HEALTHCARE REFORM: A LEXICON FOR EDUCATORS

A guide to terminology in the fields of quality improvement, patient engagement, and interprofessional continuing education, including the associated organizations, legislation, and resources.

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Medscape Education is committed to providing education designed to help the healthcare team, including the patient, succeed in the face of a new healthcare paradigm. Likewise, Medscape Education has taken a lead role in helping supporters of professional medical education identify opportunities in alignment with the 6 priorities of the National Quality Strategy. The new healthcare environment brings with it a host of new terminology, stakeholder organizations, and legislative issues. Medscape Education offers you this handy lexicon to help you know “who’s who” and “what’s what” in the quality improvement landscape.
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The Accelerating Change and Transformation in Organizations and Networks (ACTION) initiative is a model of field-based research designed to promote innovation in healthcare delivery by accelerating the diffusion of research into practice. As part of the Agency for Healthcare Research and Quality (AHRQ), the ACTION network includes 15 large partnerships and collaborating organizations that provide healthcare to more than 100 million Americans (AHRQ, 2009).

The purpose of ACTION is to promote innovation in healthcare delivery by accelerating the development, implementation, diffusion, and uptake of demand-driven and evidence-based products, tools, strategies, and findings. ACTION develops and diffuses scientific evidence about what does and does not work to improve healthcare delivery systems. It provides an impressive cadre of delivery-affiliated researchers and sites with a means of testing the application and uptake of research knowledge. This group was the successor to the Integrated Delivery System Research Network, a 5-year implementation initiative completed in 2005 (AHRQ, 2009).

**SOURCE**


**ACMEE**

Accreditation Council for Continuing Medical Education

A council that helps continuing medical education (CME) providers apply for accreditation as well as oversees, sets, and enforces standards in CME within the United States.

**SOURCE**

http://www.acmee.org/cme-providers

**APTC**

Advance Premium Tax Credit

A tax credit an individual can take in advance to lower their monthly health insurance payment (or “premium”).

**SOURCE**

https://www.healthcare.gov/glossary/advance-premium-tax-credit/

**ACI**

Advancing Care Information

ACI replaces “meaningful use” and is 1 of 4 reporting categories required by MACRA. ACI streamlines reporting requirements and emphasizes information exchange. In addition, ACI is customizable to meet the needs of individual clinicians, and is aligned with other Medicare reporting programs.

**SOURCE**

https://www.cms.gov/Medicare/Quality-PatientSafety/AdvancingCareInformation/.

**ACA**

Affordable Care Act

The Patient Protection and Affordable Care Act (commonly referred to as ACA) was signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, the ACA represents the most significant regulatory overhaul of the US healthcare system since the passage of Medicare and Medicaid in 1965. The US Department of HHS agency consumer information website highlights several provisions of the ACA (HHS, 2015), described below.

**ACTIVITY:**

- Guarantees your right to appeal. You now have the right to ask that your plan reconsider its denial of payment.
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**Ending preexisting condition exclusions for children.** Health plans can no longer limit or deny benefits to children younger than 19 years due to a pre-existing condition.

**Keeping young adults covered.** If you are younger than 26 years, you may be eligible to be covered under your parent’s health plan.

**Ending arbitrary withdrawals of insurance coverage.** Insurers can no longer cancel your coverage just because you made an honest mistake.

**Regarding costs, the ACA:**

- Ends lifetime limits on coverage. Lifetime limits on most benefits are banned for all new health insurance plans.
- Reviews premium increases. Insurance companies must now publicly justify any unreasonable rate hikes.
Regarding care, the ACA:
- Helps plan subscribers get the most from their premium dollars. Premium dollars must be spent primarily on healthcare, and not on administrative costs.

- Covers preventive care at no cost to plan subscribers. Patients may be eligible for recommended preventive health services with no copayment.

- Protects the choice of doctors. Patients can choose the primary care doctor they want from their plan’s network.

- Removes insurance company barriers to emergency services. Patients can seek emergency care at a hospital outside of their health plan’s network.

The ACA contains what is known as the “individual mandate,” which requires most individuals to obtain health insurance or potentially pay a penalty for noncompliance.

SOURCE

AHRQ
Agency for Healthcare Research and Quality

Formerly known as the Agency for Health Care Policy and Research, AHRQ is 1 of several agencies within HHS. The mission of AHRQ is to “produce evidence to make healthcare safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.” (AHRQ, n. d., Mission & Budget)

AHRQ’s priority areas of focus include the following:
- Improve healthcare quality by accelerating implementation of patient-centered outcomes research (PCOR). AHRQ invests in developing PCOR methods and training, and in disseminating PCOR findings. AHRQ will also invest in an initiative to disseminate and support the implementation of PCOR findings in primary care practices.
- Make healthcare safer. AHRQ researches the ways patients experience preventable harm during their healthcare, why this harm occurs, and how to prevent it. AHRQ translates the results into practical tools for providers to:
  - Make healthcare safer in hospitals and ambulatory and long-term care settings;
  - Reduce harm associated with obstetrical care to mothers and babies;
  - Improve safety and reduce medical liability by developing a guide for implementing a Communication and Resolution Program, and
  - Accelerate patient safety improvements in nursing homes. (AHRQ, n. d., p. 8)
- Increase accessibility by evaluating the ACA coverage expansions. The AHRQ will lead HHS efforts to evaluate the effects of the ACA-mandated Medicaid and Marketplace coverage expansions. The results will enable HHS and Congress to make better-informed decisions about the implementation of the ACA in terms of access, reduction in disparities, use and expenditures, outcomes, financial security, and employer offers and coverage take-up.
- Improve healthcare affordability, efficiency, and cost transparency by improving the data, measures, and public reporting strategies for conveying information on healthcare price, cost, and quality, and by developing and spreading evidence and tools to measure and enhance the efficiency of health systems—the capacity to produce better-quality health and outcomes while avoiding overutilization, or to maintain quality of health and outcomes with lower resource use. The AHRQ will analyze variations in quality and resource use and identify the factors that differentiate higher-performing from lower-performing systems.

SOURCE


SOURCE

AIHC
The American Interprofessional Health Collaborative

An organization that promotes the scholarship and leadership necessary to develop interprofessional education and transform health education across the learning continuum for students, practitioners, and educators. (AIHC, 2012)

SOURCE

ANCC
American Nurses Credentialing Center

A subsidiary of the American Nurses Association credentialing program that certifies and recognizes individual nurses in specialty practice areas; recognizes healthcare organizations for promoting safe, positive work environments; and accredits continuing nursing education organizations.

