecution or insurance program exclusion. Safe harbor provisions are contained in the Stark laws and the anti-kickback statute.

An example of a safe harbor commonly used by hospitals and physicians is one existing under the anti-kickback statute for personal services contracts. The required elements of that safe harbor include that:

- The agreement is contained in writing and signed by the parties.
- The agreement covers and specifies all of the services provided.
- The agreement provides the schedule of services.
- The term of the agreement is at least one year.
- Aggregate compensation is set in advance, consistent with fair market value in arm's length transactions, and not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties.
- The services provided do not involve the counseling or promotion of illegal activities.
- Aggregate services contracted for do not exceed those that are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

(See *Anti-Kickback Statute* and *Stark law & regulations*.)

Sarbanes-Oxley Act (SOA or SOX)

Comprehensive legislation passed by Congress in 2002 that affects corporate governance, financial disclosure, and the practice of public accounting for publicly-held corporations. While its provisions do not specifically affect non-profit organizations, many healthcare organizations have applied it to their practices, and since 2002 there has been much action at the government level to look at the business practices of non-profit organizations with the same scrutiny, especially healthcare organizations.

Section 4960 excise tax

2017 tax reform legislation included new Section 4960, which imposes a 21 percent excise tax on remuneration in excess of $1 million and on any excess parachute payments paid by an applicable tax-exempt organization and related organizations to a covered employee.

Sentinel event

An event, as defined by The Joint Commission, as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a person or persons, not related to the natural course of the patient's illness. Sentinel events are identified under Joint Commission accreditation policies to help aid in root cause analysis and to assist in development of preventative measures. The Joint Commission tracks events in a database to ensure events are adequately analyzed and undesirable trends or decreases in performance are caught early and mitigated.

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; COVID-19)

The scientific name of the new strain of coronavirus; the disease caused by this virus is called Coronavirus Disease 2019, or COVID-19.

Shared Savings Program (SSP)

See *Medicare Shared Savings Program.*

Silo syndrome

A reluctance to share information with employees of different divisions in the same company. It is seen as something that reduces an organization's efficiency and contributes to a damaged corporate culture.

Single-payer system

A healthcare system in which a single entity functions as the central purchaser of healthcare services. This entity collects healthcare fees and pays for all healthcare costs, but is not involved in the delivery of care.

Six Sigma

A statistical term that refers to a process that produces less than 3.4 defects out of every one million opportunities. The term is also commonly used to describe a business strategy that aims to eliminate waste and to drive the quality and cost performance of any process to this level. Many healthcare processes currently operate far below this level of performance, suggesting the opportunity for significant cost reduction and quality enhancement through application of this strategy in healthcare.

Skilled nursing facility (SNF)

An institution that provides skilled nursing care and related services to patients who no longer require hospital care but do require 24-hour medical care or rehabilitation services.

Small Business Health Options Program (SHOP)

Programs designed to help small employers access affordable insurance for their employees. SHOP exchanges offer a variety of health plans; provide comparative information on benefits, costs, and quality; and facilitate enrollment in a plan of choice. The Affordable Care Act requires states to create SHOP exchanges and allows states to combine their SHOP exchange with their exchange for individual consumers.

Social determinants of health (SDOHs)

The various factors that impact health outside the four walls of the hospital. These are often based on the conditions in which people are born, grow, live, work, and age. These can include factors such as genetics, housing, geographic location, access to health services and healthy food, education, behaviors (e.g., smoking or alcohol use), gender, and income.

Sole community hospital (SCH)

Hospitals that, according to Medicare regulations, represent the only source of inpatient and/or emergency care within a defined geographic area. SCHs are eligible for adjustments in payment rates. Often these hospitals are also designated critical access hospitals (CAHs), and thus subject to additional requirements under Medicare.

Specialty hospital

A hospital that specializes in a particular product niche, such as cardiac care or orthopedic care. These hospitals can be either for-profit or not-for-profit facilities.

