



Glossary of Healthcare Terms for Community Trustees

Revised March 2008

A

Acquired Immune Deficiency Syndrome (AIDS)

A disease caused by a virus that invades the human immune system, increasing susceptibility to infections.

Adjusted Average Per Capita Cost (AAPCC)

The basis for calculating the Medicare capitation payment an HMO receives per beneficiary for a given county, equal to 95 percent of the historical Medicare fee-for-service payment per beneficiary in that county.

Administrative Services Contract (ASC)

An agreement to administer, but not underwrite, a program for an organization that provides employee health benefits.

Advanced Practice Nurse (APN)

A nurse who has had advanced education and has met clinical practice requirements beyond the two to four years of higher education required for all registered nurses. (See *Nurse Practitioner* and *Nurse Midwife*.)

Aid to Families with Dependent Children (AFDC/ADC)

See *Temporary Assistance for Needy Families*.

Allopathic Physician

A physician who views his or her role as an active interventionist who should attempt to counteract the effect of a disease by using treatments to produce effects opposite those of the disease. Most MDs practice allopathic medicine.

All-Payer System

All payers of health care bills pay rates set by the government for services. The payers, including the government, private insurers, large companies and individuals, may be assigned different rates.

Alternative Delivery System

Refers to any way of systematically organizing the resources and programs needed to provide healthcare as differentiated from the individual services offered by the fee-for-service system.

Ambulatory Care

Health care services provided on an outpatient basis, where no overnight stay in a health care facility is required.

Ambulatory Patient Group (APG)

A method of classifying outpatients into groupings based on common characteristics, each of which can be expected to require similar services.

Ambulatory Payment Classification (APC)

A Medicare prospective payment system for outpatient services that categorizes services and treatments requiring similar resources.

Ambulatory Surgical Center (ASC)

A facility where surgical procedures are performed on an outpatient basis. The facility may be freestanding or affiliated with a hospital.

American Association of Health Plans (AAHP)

A national trade association representing a broad spectrum of managed care organizations. Formed in November 1995 by the merger of the Group Health Association of America and the American Managed Care and Review Association.

American Association of Retired Persons (AARP)

A national association that represents the interests of Americans over age 50 on issues such as Social Security and Medicare.

American College of Healthcare Executives (ACHE)

A professional association designed to promote professional growth of health care executives.

American Hospital Association (AHA)

The nation's principal trade association for hospitals with offices in Washington, DC, and Chicago.

American Managed Care and Review Association (AMCRA)

A former national trade association that represented a broad spectrum of managed care organizations. In November 1995, AMCRA merged with the Group Health Association of America to form the American Association of Health Plans.

American Medical Association (AMA)

The principal professional association for allopathic physicians in the United States.

American Nurses Association (ANA)

The principal professional association for nurses in the United States.

American Organization of Nurse Executives (AONE)

A national trade association for nurse executives.

American Osteopathic Association (AOA)

The principal professional association of osteopathic physicians in the United States.

American Osteopathic Hospital Association (AOHA)

A national trade association for osteopathic hospitals.

Ancillary Care Services

Diagnostic or therapeutic services, such as laboratory, radiology, pharmacy and physical therapy, performed by non-nursing departments.

Any Willing Provider

Terminology relating to legislation which would require managed care plans to allow any individual physician or other provider to serve on the provider panels they do business with.

Associate Degree in Nursing (ADN)

A two-year education program in the field of nursing. Nurses usually obtain the associate degree at a junior or community college.

Attorney General (AG)

The chief federal or state law officer who represents the government in litigation and serves as its principal legal advisor.

Average Length of Stay (ALOS)

A measure of the use of health facilities, measuring the average number of days a patient stays in the hospital.

B

Bachelor of Science in Nursing (BSN)

A four-year college or university program that educates registered nurses, granting a bachelor of science degree upon graduation.

Bad Debts

An unpaid obligation by an individual who could pay for the health care service they received. Currently accepted health care accounting practices, and the challenge at the time of a patient's admission to identify those who need care but do not have the ability to pay, tend to blur the lines between bad debt and charity care.