SOURCE
http://www.nursecredentialing.org

AHCRC
American Nurses Credentialing Center

A program to facilitate shared decision making, which calls for HHS to contract with an entity to develop independent standards for educational tools known as “patient decision aids” for preference-sensitive care. (IDMF, 2015)

SOURCE

ACA, Section 3506
Affordable Care Act

A program to facilitate shared decision making, which calls for HHS to contract with an entity to develop independent standards for educational tools known as “patient decision aids” for preference-sensitive care. (IDMF, 2015)

SOURCE

ABMS
American Board of Medical Specialties

A nonprofit organization of 24 medical specialty boards (known as the “Member Boards”). The ABMS is the largest physician-led specialty certification organization in the United States. The ABMS Member Boards maintain a rigorous process for the evaluation and certification of physicians in more than 150 medical specialties and subspecialties. More than 80% of practicing physicians in the United States have achieved board certification by 1 or more of the Member Boards. (ABMS, 2015)

The ABMS Maintenance of Certification® (MOC®) program supports lifelong learning by physicians. The ABMS also collaborates with other professional medical organizations and agencies to set standards for graduate medical school education and accreditation of residency programs. The ABMS makes information available to the public about the board certification of physicians and their participation in the ABMS MOC® program. (ABMS, 2015)

SOURCE
A function that helps ensure that a patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time. 

SOURCES


Cardiac Rehabilitation Incentive Payment Model

A model that provides an incentive payment to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery, which would be based on beneficiary utilization of cardiac rehabilitation and intensive cardiac rehabilitation services.

SOURCES
https://innovation.cms.gov/initiatives/cardiac-rehabilitation/

CMS

Centers for Medicare & Medicaid Services

The government agency that administers the Medicare program. CMS also works in partnership with state governments to administer Medicaid, the State Children’s Health Insurance Program (SCHIP or CHIP), and health insurance portability standards.

BTE

Bridges to Excellence

An initiative created by a group of employers, physicians, health plans, and patients that has come together to create programs that will help reignite medical innovations around key 6 key attributes identified by the IOM (2001) report. The IOM advocated bridging this chasm by redesigning the healthcare system around key 6 attributes to make the system safer, timelier, and more effective, efficient, equitable, and patient-centered. (IOM, 2001; NCQA, 2013)

BTE has a number of programs that recognize and reward clinicians who deliver superior patient care. These programs measure the quality of care delivered in provider practices and place special emphasis on managing patients with chronic conditions, who are at most risk of incurring potentially avoidable complications. The BTE Recognitions cover all major chronic conditions plus office systems and also include a real PCMH measurement scheme to promote comprehensive care delivery and strong relationships between patients and their care teams. (HCI3, 2012; NCQA, 2013)

Physicians, nurse practitioners, and physician assistants who meet performance benchmarks for BTE Recognition can earn a range of incentives, sometimes including substantial cash payouts. Insurers and employers fund these payouts from the savings they achieve through lower healthcare costs and increased employee productivity. (HCI3, 2012)

SOURCES


CMS

Centers for Medicare & Medicaid Services

The government agency that administers the Medicare program. CMS also works in partnership with state governments to administer Medicaid, the State Children’s Health Insurance Program (SCHIP or CHIP), and health insurance portability standards.

APM

Alternative Payment Model

One of two pathways by which healthcare providers can submit QPP data. The other pathway is called the MIPS. In order to qualify for incentives and benefits under MACRA, physicians are required to participate in APMs that are based on the same quality measures used for MIPS. Since APM options are not yet available in much of the country, or are unavailable for providers with certain specialties, MACRA is trying to encourage providers to participate in developing a number of new payment models: specialty models, models in partnership with payers, models with networks of 15 or providers, statewide payment models, and Medicare-based models.

SOURCE

Therapeutic Biologic Applications/Biosimilars

How Drugs are Developed and Approved/Approval Applications/
SOURCE
Administration.

Biological products that can be interchanged
Biosimilar

http://www.nber.org/papers/w7948
SOURCE
The investigation of why people make certain
Behavioral economics

The investigation of why people make certain economic decisions, using a psychological framework.

SOURCE
http://www.nber.org/papers/w7948

Bundled payment

The reimbursement of healthcare providers for expected costs of care administered while a patient in the hospital. (That is, the hospital receives a lump payment for an episode of care for a patient, such as admission to the hospital for a heart attack, and the bundled payment amount covers all care administered to the patient for the time he or she is in the hospital. This is in contrast to each physician performing his or her own services on the patient and billing separately for the services provided.)

SOURCE
https://innovation.cms.gov/initiatives/bundled-payments/

BPCl

Bundled Payments for Care Improvement

An initiative that links payments for multiple services beneficiaries received during an episode of care that leads to more coordinated care at a lower cost to Medicare. (CMS, 2015)

SOURCE

Cardiac Rehabilitation Incentive Payment Model

A model that provides an incentive payment to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery, which would be based on beneficiary utilization of cardiac rehabilitation and intensive cardiac rehabilitation services.

SOURCE
https://innovation.cms.gov/initiatives/cardiac-rehabilitation/

Care coordination

A function that helps ensure that a patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.

SOURCES


BTE Recognition can earn a range of incentives, sometimes including substantial cash payouts. Insurers and employers fund these payouts from the savings they achieve through lower healthcare costs and increased employee productivity. (HCI3, 2012)

SOURCES
Additional responsibilities for CMS include implementing the administrative simplification standards from the HIPAA and developing and implementing quality standards, certification for long-term care facilities, along with clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments. CMS is also responsible for other tasks to advance health information technology, including the implementation of EHR Incentive Programs, the creation of standards for the certification of EHRs, and the updating of privacy and security regulations under HIPAA. (CMS, 2015a)

CMS Innovation Center

Centers for Medicare & Medicaid Services Innovation Center

Established by section 1110A of the Social Security Act (as added by section 3021 of the ACA), this is a warehouse of various tested or promising payment and service delivery models. The CMS Innovation Center is currently focused on testing new payment and delivery models, evaluating results, advancing best practices, and engaging a broad range of stakeholders to develop additional models for testing. (CMS, 2015)

SOURCE

Change management

The application of evidence-based strategies, methodologies, and tools for preparing an organization to adapt to changing needs and achieving desired patient health outcomes.

SOURCE

CCMC

Chronic Care Management Code

New service billing code for payment of non-face-to-face chronic care management services for Medicare beneficiaries with multiple (2 or more) significant chronic conditions. Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. (Goodson & Engel, 2014)

SOURCE

CCM

Chronic Care Model

An organizational approach to caring for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidence-based interactions between an informed, activated patient and a prepared, proactive practice team. (Improving Chronic Illness Care, n.d.)