Spend-down

A method by which an individual reduces his or her gross income and assets until that individual meets the financial requirements to be eligible for Medicaid.

SSI/SSDI Outreach, Access, and Recovery (SOAR) program

Enables states and communities to tackle homelessness through increased access to Social Security disability benefits.

Staff model HMO

A type of HMO that employs its own physicians to provide healthcare to its enrollees; physician employees usually provide all ambulatory care services under one roof and are compensated by salary and bonus based on the HMO's profits. Kaiser is the most well-known staff model HMO.

Stand in the shoes

A provision under the Stark II Phase III, which states that a physician "stands in the shoes" of his or her group practice for the purpose of determining whether Stark covers the doctor's relationship with another entity. This requirement was postponed starting December 2007 for academic medical centers. Effective October 2008, the stand in the shoes rule was modified to permit—but not require—a physician to stand in the shoes of his or her physician organization if that physician had no ownership or investment interest in the physician organization. (See *Stark law & regulations*.)

Star Ratings

A five-point rating system used by CMS for hospitals, health plans, and other care providers to help consumers, families, and caregivers compare providers more easily and to help identify areas for improvement in quality outcomes and experience. Datasets included in the rating are CAHPS, HEDIS, and various CMS quality incentive programs. A similar program is used to evaluate nursing homes, known as the Five-Star Quality Ratings program.

Stark law & regulations

Stark I: Colloquial name for the physician self-referral prohibitions introduced to Congress in 1988 by California representative Fortney Pete Stark. The law provides that a physician or an immediate family member who has a financial relationship with an entity may not refer a Medicare patient to that entity for clinical laboratory services, unless an applicable exception exists. In addition, the law prevents an entity with which a physician has a financial relationship from billing Medicare or a beneficiary for clinical laboratory services furnished pursuant to a prohibited referral.

Stark II: The 1993 amendments to Stark I extended the physician self-referral restrictions to Medicaid services and beneficiaries and expanded the referral and billing prohibitions to 10 additional designated health services reimbursable by Medicare or Medicaid. The 10 services are 1) physical therapy, 2) occupational

therapy, 3) radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services, 4) radiation therapy services and supplies, 5) DME and supplies, 6) parenteral and enteral nutrients, equipment, and supplies, 7) prosthetics, orthotics, and prosthetic devices, 8) home health services and supplies, 9) outpatient prescription drugs, and 10) inpatient and outpatient hospital services. Stark II became effective on January 1, 1995. The statute contains many exceptions, which can be grouped into categories applicable to all financial relationships, to ownership and investment interests, and to compensation arrangements.

Stark II Phase III: Additional regulations interpreting the Stark statutes, which were promulgated and went in to effect in December of 2007. Their most controversial provision says that a physician "stands in the shoes" of his or her group practice for the purpose of determining whether Stark covers the doctor's relationship with another entity. This requirement was said to be postponed until December 2008 for academic medical centers and was then amended starting October 2008 so that physicians are permitted, but not required to stand in the shoes of their physician organization if they have no ownership or investment interest in them. One positive feature of the Stark II Phase III regulations was making the rules regarding physician recruitment more flexible.

State Children's Health Insurance Program (SCHIP)

State-run programs that provide insurance coverage to children in low-income families who are not eligible for Medicaid. The federal government provides significant financial support to the states for SCHIP.

STEEEP

See *quality.*

Supply-side disruption

Market disruption affecting the supply chain, such as a global pandemic or other occurrence that requires manufacturing to slow or halt. Alternatively, such disruption occurs in circumstances where there is demand for a completely new product or service that doesn't yet exist or, given its newness, is still in short supply.