Balanced Budget Act (BBA)

Federal legislation (August 1997) that mandated a reduction in Medicare spending of \$116 billion over five years.

Basic Benefits

A minimum set of health services that should be generally and uniformly available in order to provide adequate health protection of the population from disease or to meet some other criteria or standards.

Benchmark

A standard by which something can be measured, compared, or judged. Benchmarking involves measuring another organization's or person's product or service by specific standards and comparing it with one's own product or service. For example, HCIA Inc. (a health care information company) conducts an annual study to identify a set of benchmarks for the hospital industry that represents a balance of high-quality care, efficient delivery, and superior financial performance.

Beneficiary

Any individual who is eligible as a participant, subscriber, or dependent for health care services provided under a health plan, as defined in the benefits package. The term is frequently used in reference to Medicare and Medicaid participants.

Benefit Package

The list of covered services offered to a group or individual by an insurance company, health maintenance organization, preferred provider organization, or government agency.

Blue Cross Blue Shield of Utah (BCBSU)

A major provider of health benefits in Utah, BCBSU is part of a nationwide federation of locally governed, autonomous corporations.

Boren Amendment

A federal law amendment passed in 1981 that was designed to control costs for Medicaid beneficiaries. The Boren Amendment required states to establish reimbursement rates for hospitals, nursing facilities, and intermediate care facilities that provide Medicaid-related services. State-determined reimbursement rates had

to be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. The Boren Amendment was repealed in 1997 by the Balanced Budget Act.

Budget Neutral

A term used by the Congressional Budget Office to identify a federal or state budget item that has no cost implications relative to the federal budget.

Budget Resolution

A framework for setting federal spending priorities. A budget resolution is an internal congressional document.

C

Capitation

Method of payment for health services in which the purchaser pays the provider a fixed amount per period for each person, regardless of the type and number of services used. Often referred to as a “per member per month” amount.

Cardiac Care

Cases related to heart care.

Carve-Out Service

A strategy used by some managed care plans to separately manage certain high-cost or specialty services, such as mental health and substance abuse services, vision or dental benefits, etc. The aim is to manage care on an individual basis and make money available to pay for selected high-cost services that the patient needs, rather than tailoring treatment to available coverage. Also called clinical exclusions.

Case Management

The process by which all health-related matters of a case are managed by a health care professional to ensure continuity of services and accessibility and to avoid misuse of facilities and resources.

Case Manager

An experienced professional (e.g., nurse, doctor, or social worker) who works with patients, providers, and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

Case Mix Adjustment

A method of accounting for the difference in the severity of illness or resource intensity between patients at different hospitals.

Cash and In-kind Donations

Donations by a hospital or health system made to support social service and community agencies for health care-related activities. Also includes sponsorship of health-related activities.

Centers for Disease Control and Prevention (CDC)

The agency within the US Department of Health and Human Services principally responsible for administration of disease control, health promotion, occupational health and public health programs.

Centers for Medicare and Medicaid Services (CMS)

(formally known as the Health Care Financing Administration) administers the Medicare program, as well as partnering with the states to administer the Medicaid, SCHIP, and Health Insurance Portability Standards.

Certificate of Need (CON)

A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility or to offer a new or different health service. Utah does not currently have a CON law.

Certified Healthcare Executive (CHE)

A distinction given to a health care executive who has achieved Diplomate status in the American College of Healthcare Executives by meeting application requirements and passing extensive written and oral examinations.

Charity Care

The unreimbursed cost to a hospital or health system for providing free or discounted care to persons who cannot pay and who are not eligible for public programs.

Chief Executive Officer (CEO)

Principal executive leader of an organization.

Chief Financial Officer (CFO)

An executive leader who oversees financial operations.

Chief Operating Officer (COO)

An executive leader who oversees day-to-day management and internal operations.