SOURCE

Clarity

Providing transparency of information to individuals to enable and empower them to make decisions and take actions related to their care.

SOURCE

Coaching

A method of directing or instructing a person to achieve a goal or develop a specific skill or competency. (Meakim et al., 2013)

SOURCE

Clinical decision support

A collection of tools used to enhance decision making in the clinical workforce. These tools include computerized alerts and reminders to care providers and patients, clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, and contextually relevant reference information. (AHRQ, 2009)

SOURCE

Comparative effectiveness research

Research designed to inform healthcare decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options.

SOURCE
http://effectivehealthcare.ahrq.gov/index.cfm?section=effectiveness-research/1
CJR  
Comprehensive Care for Joint Replacement

A model that aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements).

SOURCE
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/

CPC+  
Comprehensive Primary Care Plus

A model that aims to strengthen primary care through a regionally based mulipayer payment reform and care delivery transformation.

SOURCE
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/

CO-OP  
Consumer Operated and Oriented Plan

A program that fosters the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

SOURCE
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html

CQI  
Continuous Quality Improvement

Routine patient feedback to practice, measuring patient outcomes against benchmarks or evidence-based practices and many other process and outcome measures.

SOURCES

CoC  
Continuum of Care

An integrated system of care that guides and tracks patient care over time through a comprehensive array of health services spanning all levels of intensity of care. Including all aspects of care provided at home, by primary providers, specialists, social and mental health workers, and others involved in delivering care for a patient as part of a comprehensive treatment plan. (Truesdell, 2012)

SOURCE

Counseling, coaching, question prompts, motivational interviewing, decision aids, and helplines

Interventions that can be used to engage patients at various points of the care continuum. The ultimate goal of all the interventions is for patients to take action and be active participants in their healthcare decisions. (Truesdell, 2012).

SOURCE

Data infrastructure

Technology, processes, tools, and standards needed to promote data sharing and consumption. (HITRC, 2013).

SOURCE

Data integration

A combination of technical and business processes used to combine data from disparate sources into meaningful and valuable information. (HITRC, 2013)

SOURCE

Debriefing

An activity that follows a simulation experience led by a facilitator to provide feedback regarding the participants’ performance. (Meakim et al., 2013)

SOURCE

Decision aids

Tools designed for patients to become involved in decision making by making explicit the decision that needs to be made, providing information about the options and outcomes, and clarifying personal values. They are designed to complement, rather than replace, counseling from a health practitioner.

SOURCES

 Cueing

Providing cues, triggers, prompts, hints, and instructional support to participants during simulation-based training or learning. (Paige & Morin, 2010)

SOURCE

INDEX soils/nlc_continuousqualityimprovementprimer.pdf
Healthcare Reform: A Lexicon for Educators

Disease prevention and health promotion

Services to address the health of patients before the onset of illness or occurrence of disease that also encourage patients to lead healthy lives by changing behaviors.

Disease self-management

Providing education and tools needed to help patients cope with chronic diseases such as managing stress, encouraging physical activity and good nutrition, communicating effectively with healthcare providers, and developing action plans through structured planning and feedback exercises. (Truesdell, 2012)

EHR

Electronic health record

An electronic version of a patient’s medical history that is maintained by care providers over time and is a real-time longitudinal health record generated by 1 or more encounters in any care delivery setting. Unlike EMRs, EHRs also allow patients’ health records to move with them to other healthcare providers, specialists, hospitals, and nursing homes, and are consulted by authorized providers and staff from across more than 1 healthcare organization.

The EHR automates access to information and can streamline the clinician’s workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various information technology (IT) interfaces, including evidence-based decision support, quality management, and outcomes reporting. (CMS, 2012)

The use of EHRs is intended to strengthen the relationship between patients and clinicians. The data, and the timeliness and availability of it, will enable providers to make better decisions and provide better care.

The EHR can improve patient care by (CMS, 2012):
- Reducing the incidence of medical error by improving the accuracy and clarity of medical records;
- Making the health information available, thereby reducing duplication of tests and delays in treatment, and encouraging patients to be well informed to make better decisions; and
- Reducing medical error by improving the accuracy and clarity of medical records.

An EHR is different from an electronic medical record (EMR). An EMR contains the standard medical and clinical data gathered in only 1 provider’s office. EHRs go beyond the data collected in the individual provider’s office and include a more comprehensive patient history. EHRs can contain and share information from all providers involved in a patient’s care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than 1 healthcare organization.

Unlike EMRs, EHRs also allow patients’ health records to move with them to other healthcare providers, specialists, hospitals, and nursing homes, and across states. (HealthIT.gov, 2013)

SOURCES

ECPs

Essential community providers

Medical care providers who serve predominantly low-income or medically underserved patient populations. (HIVMA, 2013)

SOURCES

EHB

Essential Health Benefits

A plan requiring nongrandfathered health plans in the individual and small group markets to cover essential health benefits.

SOURCES

EPMs

Episode Payment Models

New models that continue to shift Medicare reimbursements from quantity to quality by creating strong incentives for hospitals to deliver better care at a lower cost. These models would reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions, and speed recovery in 3 areas: heart attacks, bypass surgery, and hip/femur fractures.

SOURCES
- https://innovation.cms.gov/initiatives/epm/

Engagement

Engagement is the act of becoming involved that individuals must take in order to obtain the greatest benefit from available healthcare services. (Center for Advancing Health, 2010)

SOURCES

Evidence-based medicine or practice

Use of current and most accurate science and guidelines in making decisions about the care of individual patients. (Truesdell, 2012)

SOURCES
Description of a healthcare delivery system through which some Medicaid enrollees are served. In this system, healthcare providers are paid for each medical service (such as an office visit, test, or procedure). Individual states select payment methodologies such as FFS for Medicaid services in their Medicaid State plan. CMS (see CMS) reviews all state plans to ensure reimbursement methodologies are consistent with federal statutes and regulations. (CMS, 2013)

States may develop their FFS provider payment rates based on the costs of providing the service, a review of what commercial payers pay in the private market, or a percentage of what Medicare pays for equivalent services.

FFS payment rates are often updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate. The methodologies for service rates are described in the individual Medicaid state plan. (CMS, 2013)

SOURCE

The process of using quantitative and qualitative methods to systematically collect and analyze data to understand health or organizational needs. (CDC, 2010)

SOURCE

The study of DNA to learn more about the genetic basis for health and disease.

SOURCE
https://www.genome.gov/18016863

The capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged.

SOURCE

The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision making.

SOURCE


Continuous quality improvement (CQI) strategies to optimize your practice.