Swap

In finance, a swap is a derivative in which two counterparties agree to exchange one stream of cash flows against another stream. These streams are called the legs of the swap. The cash flows are calculated over a notional principal amount, which is usually not exchanged between counterparties. Consequently, swaps can be used to create unfunded exposures to an underlying asset, since counterparties can earn the profit or loss from movements in price without having to post the notional amount in cash or collateral. Swaps can be used to hedge certain risks such as interest-rate risk, or to speculate on changes in the underlying prices.

Systemness

The state, quality, or condition of a complex system; a set of interconnected elements that behave as a whole. In healthcare, the term applies to efforts to drive operational and cost consistency and care standardization across an entire organization by bringing services together from multiple facilities under one management and governance structure.

Tax Cuts and Jobs Act of 2017

A law passed by Congress on December 20, 2017, that is designed to cut taxes on individuals and businesses, stimulate the economy, and create jobs. The 2017 tax reform legislation includes two organization-paid excise taxes that apply to all tax-exempt healthcare organizations on compensation arrangements for "covered employees": 1) a 21 percent tax on taxable compensation above $1 million, and 2) a 21 percent tax on "excess" termination payments.

Telehealth/telemedicine

See *virtual care.*

Tertiary care

Highly specialized medical care or procedures, such as CABG surgery, that are performed by specialized physicians in a hospital setting.

Third-party administrator (TPA)

A firm or agency, outside the insuring organization, which handles the administration of a group insurance plan, including the processing of claims and billing.

Third-party payer

An organization, usually an insurance company, that acts as an intermediary between the provider and the consumer of care, that pays for the services provided but does not provide the services (e.g., HMOs, insurance carriers, the government).

Toyota Lean

A management philosophy based on Toyota's production model that focuses on reduction of the seven wastes (over-production, waiting time, transportation, processing, inventory, motion, and scrap). By eliminating waste, quality is improved, production time is reduced, and cost is reduced. Tools include constant process analysis, "pull" production, and mistake-proofing. Toyota Lean is also focused on creating a better workplace. One of the recent trends in healthcare has been the application of lean principles to improving patient care and reducing medical errors. (See *Six Sigma.*)

Transparency

A metaphorical extension of the meaning of "transparent:" a transparent object is one that can be seen through. It implies openness, communication, and accountability. It is introduced as a means of holding directors and public officers accountable and fighting corruption. Transparency is the opposite of privacy; an activity is transparent if all information about it is open and freely available.

Triage

A method by which patients are directed to services and prioritized for care based on the severity or urgency of their injury or illness.

Triple Aim

A community health initiative the Institute for Healthcare Improvement (IHI) launched in October 2007 that is designed to help a diverse group of healthcare organizations, health plans, public health departments, social service organizations, community-based coalitions, and others: 1) improve the overall health of a population, 2) improve the patients' experience of care (including quality, access, and reliability), and 3) reduce the per capita cost of care. The IHI believes these three aims are intricately related and emphasizes the need to pursue all three objectives at once. (See also, Quadruple Aim.)

Unbundling

The unethical practice of a provider, in order to increase total revenues for a service or procedure, to bill for multiple, separate components of a medical service or procedure that are normally covered under one procedure code.

"Under arrangements" joint venture

This type of joint venture takes its name from a Medicare rule that allows hospitals to purchase some of the services they bill to Medicare from third parties "under arrangements." As adapted to hospital–physician joint ventures, the physicians form an LLC (or other partnership entity), either alone or, more commonly, with the hospital. The LLC contracts with the hospital for the LLC to provide a bundle of services within a hospital service line. In return, the LLC would receive fair market value compensation, calculated either as an annual amount set in advance, or on a fee-schedule basis for each Ambulatory Payment Classification or APC (the outpatient equivalent of the DRG). Thus, compensation differs from an equity joint venture in which distributions are based on variable cash flow.