Children's Health Insurance Program (CHIP)

CHIP is short for the Children's Health Insurance Program - a program to provide health insurance to all uninsured children and teens who are not eligible for or enrolled in Medical Assistance.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

A program that pays for care delivered by civilian health providers to retired members and dependents of active and retired members of the seven uniformed services of the United States.

Clean Claim

While no universally accepted definition exists at this time, ideally a clean claim is one that is billed electronically or on paper using nationally accepted code sets on nationally accepted claim forms, includes patient and provider identification information, and does not require further documentation from a provider for a health plan's/insurer's routine processing of claims. Submitted claims not meeting clean claim requirements will necessitate a health plan/insurer providing clear explanation of the reason(s) for denial of the claimant's claim in a timely manner.

Clinical Pathway

See *Critical Pathway*.

Coinsurance

Sharing the costs between insured and insurer according to a predetermined percentage. In many traditional health insurance policies, the insured pays a 20-percent coinsurance and the insurer pays the remaining 80

percent, usually with a predetermined maximum for the insured's out-of-pocket expenditure. (See *Copayment* and *Cost Sharing*.)

College of Osteopathic Healthcare Executives (COHE)

A national organization for executives of osteopathic hospitals.

Community Benefit

Programs or services that address community health needs — particularly those of the poor, minorities, and other underserved groups — and provide measurable improvement in health access, health status and use of health care resources.

Community Care Networks[®]

An organization or group of organizations providing comprehensive health care services through a coordinated, client-centered continuum designed to improve the health of people in specific geographic areas within economic limits (i.e. capitation). Also referred to as integrated delivery network, accountable health plan, responsible health organization, provider service organization, etc.

Community Collaborative

Individuals, groups and organizations that work independently or collectively to combine assets, resources and energies to achieve a common purpose and create change in a community.

Community Health Information Network (CHIN)

Electronic network that links stakeholders in health care delivery. Patients' encoded cards allow clinical and administrative information to be immediately available to any health care provider.

Community Rating

A method of calculating health insurance premiums based on the average use rate in the community, rather than specific experiences. (See *Experience Rating*.)

Concurrent Resolution

A legislative document, limited in nature, used to express facts, opinions, principles, and purposes of both the House and Senate. With approval of both houses, a concurrent resolution is published as part of the statute at large.

Conditions of Participation (COP)

Centers for Medicare and Medicaid Services (CMS) regulations that Medicare certified providers must follow.

Congressional Budget Office (CBO)

A nonpartisan organization that provides the US Congress with budget-related information and analyses of alternative fiscal, budgetary, and program issues.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

The 1985 federal spending plan which included several health provisions and protections, including protection against denial of emergency medical care to patients who are unable to pay and the opportunity to extend employer insurance coverage following the termination of employment.

Consolidation

The blending of two or more entities into a single new entity so the previous entities cease to exist. An example is the formal combination of two hospitals into a single new legal entity that has an identity separate from either of the original hospitals. (See *Merger*)

Consumer Price Index (CPI)

Widely used as an indicator of changes in the cost of living, as a measure of inflation, and as a means of studying price trends. Measures the change in cost of a constant bundle of goods and services purchased by consumers.

Continuum of Care

A comprehensive set of services ranging from preventive and ambulatory services to acute care to long-term and rehabilitative services. By providing continuity of care, the continuum focuses on prevention and early intervention and provides easy transition from service to service as needs change.

Coordination of Benefits (COB)

Provisions and procedures of insurers used to avoid duplicate payments when claims are covered by more than one insurance company.

Copayment

A type of cost sharing that requires the insured or subscriber to pay a specified, flat-fee, out-of-pocket payment at the time a service is rendered, with the insurer reimbursing some portion of remaining charges. (See *Cost Sharing* and *Coinsurance*.)

Core Benefit Plan

Basic plan of benefits provided to all subscribers of a health insurer.

Cost Per Case

The average expense incurred by a hospital for the treatment of each patient.