SOURCE

The HITECH Act seeks to improve American healthcare delivery and patient care through an unprecedented investment in HIT. This HITECH program provides the necessary assistance and technical support to providers, enable coordination and alignment within and among states, establish connectivity to the public health community in case of emergencies, and ensure the workforce is properly trained and equipped to be meaningful users of certified EHRs. These programs collaboratively build the foundation for every American to benefit from an EHR as part of a modernized, interconnected, and vastly improved system of care delivery. (HealthIT.gov, 2015)

Title IV, Division B of the Hitech Act establishes incentive payments under the Medicare and Medicaid programs for eligible professionals (EPs) and eligible hospitals (EHS) that meaningfully use Certified EHR Technology (CEHRT). The HITECH program has been amended in several sections of the Social Security Act (SSA) to establish the availability of incentive payments to EPs and EHSs to promote the adoption and meaningful use of CEHRT. (HealthIT.gov, 2015)
HEDIS
Healthcare Effectiveness Data and Information Set

A set of standardized performance measures designed to ensure that consumers have the information they need to reliably compare the performance of healthcare plans. HEDIS is sponsored, supported, and maintained by the NCQA. (NCQA, 2014)

The performance measures in HEDIS are related to several significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. These performance measures (NCQA, 2014) include a standardized survey of consumers’ experiences, which evaluates the performance of healthcare plans in areas such as customer service, access to care, and claims processing.

Health plans seek NCQA (2014) accreditation by administering the HEDIS performance measures across their plans. In general, compliance with conventional reporting practices and HEDIS specifications for the following domains is measured:

- Effectiveness of care
- Access/availability of care
- Satisfaction with the experience of care
- Health plan stability
- Use of services
- Cost of care
- Informed healthcare choices
- Health plan descriptive information. (NCQA, 2014)

SOURCE

IPA
Independent Practice Association

A type of health maintenance organization (HMO) or other legal entity in which individual practitioners or smaller groups of physicians see patients enrolled in the HMO but also treat their own patients who are not HMO participants. Compensation to the physician is based on either a per patient fee or a discounted fee schedule. (RMI, 2015)

SOURCE


HIMSS Patient Engagement Framework

A model created to guide healthcare organizations in developing and strengthening their patient engagement strategies through the use of eHealth tools and resources. Designed to assist healthcare organizations of all sizes and in all stages of implementation of their patient engagement strategies. (HIMSS Foundation, 2015)

SOURCE

HCPFC
HIMSS Center for Patient- and Family-Centered Care

A HIMSS Foundation and the National eHealth Collaborative project, the center educates and engages providers and patients to e-connect by understanding the value of the adoption and use of health IT. (HIMSS Foundation, 2016)

SOURCE

Human patient simulators

A full-sized patient mannequin that blinks, breathes, and has a heartbeat and pulse. Provides a virtual simulation of almost every major bodily function. Can be used for a range of scenarios from physical examination to major trauma.

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Integrated Delivery Network

**Groups of physicians, hospitals, HMOs, and other facilities and providers that work together to offer care to a specific geographic region or market. The make-up of the networks varies to address a spectrum of issues including capitation, excess capacity, decreased margins, and complaints from patients regarding access. (HIMSS, 2015)**

The IDN concept was developed in the 1980s and has since evolved to the point where IDNs include many types of associations across the continuum of care. For example, 1 type of IDN might include a short- and long-term hospital, a health management plan, a physician hospital organization, a home health agency, and hospice services. Multiple hospital systems and mergers may be considered limited IDNs, as different entities are joining together to provide care. (HIMSS, 2015)

Some members of an IDN may provide identical or complementary services to patients (horizontal integration), whereas others may provide various levels of care (vertical integration).

**SOURCE**

**ICD-9**

**International Classification of Diseases, Ninth Revision**

A classification system designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems. (CMS, 2013)

The ICD-9 provides a format for reporting causes of death on the death certificate. The reported conditions are then translated into medical codes through use of the classification structure and the selection and modification rules contained in the applicable revision of the ICD, published by the World Health Organization (WHO). Those coding rules improve the usefulness of mortality statistics by giving preference to certain categories; by consolidating conditions, and by systematically selecting a single cause of death from a reported sequence of conditions. (CDC, 2009)

The ICD has been revised periodically. The ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as of 1994. The ICD-10 is currently being phased in to replace the ICD-9 in various segments of the US healthcare system. (CMS, 2013) On October 1, 2014, ICD-10 code sets replaced ICD-9 code sets. The transition to ICD-10 is required for everyone covered by HIPAA. The change to ICD-10 does not affect current procedural terminology coding for outpatient procedures and physician services. The 11th revision of the ICD classification has already started and will continue until 2015. (WHO, 2010)

**SOURCE**

**Interoperability**

The ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.

**SOURCE**
The Joint Commission

A nonprofit organization that accredits more than 20,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality and reflects an organization’s commitment to meeting certain performance standards.

The mission of the Joint Commission is “to continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.” (The Joint Commission, 2015)

MOC

Maintenance of Certification

The process of physicians keeping their certification up to date through 1 of the 24 medical specialty boards of the ABMS (see ABMS), as well as some of the medical specialty boards of the American Osteopathic Association. In 2000, the Member Boards of ABMS agreed to evolve their recertification programs to one of continuous professional development; the ABMS Maintenance of Certification (ABMS MOC®). The ABMS MOC ensures that a physician is committed to lifelong learning and competency in a specialty and/or subspecialty by requiring ongoing measurement of 6 core competencies adopted by the ABMS and the Accreditation Council for Graduate Medical Education in 1999. (ABMS, 2014)

The 6 core competencies are measured in a variety of ways, some of which vary according to specialty, using a 4-part process that is designed to keep certification continuous. The ABMS MOC program plans were approved in 2006, and the boards are now in the process of implementation. (ABMS, 2014)

CMS promotes MOC through its Physician Quality Reporting System (PQRS). The PQRS is a voluntary reporting program that provides incentive payments to identified EPs who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. (See FFS)

Physicians who are incentive-eligible for 2014 PQRS can receive an additional 0.5% incentive payment when MOC Program Incentive requirements have been met. Physicians cannot receive more than 1 additional 0.5% MOC Program incentive, even if they complete an MOC Program in more than one specialty. (CMS, 2014)

MU

Meaningful use

MU is the set of standards, defined by the Incentive Programs of the CMS, that governs the use of EHRs. The goal of meaningful use is to improve US healthcare by promoting the spread of EHRs. (HealthIT.gov, 2014)

Using certified EHR technology to: 1) improve quality, safety, and efficiency and reduce health disparities, 2) engage patients and family, 3) improve care coordination [and population and public health], and 4) maintain privacy and security of patient health information. The overall mission of meaningful use is a better clinical outcomes, improved population health outcomes, increased transparency and efficiency, empowered individuals, and more robust research data on health systems. (HITRC, 2013)