In CMS's Physician Self-Referral and Hospital Ownership Disclosure Provisions in the IPPS FY 2009 final rule, CMS has revised the definition of "entity" concerning "under arrangements" joint ventures. Under existing rules, an entity is considered to be furnishing designated health services (DHS), and thus subject to the physician self-referral rules, only if it is billing Medicare for the DHS. Currently, hospitals are able to refer patients to a physician service provider in which they have an ownership/investment interest, without having to meet an ownership exception, if the physician service provider performs the service but sells it to a hospital or other provider that bills it as DHS to Medicare. The final rule revises the definition of a DHS "entity" to include both the entity that bills Medicare for the service as well as the entity that performs the service.

Underwriting cycle

Repeating patterns of gains and losses within the insurance industry.

Unit-cost reduction

In the context of healthcare, reducing per-unit costs requires monitoring costs of individual services over time and determining how to lower costs by reducing waste and improving efficiency, while still maintaining high-quality care.

Upper payment limit (UPL)

A federal limit placed on fee-for-service (FFS) reimbursement of Medicaid providers. It is the maximum a given state Medicaid program can pay a type of provider in the aggregate, statewide in Medicaid FFS.

URAC (formerly Utilization Review Accreditation Commission)

An independent, not-for-profit organization that accredits and certifies PPOs and promotes quality through various benchmarking and quality improvement programs.

U.S. Preventative Services Task Force (USPSTF)

An independent panel of primary care and prevention experts that conducts scientific evidence reviews in order to make recommendations for clinical preventative services. The task force is funded and regulated by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ).

Utilization

Patterns of use for particular healthcare services such as hospital care, physician visits, or prescription drugs.

Value-Based Insurance Design (VBID)

A mechanism gaining traction in the commercial insurance market to better align patient copayments and premiums with the value of healthcare services. VBID plans reduce out-of-pocket expenses for consumers for high-value treatments, drugs, and services that are proven to prevent or manage disease.

Value-Based Purchasing Program (VBP)

Established by the Affordable Care Act, this program began linking provider payments to improved performance by healthcare providers starting on October 1, 2012. This form of payment holds hospitals and health systems accountable for both the cost and quality of care they provide. It is designed to promote better clinical outcomes for patients as well as improve their experience of care during hospital stays, and to identify and reward the best-performing providers.

Variable cost

A cost that varies with output or organizational activity (e.g., labor, materials).

Vertical integration

An integrated delivery system (IDS) that provides a full range of healthcare services, from outpatient to hospital long-term care, for the purpose of serving total healthcare needs of a geographic population; may include financing mechanisms and alliances with managed care plans to distribute/manage risk and capture market share.

Virtual care

A broad term that encompasses all the ways healthcare providers remotely interact with their patients. In addition to treating patients via telemedicine, providers may use live video, audio, and instant messaging to communicate with and monitor their patients remotely.

Vital Conditions of Health (VCOH)

A new way of describing social determinants of health, including reliable transportation, thriving natural world, basic needs for health and safety, humane housing, meaningful work and wealth, and lifelong learning. The Vital Conditions for Health and Well-Being framework, part of the Federal Plan for Equitable Long-Term Recovery and Resilience, provides an actionable organizing structure to build connections and alignment across federal agencies and sectors to support efforts to build a strengths-based and community-driven federal response to address the factors identified in the framework. (See Federal Plan for ELTRR.)

v-safe

A smartphone-based tool that checks in with patients to ask about side-effects after receiving the COVID-19 vaccine.

WE in the World

A non-governmental organization (NGO) working to advance intergenerational well-being and equity on a foundation of racial and economic justice.

Well-Being in the Nation (WIN)

A growing strategic network of organizations and communities coming together to advance intergenerational well-being and equity by expanding the vital conditions everyone needs to thrive through relationships and system change.

Women, Infants, and Children (WIC) Program

A federal program that provides food, nutrition education, and access to healthcare to low income pregnant women and new mothers, as well as to infants and children living below 185 percent of the poverty line who are at nutritional risk.

Working capital

A corporation's investment in current assets; net working capital is the excess of current assets over current liabilities.