Cost Sharing

The generic term that includes employee contributions for premiums, copayments, coinsurance, and deductibles. Copayments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (e.g., 20 percent) that an insured person must pay out-of-pocket, up to a maximum limit. Deductibles are specified out-of-pocket expenditures that an individual or a family must incur before insurance begins to make payments. (See *Copayment* and *Coinsurance*.)

Cost Shifting

A phenomenon occurring in the US health care system in which providers are inadequately reimbursed for their costs by some payers and subsequently raise their prices to other payers in an effort to recoup costs.

Covered Lives

People who are insured, whether by commercial insurance carriers, Medicare, or Medicaid.

Covered Services

Specific health care benefits, services and products a health plan or insurer will provide reimbursement for.

Credentialing

The process of reviewing and validating the qualifications of a licensed practitioner to provide services in a health care organization.

Critical Access Hospital (CAH)

Established under the Balanced Budget Act of 1997, CAHs are limited-service hospitals located in rural areas with no more than 15 acute-care beds. They receive cost-based reimbursement for Medicare patients and are relieved from some Medicare regulations.

Critical Care Unit (CCU)

Synonymous with intensive or special care unit. Service area of a hospital established to provide continuous intensive care to critically ill patients.

Critical Pathway

A treatment protocol including only the vital components or items proved to affect patient outcomes.

D

Deductible

The portion of health care expenses that a health plan member or insured person must pay out-of-pocket before any insurance coverage applies or reimbursement for expenses begins.

Deemed Status

Generally, an arrangement whereby certification or the meeting of one set of standards means that other sets of standards are deemed to have also been met, without additional verification. May apply to licensing or participation standards.

Delivery System

The formal and informal relationships among facilities and providers through which care is coordinated and delivered. In the US, most care is delivered on an ad hoc basis.

Department of Community Health (DCH)

A department of the state government instituted in April 1996 to coordinate the state's health care efforts. It combines the former departments of Mental Health and Public Health and the Medical Services Administration (Medicaid).

Department of Health and Human Services (DHHS)

(See *Health and Human Services*.)

Department of Management and Budget (DMB)

A state department that provides budgeting, forecasting and centralized management services to all other state departments, as well as support services to a number of state boards, commissions and councils. Services include leasing, planning, purchasing, construction and maintenance, collective bargaining, payroll, record retention, data processing, publishing, and retirement programs.

Diagnosis Related Group (DRG)

A method of classifying inpatients into groupings based on common characteristics, each of which can be expected to require similar services.

Direct Contracting

An arrangement whereby employers, unions and other "primary" payers bypass insurance companies and HMOs and contract directly with organized provider networks (e.g., a hospital system and/or a large physician group).

Director of Volunteer Services (DVS)

A staff position in hospitals and health systems with responsibility for coordinating the programs and activities of volunteer groups. The DVS may also have responsibility for auxiliary activities.

Discharge Planning

A process to appropriately coordinate length of inpatient hospital stays and assure appropriate care by transferring patients to more appropriate health care facilities based on the patient's health needs.

Disenrollment

Termination, either voluntarily or involuntarily, of an individual's enrollment in a group health plan.

Disproportionate Share Hospital (DSH)

A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Doctor of Medicine (MD)

An individual holding a doctoral degree in medicine.

Doctor of Osteopathy (DO)

A licensed physician who is a graduate of an accredited school of osteopathic medicine.

Do-Not-Resuscitate (DNR) Order

An order placed in a patient's medical record by an attending physician, with the consent of the patient or an authorized agent, that directs hospital personnel not to revive the patient if cardiopulmonary arrest occurs.

Drug Formulary

A listing of prescription medications and appropriate dosages felt to be the most useful and cost effective for patient care. Health plans that have adopted a "closed, select or mandatory" formulary limit coverage to those drugs in the formulary.

Durable Medical Equipment (DME)

Medical equipment, such as a respirator or home dialysis system, that is prescribed by a physician for a patient's use and that is usable for an extended period of time.

Durable Power of Attorney for Health Care

An advance directive that designates a family member or friend to make decisions about a patient's care should the patient become unable to do so. The durable power of attorney has a wider scope than a living will. (See *Living Will*.)