The benefits of the meaningful use of EHRs include:

- Complete and accurate information. EHRs give providers the information they need to deliver the best possible care. They will know more about their patients and their health history before they enter the examination room.
- Better access to information. EHRs facilitate greater access to the information that providers need to diagnose health problems earlier and improve the outcomes of their patients. EHRs also allow information to be shared more easily among doctors’ offices and hospitals, and across health systems, leading to better coordination of care.
- Patient empowerment. EHRs will help empower patients to take a more active role in their health and in the health of their families. Patients can receive electronic copies of their medical records and share their health information securely over the Internet with their families. (HealthIT.gov, 2014)

The HITECH Act establishes incentive payments under the Medicare and Medicaid programs that can be earned by EPs, EHRs, and critical access hospitals that demonstrate that they meaningfully use certified EHR technology. (CMS, 2013)

SOURCES
- Joint Accreditation Accreditation offers programs, including Medscape as of June 2016, the opportunity to take a more active role in their health and in the health of their families. Patients can receive electronic copies of their medical records and share their health information securely over the Internet with their families. (HealthIT.gov, 2014)

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SOURCES
of quality and efficiency measures for use in public reporting and performance-based payment programs. The MAP Initiative is the first of its kind, blending the views of diverse groups in order to provide recommendations to the federal government in advance of the regulatory rule-making process. The MAP collaboration represents a variety of interests, including consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers, in an effort to promote fair and balanced input to HHS on performance measure selection. (NQF, 2015)

SOURCE

MLR Medical Loss Ratio
A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees.

SOURCE
https://www.healthcare.gov/glossary/medical-loss-ratio-MLR/

MSSP Medicare Shared Savings Program
Established by the ACA, the MSSP encourages and incentivizes providers to work collaboratively through an ACO to improve quality of care and reduce costs.

SOURCE
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payments/SharedSavingsProgram/MLSSP.html

Medicare Star Rating
Centers for Medicare & Medicaid Services (CMS), 2015. Five-Star Quality Rating System: Medicare Star Rating to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which consumers may have questions.

SOURCE
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payments/SharedSavingsProgram/MLSSP.html

SOURCE
http://www.mdpi.com/2227-9032/3/1/50

MIPS Merit-Based Incentive Programs
MIPS is intended to integrate and simplify several of the current CMS quality programs, namely, the Base EHR portion of MU, the PQRS, and the Value Based Payment Modifier. It is 1 of 2 pathways by which healthcare providers can submit QPP data. The other pathway is called the APM.

SOURCE

MTM Medication therapy management
A type of patient care that focuses on goal achievement, while also minimizing the burden of treatment.

SOURCE
http://www.mdpi.com/2227-0312/3/10/
Multidisciplinary team approach

An approach that encompasses all members of the treatment and/or care team, allowing coordination of all relevant aspects of a patient’s healthcare needs. These team members consider every facet involved with the patient’s care, treatment planning, and disease or symptom management, resulting in more effective communication among the full healthcare team and the patient. (PHYTEL, 2012; Truesdell, 2012)

SOURCE

Narrow-network plan

A limited provider network health plan to control cost. (McKinsey & Company, 2014)

SOURCE

NCQA
National Committee for Quality Assurance

A private, nonprofit organization dedicated to improving healthcare quality in the United States. Its governing board includes employers, consumers and labor representatives, health plans, quality experts, regulators, and representatives from organized medicine. (NCQA, 2015a)

The NCQA’s quality improvement efforts are primarily organized around accreditation and performance measurement. The organization manages voluntary accreditation programs for individual physicians, medical groups, and health plans. Health plans seek accreditation through the administration and submission of HEDIS, which consists of a set of performance measures that compare how well a healthcare plan performs across several domains of care.

Consumers can compare health plans on NCQA’s Health Plan Report Card, which rates plans in 5 categories: Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness. (NCQA, 2015)

SOURCE

NQF
National Quality Forum

A nonprofit, nonpartisan membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. The NQF reviews, endorses, and recommends the use of standardized healthcare performance measures. These performance measures, also called quality measures, are essential tools used to evaluate how well healthcare services are being delivered. (NQF, 2015)

NQF performance measures are intended to:
- Make our healthcare system more information rich;
- Point to actions physicians, other clinicians, and organizations can take to make healthcare safe and equitable;
- Enhance transparency in healthcare;
- Ensure accountability of healthcare providers; and
- Generate data that help consumers make informed choices about their care. (NQF, 2015)

The NQF operates under a 3-part mission to improve the quality of healthcare by:
- Building consensus on national priorities and goals for performance improvement, and working in partnership to achieve;
HEALTHCARE REFORM: A LEXICON FOR EDUCATORS


NQF measures
National Quality Forum measures

Standards that are evaluated through the Consensus Development Process for measuring and publicly reporting on the performance of different aspects of the healthcare system. Standards endorsed by NQF are widely viewed as the “gold standard” for the measurement of healthcare quality. (NQF, 2015)


NQS
National Quality Strategy

This term is shorthand for the National Strategy for Quality Improvement in Health Care, a nationwide effort to align public and private interests to improve the quality of health and healthcare. Part of the ACA, the NQS is guided by 3 aims: to provide better care, the quality of health and healthcare. Part of the ACA, the NQS is guided by 3 aims: to provide better care, to facilitate healthy people/healthy communities, and to provide affordable care.

To achieve these aims, the NQS applies 6 priorities that address the range of quality concerns that affect most Americans. These aims and priorities have the potential to rapidly improve health outcomes and increase the effectiveness of care for all populations. (AHRQ, 2017)

The 6 NQS priorities are:

- Making care safer by reducing harm caused in the delivery of care;
- Ensuring that each person and family are engaged as partners in their care;
- Promoting effective communication and coordination of care;
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models. (AHRQ, 2014)


OCM
Oncology Care Model

A voluntary physician payment performance program focused on the total cost of care for patients with cancer receiving chemotherapy during a 6-month period, with payments tied to quality metrics.

SOURCE https://innovation.cms.gov/initiatives/oncology-care/

Navigator/ patient navigator/ patient navigation
An individual focused on guiding the patient through stages of care to reduce barriers and ensure compliance.

SOURCE http://www.patientnavigation.com/what-is-patient-navigation

Next generation
Next generation refers to the most current or soon-to-be-released use of technology to engage patients in their healthcare. “Next generation” can apply to developments in topics such as: e-visits, e-consults, health evaluation, coaching, interoperability across organizations/platforms, and patient goals and outcomes.