E

E-health

The use of the Internet to facilitate health care transactions between patients, providers, insurers and other entities.

Emergency Department (ED)

The unit in a health care facility that administers emergency medical services.

Emergency Medical Services (EMS)

Services intended for care in medical emergencies, including those of ambulances, emergency rooms, and emergency telephone numbers and hot lines.

Emergency Medical Technician (EMT)

A person certified to provide basic medical services before or during transport to a hospital.

Emergency Medical Treatment and Labor Act (EMTALA)

An act created by Congress as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. It is designed to prevent hospitals from refusing to treat patients or transferring them to “charity” or “county” hospitals because they are unable to pay or are covered by Medicare or Medicaid programs.

Emergency Room (ER)

A hospital department or area with personnel and equipment for the care of acute illness, trauma, or other conditions needing immediate medical attention.

Employee Retirement Income Security Act (ERISA)

A federal act created in 1974 to regulate employee benefit and retirement plans. It has been interpreted to exempt self-insured health plans from state mandates on health insurance and rating laws.

Employer Mandate

A legal requirement that employers provide health insurance and/or coverage for specific services for their employees.

Enrollee

A person eligible to receive benefits from a health maintenance organization or insurance policy. Also called a “member,” the term includes both those who have enrolled or “subscribed” and their eligible dependents.

Environmental Protection Agency (EPA)

A federal agency that administers environmental protection programs to control air pollution, noise, solid waste disposal and water pollution.

Episodic Payment Group (EPG)

A grouping of services, treatments, procedures, and diagnoses rendered to one patient over a period of time that is billed and paid in one lump payment.

Episodic Treatment Group (ETG)

(See *Episodic Payment Group*.)

Exclusive Provider Organization (EPO)

A managed care organization similar to a PPO, but providing benefits only when the services of contracting providers are used.

Expected Range

The predicted acceptable range of numbers that would be expected in a hospital given its specific population of patients and the total number of cases performed.

Experience Rating

A method of calculating health insurance premiums for a group based entirely or partly on the risks the group presents, as measured by past use and demographics. An employer whose employees are unhealthy will pay higher rates than another whose employees are healthier. (See *Community Rating*.)

Extended Care

Care provided in a treatment facility rather than a hospital or home when acute care is not necessary but nursing care is needed.

Extended Care Facility

A nursing facility that qualifies for participation in both Medicare and Medicaid.

F

Family Medical Leave Act (FMLA)

The Family and Medical Leave Act guarantees each letter carrier up to 12 weeks of leave each year for, a new child in the family—by birth, by adoption or by placement in foster care; caring for a family member with a serious health condition; or The employee's own serious health condition that prevents him or her from performing the job.

Family Practitioner

A physician specializing in family practice, dealing with the prevention, diagnosis, and treatment of a wide variety of ailments in patients of all ages.

Federal Trade Commission (FTC)

A federal agency created to protect consumers against unfair methods of competition and deceptive business practices, such as sales fraud and price fixing. Investigates and applies antitrust laws.

Federally Qualified Health Center (FQHC)

A primary care clinic located in an underserved area that meets the health care needs of special populations and receives special reimbursement for doing so.

Fee-for-Service (FFS)

The traditional practice of providers billing for each encounter or service rendered.

Fellow of the American College of Healthcare Executives (FACHE)

A distinction given to a health care executive who has achieved the rank of Fellow in the American College of Healthcare Executives. Fellow status is the highest level of professional achievement in the College.

Fellow of the Healthcare Financial Management Association (FHFMA)

A distinction given to a health care financial manager who has achieved the rank of Fellow after meeting additional requirements beyond those required for membership in the Healthcare Financial Management Association.

Fiscal Year (FY)

Any 12-month period for which annual financial records are kept.

Food and Drug Administration (FDA)

The federal agency responsible for regulating the safety, efficacy, labeling and packaging of food, drugs, biologics and cosmetics offered for sale in the United States.

Foreign Medical Graduate (FMG)

Persons who have completed graduation requirements at a medical school outside of the United States.