SOURCE http://www.jointcommission.org/jc_physician_blog/oppe_fppe_tools_privileging_decisions/

Outcome vs impact

“Outcome” is a predefined, specific, measurable change resulting from an intervention of some sort.

Example: Twenty-three percent more physicians were able to answer a question correctly after participation in our educational intervention

Example: Thirty-one percent of individuals were able to reach target A1C level <7% after being educated by 1 or more members of the care team

“Impact” is the extension of the outcome to a broader arena. “Impact” is something that happens as a result of an outcome.

Example: A newly educated patient is now...
Outcomes research

Research that includes the collection of real-world data allowing for the analysis of the impact of healthcare interventions on patient well-being including clinical, economic, and patient-centered outcomes.

Also refers to the analysis of the effect and impact of healthcare interventions on healthcare provider knowledge and competence, as well as on patient well-being, includes focus on clinical, economic, and patient-centered outcomes and impact.

SOURCE
http://www.patientadvocate.org/54out-expert.asp

Patient advocacy

An individual or organization acting as a liaison between the patient and provider to ensure the needs (medical, social, psychological, community support, and others) of patients are addressed as part of an integrated and comprehensive patient-centered care approach. (Gilkey & Earp, 2009)

SOURCE

Patient-centered care

Active involvement of patients and their families and respecting individual and cultural values, needs, and choices/decisions in care delivery and decision-making. (PHYTEL, 2012; Truesdell, 2012)

SOURCE


PCMH

Patient-Centered Medical Home

The PCMH is not a place: it is a promising model for transforming the organization and delivery of primary care. The PCMH offers a way to organize primary care that emphasizes care coordination and communication in order to transform primary care in fundamental ways that can lead to higher quality and lower costs and can improve patients’ and providers’ experience of care.

The PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient’s lifetime to maximize health outcomes. (ACP, 2015)

The PCMH has become a widely accepted model for how primary care should be organized and delivered throughout the healthcare system and is intended to ensure that patients are treated with respect, dignity, and compassion and to enable strong and trusting relationships with providers and staff.

SOURCES


PCORI

Patient-Centered Outcomes Research Institute

A US-based nongovernmental institute created as part of a modification to the Social Security Act by clauses in the Patient Protection and ACA.
HEALTHCARE REFORM: A LEXICON FOR EDUCATORS

2017

Authorized by Congress to conduct research to provide information about the best available evidence to help patients and their healthcare providers make more informed decisions. The aim of PCORI’s research is to give patients a better understanding of the prevention, treatment, and care options available, and the science that supports those options. (PCORI, 2013a)

The institute is responsible for setting priorities for national clinical comparative effectiveness research, its ultimate purpose is to improve healthcare delivery and outcomes by producing and promoting high-integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader healthcare community. (PCORI, 2013b)

Patient-generated health data (PGHD)

The health-related data created, recorded, or gathered by or from patients (or family members or other caregivers) to help address a health concern. (Deering, 2013; HealthIT.gov, 2015)

SOURCES


Patient education

A planned, systematic, sequential, and logical process of teaching and learning provided to patients and clients in all clinical settings. (Jones and Bartlett, n.d.)

SOURCES


Patient empowerment

Allowing patients access to choices that affect health outcomes. (Center for Advancing Health, 2010; Nursing Alliance for Quality Care, 2011)

SOURCES


The Patient Engagement Framework is a model created to guide health care organizations of all sizes in developing and strengthening their patient and family engagement strategies through the use of eHealth tools and resources, designed to assist in implementing their patient engagement strategies. (RWJF, 2014)

SOURCES


Patient/family outreach

Proactive efforts to understand and reach out to the patient and family to ensure adherence to treatment, with the goal of sustaining new healthy behaviors or for prevention screening outreach.

SOURCES


Patient health literacy

The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services available to be able to make appropriate health decisions. (The Joint Commission, 2007)

Source

Patient-oriented research

A continuum of research, conducted by multidisciplinary teams in partnership with relevant stakeholders, that engages patients as partners, focuses on patient-identified priorities, and improves patient outcomes. (Canadian Institutes of Health Research, 2014)

Source

Patient technology competence

The skills, competence, and use of technology that a patient may have to access his or her own health information or electronic personal health record. (Rogers & Mead, 2004)

Source
Rogers, A. & Mead, N. (2004). More than technology and access: Primary care patients’ views on the use and non-use of health information in the Internet age. Health Social Care Community, 12(2), 132-139

PRO Patient-reported outcome

PROs are defined as “any report of the status of a patient’s (or person(s)) health condition, health behavior, or experience with healthcare that comes directly from the patient, without interpretation of the patient’s response by a clinician or anyone else.” NQF, with funding from the US Department of Health and Human Services, brought together a diverse set of stakeholders who could facilitate the groundwork for developing, testing, endorsing, and implementing PRO performance measures.

Sources
https://www.qualityforum.org/Publications/2012/12/Patient-Reported_Outcome_in_Performance_Measurement.aspx
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3227331

P4P Pay for performance

An emerging movement in health insurance, in which providers are compensated by payers for meeting certain preestablished measures for quality and efficiency. P4P programs have been implemented by both Medicare and private insurers. The CMS has numerous demonstration projects underway to pilot P4P programs in a range of care settings, from primary care clinics to hospitals. The goal is to improve the transparency and accountability of the quality improvement process as a complement to other incentives. (CMS, 2005)

There are financial incentives attached to P4P contracts explicitly to improve the quality and effective management of clinical care objectives. Using quantitative metrics, a percentage of physician compensation can be tied to achieving specific clinical benchmarks in the care they provide. The key difficulty in establishing a P4P program is in choosing appropriate benchmarks. In general, stressing adherence to evidence-based guidelines for care (e.g., ordering of pneumonia vaccines for all patients over the age of 65 years) should be preferred over patient outcomes (e.g., number of diabetic patients with an HbA1c less than 70%), because patient outcomes often depend on factors outside the provider’s control. (CMS, 2005)

The CMS, Health Affairs, 2012; Integrated Healthcare Association, 2014

Sources

PMPM Per member per month

An emerging movement in health insurance, in which providers are compensated by payers for meeting certain preestablished measures for quality and efficiency. P4P programs have been implemented by both Medicare and private insurers. The CMS has numerous demonstration projects underway to pilot P4P programs in a range of care settings, from primary care clinics to hospitals. The goal is to improve the transparency and accountability of the quality improvement process as a complement to other incentives. (CMS, 2005)

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The CMS, Health Affairs, 2012; Integrated Healthcare Association, 2014

Sources

Performance improvement

Positive changes in capacity, process, and outcomes within an organization. (CDC, 2011; HealthIT.gov, 2013)

Sources
PI CME Performance Improvement Continuing Medical Education

CME that includes outcomes that are focused on quality improvement.

**SOURCE**
https://cme.medicine.iu.edu/cme-activities/performance-improvement/

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PHR Personal health records

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards that can be drawn from multiple sources while being managed, shared, and controlled by the individual. (HITRC, 2013; HealthIT.gov, 2013)

**SOURCES**

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Performance management

The practice of actively using performance data to improve patient health. This involves the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an organization achieves desired results. (CDC, 2011; HITRC, 2013)

**SOURCES**

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Personalized medicine

An evolving field, beneficial to both patients and health systems, involving the use of diagnostic testing combined with data from a patient’s medical history, circumstances, and values. Healthcare professionals can develop targeted treatment and prevention plans resulting in optimal treatment regimens.

**SOURCE**
http://www.personalizedmedicinecoalition.org/

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Pharmaceutical outcomes-based contracting

Pharmaceutical contracts between payers and pharmaceutical companies that are based on predefined outcomes attained by a pharmaceutical company. With the implementation of risk-based payment models and the rapid growth of specialty pharmacy spending, opportunities exist to establish collaborative and outcomes-based specialty pharmacy contracts and related programs with regional third-party payers.

**SOURCE**
http://tinyurl.com/j4r6qgp

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Pharmacoeconomics

An area of health economics that compares pharmaceutical products and treatment strategies.

**SOURCE**

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Pharmacogenomics

Pharmacogenomics, a part of precision medicine, refers to the study of how genes affect a patient's response to particular drugs. This new and expanding field combines the science of drugs (pharmacology) and the study of genes and their functions (genomics) to develop effective, safe medications and doses that will be tailored to variations in a person's genes.

**SOURCE**

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PQA Pharmacy Quality Alliance

A 501(c)(3) designated nonprofit alliance with more than 100 member organizations. The mission is to improve the quality of medication management and use across healthcare settings, in order to improve patients’ health. The PQA undertakes this effort through a collaborative process to develop and implement performance measures and to recognize examples of exceptional pharmacy quality. (PQA, 2015)

As a multistakeholder, consensus-based membership organization, PQA collaboratively promotes appropriate medication use and develops strategies for measuring and reporting performance information related to medications. (PQA, 2015)

**SOURCE**

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PCPI Physician Consortium for Performance Improvement

A national, physician-led program convened by the American Medical Association (AMA) and dedicated to enhancing healthcare quality and patient safety. The organization seeks to accomplish aligning patient-centered care, performance measurement, and quality improvement. The PCPI develops, tests, implements, and disseminates evidence-based measures that reflect the best practices and best interest of medicine. (AMA, 2015)

The PCPI focuses on improving patient health and safety by:

**SOURCE**
http://psqh.com/marapr05/simulation.html
HEALTHCARE REFORM: A LEXICON FOR EDUCATORS

- Promoting the implementation of effective and relevant clinical performance improvement activities;
- Identifying and developing evidence-based clinical performance measures and measurement resources that enhance the quality of patient care and foster accountability;
- Promoting the implementation of effective and relevant clinical performance improvement activities; and
- Advancing the science of clinical performance measurement and improvement. (AMA, 2015)

The PCPI is nationally recognized for measure development, specification and testing of measures, and enabling the use of measures in EHRs. The PCPI’s measure development resources include a measure testing protocol, a position statement on the evidence base required for measure development, a composite framework, specification and categorization of measure exceptions, and an outcomes measure framework. (AMA, 2015)

SOURCE

EPs who do not satisfactorily report data on quality measures for covered professional services. The PQRS reporting set pulls data from the PCPI, MEDS, and other measures, but is primarily vetted by the NOQ: (CMS, 2015)

SOURCES


Pioneer ACO Model
CME that includes outcomes that are focused on quality improvement.

SOURCE
https://innovation.cms.gov/initiatives/Pioneer-aco-model

Population health
A term used to describe the “potent opportunity for health care delivery systems, public health agencies, community-based organizations, and many other entities to work together to improve health outcomes in the communities they serve” (Stoto, 2013). One of the 3 elements in the IHI’s Triple Aim for improving the US healthcare system.

SOURCE

PQRS
Physician Quality Reporting System
A reporting program run by CMS that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by EPs. The PQRS provides an incentive payment to practices with EPs identified on claims by their individual National Provider Identifier and Tax Identification Number. EPs qualify for the payments by satisfactorily reporting data on quality measures for covered PFS services furnished to Medicare Part B FFS beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the PQRS also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. The PQRS reporting set pulls data from the PCPI, MEDS, and other measures, but is primarily vetted by the NOQ: (CMS, 2015)

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SOURCE

PCIP Primary Care Bonus Incentive Payment Program
This program allows physicians in primary care practices a 10% bonus regardless of which ZIP code they practice in. The 10% will be paid quarterly and will be based on the actual amount paid, not the allowed amount. If the EPs practice in a Health Professional Shortage Areas (HPSA) area, they will qualify for both the PCPI and HPSA bonus payments. (ACP, 2015)

SOURCES


Provider/physician engagement
The process of bringing together healthcare professionals and other stakeholders in an effort to improve outcomes and address quality-of-care gaps.

SOURCE

Public health
Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. It focuses on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system, and not only the eradication of a particular disease. According to WHO (2015), the 3 main public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
Quality and safety

Quality care is safe, effective, patient-centered, timely, efficient, and equitable. Safety is the foundation upon which all other aspects of quality care are built. (Hibbard & Green, 2013)

SOURCE

QCDR
Qualified Clinical Disease Registry

A new reporting mechanism available for the PQRS for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. (CMS, 2015)

SOURCE

QI
Quality improvement

Systematic and continuous actions that lead to measurable improvement in healthcare services and the health status of targeted patient groups. Also, the process of continuous effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes that achieve equity and improve the health of individuals or communities. (American Telemedicine Association, 2012; HITRC, 2013; Riley et al., 2010)

SOURCE


QPP
Quality Payment Program

The value-based reimbursement system implemented by MACRA, using both a MIPS and APM path.

SOURCE

Real-world data

Data that are not collected during random controlled trials; instead, the data come from the real-life practice of clinicians, hospitals, and health settings.

SOURCE
http://www.rand.org/content/dam/rand/pubs/research_reports/RR500/RR500/RAND_RR500.pdf

QIos
Quality Improvement Organizations

A CMS-coordinated group of health quality experts and clinicians that assist Medicare providers with quality improvement and review of quality concerns. There is 1 QIO for each US state territory and the District of Columbia (QIOs, 2015)

SOURCE

QIs
Quality measures

Tools that help quantify healthcare processes, outcomes, patient perceptions, and organizational structures and/or systems. A method for quantifying patient healthcare in comparison with baseline criteria (such as using evidence-based recommendations as baseline for cholesterol measurement). (CMS, 2015)

SOURCE


Health Research and Education Trust (HPOE, HRET, AHA). (2013). A QIOSs

Remote monitoring devices

Mobile medical devices used to perform a routine test and send the test data, such as blood pressure or weight, to a healthcare professional in real-time. These data are sent directly to a healthcare professional for instant feedback.

SOURCE
http://www.americantelemed.org/about-telemedicine/what-is-telemedicine
SDM

**Shared decision-making**

A process in which healthcare providers and patients collaboratively discuss and select tests, interventions, management, and next steps that are based on evidence-based research and patient preferences. (Barello, Grifﬁnﬁ, & Vagni, 2012; Gambé, 2014; Hibbard, Greene, & Overton, 2013; PHYTEL, 2012; Truesdell, 2012)

An approach to clinical decision making in which both the provider and the patient are recognized as having unique expertise relevant to care decisions. (AHRQ, n.d.; Gambé, 2014)

**SOURCE**


Hibbard, J. H., Greene, J. J., & Overton, V. (2013). Patients with lower activation associated with higher costs; Delivery systems should address engagement, even for ACOs. Health Affairs, 32(2), 216-222


SSH

**Society for Simulation in Healthcare**

A society that studies the use of simulation to improve performance in healthcare and reduce errors in patient care.

**SOURCE**

http://www.ssh.org/about

Simulation

**An interactive teaching method that allows the learner to practice techniques and apply knowledge in scenarios that would be experienced in the real world, in a controlled and safe environment.** (Abdolrasulnia & Roy, n.d.)

**SOURCE**


Telemedicine

**The use of medical information exchanged from 1 site to another via electronic communications to improve a patient’s health status.** (American Telemedicine Association, 2012)

**SOURCE**


US Department of Health & Human Services

The US Department of Health and Human Services, or HHS (2014), is the US government’s principal agency for protecting the health of Americans and delivering essential human services. The HHS has 11 separate divisions, including 8 public health agencies and 3 human services agencies, which conduct research and provide a variety of health and human services. The 11 divisions include:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

The HHS administers more than 300 programs covering a broad spectrum of activities. Some of the agency’s chief responsibilities include administration of the Medicare and Medicaid programs, health and social science research, preventing disease, ensuring food and drug safety, substance abuse treatment and prevention, and improving maternal and infant health. (HHS, 2014)

**SOURCE**


**TOC**

**Transition of care**

The movement of a patient from 1 setting of care (hospital, ambulatory primary care practice, specialty care practice, long-term care, home health, rehabilitation facility) to another.

**SOURCE**


**SOURCE**


**SSH**

**Standardized patient**

A layperson or actor hired and trained to portray the role of actual patient, presenting a faculty-deﬁned clinical scenario with patient history and physical symptoms for teaching and assessment purposes. (Anderson, n.d.)

**SOURCE**


**Simulation**

An interactive teaching method that allows the learner to practice techniques and apply knowledge in scenarios that would be experienced in the real world, in a controlled and safe environment. (Abdolrasulnia & Roy, n.d.)

**SOURCE**


**Telemedicine**

The use of medical information exchanged from 1 site to another via electronic communications to improve a patient’s health status. (American Telemedicine Association, 2012)

**SOURCE**


**Transition and continuity**

Information that will help patients care for themselves away from a clinical setting, and the follow-up coordination, planning, and support to ease transitions in care. (Chen et al., 2013; Truesdell, 2012)

**SOURCE**


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**SOURCE**

US Health Information Knowledgebase

An online registry and portal for meaningful use. Designed as a 1-stop shop for publically accessing the components of meaningful use quality measures, providing technical specifications including definitions, measure compilation logic, data elements, context, version comparisons, and value (code) sets. This registry is funded and directed by the AHFG (AHFG, n.d.)

SOURCE

Utilization Review Accreditation Commission

An independent nonprofit organization that promotes healthcare quality and efficiency through its accreditation, education, and measurement programs. This organization is independent of any single stakeholder group. The governing board of directors was founded with representatives from all affected constituencies: consumers, providers, employers, regulators, and industry experts. The URAC offers a wide range of quality benchmarking programs and services through which organizations can validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards-development process, URAC ensures that all stakeholders are represented in its efforts to establish meaningful quality measures for the entire healthcare industry. (URAC, 2013)

SOURCE

Value-based payment

An approach to paying for healthcare that financially rewards physicians who provide care that is high value—that is, high in quality while also low in cost. CMS implemented VBP for Medicare and Medicaid providers in 2015, as mandated by the ACA. To accomplish this, CMS has begun applying a value modifier under the Medicare Physician Fee Schedule that will factor cost and quality data into the calculations for payments for physicians. (CMS, 2016)

The reward formula is a simple system: performance is assessed in 2 dimensions (quality and cost), and payments go to physicians who have above-average performance in 2 dimensions. Physicians who perform worse than average or choose not to be involved are paid less, and there will be no change for physicians with average performance. The maximum bonus is about 2% of Medicare fees, and the maximum penalty is approximately 1%. Scoring physicians relative to one another achieves budget neutrality for CMS. For physicians, it eliminates the effects of common shocks to performance, such as an influenza epidemic or vaccine shortage. The disadvantage of this incentive structure is the uncertainty for physicians about the amount of improvement that will be necessary to receive a bonus or avoid a penalty. (Chien & Rosenthal, 2013; CMS, 2015)

The CMS implemented VBP in 2 stages. Groups of 100 or more physicians who submit claims to Medicare under a single tax identification number were subject to the value modifier in 2015. All physicians who participate in FFS Medicare will be affected by the value modifier by January 1, 2017. (CMS, 2016)

The ACA directs the CMS to provide information to physicians and medical practice groups about their resource use and the quality of care provided to their Medicare patients, including patterns of resource use/cost among different healthcare providers, as part of Medicare’s efforts to improve the quality and efficiency of clinical care. (ACP, n.d.) This actionable information is intended to help physicians improve the care they furnish, so the CMS moves toward physician reimbursement that rewards value rather than volume. (CMS, 2016)

SOURCE
https://www.urac.org/physicianfeedbackprogram/

Virtual procedure stations

A computer-controlled simulation device available for teaching such as bronchoscopy, colonoscopy, blood-drawing, puncture technique, and generates a report that helps track the student’s progress over time and helps identify areas for improvement. (Patow, 2005)

SOURCE

Wireless and wearable health technology

Mobile devices that monitor health conditions in real time and automatically import those data into health information systems, allowing for quicker assessments and care interventions.

SOURCE