For-Profit Health Care Organization

A hospital or other health care provider that is owned and operated by a corporation, individual, or group of individuals and that operates on a for-profit basis. (See *Taxable For-Profit Health Organization*.)

Functional Related Group (FRG)

A Medicare prospective payment system for rehabilitation hospitals and units based on the functional independence measure rehabilitation coding system.

G

Gatekeeper

A health care professional who coordinates, manages and authorizes all health care services provided to a covered beneficiary. May be a nurse, social worker, physician's assistant or physician. Gatekeepers are frequently used by managed care plans as a method for controlling costs through limiting unnecessary utilization.

General Practitioner (GP)

A practicing physician who treats a variety of medical problems in patients of all ages.

Generic Drug

Pertaining to the descriptive or nontrade name of a drug or other product; for example, diazepam is the generic name for *Valium*.

Global Budget

Prospectively defined limits on spending for some portion of the health care industry, such as hospital operating budgets or physician services.

Governing Board

The individual(s), group, or agency that has ultimate authority and responsibility for establishing policy, maintaining patient care quality, and providing for organizational management and planning in a non-profit health care organization. This board represents the community and is the policy-making body of the institution.

Graduate Medical Education (GME)

Medical education after receiving the medical doctorate or equivalent degree, including education received as an intern, resident or fellow.

Group Health Association of America (GHAA)

A former national trade association that represented group practice prepayment health plans and related organizations that support health maintenance organizations. In November 1995, GHAA merged with the American Managed Care and Review Association to form the American Association of Health Plans.

Group Practice

A formal association of three or more physicians, dentists, or other health professionals providing services, with income from the medical practice distributed to the group members according to a prearranged plan.

H

Health Alliance

A purchasing group comprised of individual consumers and employer groups that purchases health care services from health plans for its members to obtain more favorable terms.

Health and Human Services, Department of (HHS or DHHS)

The federal cabinet-level department that administers all federal programs related to health and social services.

Health Care Prepayment Plan (HCPP)

A cost contract with CMS that prepays a health plan a flat amount per month to provide Medicare-eligible Part B medical services to enrolled members. Members pay premiums to cover the Medicare coinsurance, deductibles, co-payments and any additional non-Medicare covered services that the plan provides. The HCPP does not arrange for Part A services.

Health Care System

A corporate body that owns and/or manages multiple entities including hospitals, long-term care facilities, other institutional providers and programs, physician practices, and/or insurance functions. Also called health system, multihospital system, or network.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

An act that protects health coverage for workers and their families should they change or lose their jobs. This act also expands fraud and abuse control, provides tax incentives, and sets regulations relating to standardization of code sets, health care identifiers, billing transactions, security and confidentiality, and documentation supporting claims.

Health Maintenance Organization (HMO)

A managed care organization that provides health services to enrolled individuals. There are four primary HMO models:

Group Model: The HMO rents the services of the physicians in a separate group practice and pays the group a per capita rate. The physician group, in turn, distributes the payment among its members and self-manages the practices of its physicians.

Independent Practice Association (IPA): A group of physicians that has financially organized to enter into patient care contracts to provide services at a negotiated per capita rate, flat retainer or negotiated fee-for-service rate to HMO members.

Network Model: The HMO contracts with two or more independent physician group practices to provide services and pays a fixed monthly fee per patient. The groups manage themselves and decide how fees are distributed.

Staff Model: Physicians are on the staff of the HMO and are usually paid a salary.

Health Plan

A network of hospitals, doctors, clinics, etc., that provides consumers with a comprehensive range of health services.

Health Plan Employer Data and Information Set (HEDIS)

Part of the process used by the National Committee for Quality Assurance in accrediting managed care organizations. Includes different measurements of operational performance on a health plan level.

Health Status

The condition of health of an individual or a population, especially as measured and compared with benchmarks for similar populations or national standards.

Healthcare Financial Management Association (HFMA)

A professional association of healthcare finance managers.

Health Political Action Committee (HEALTH PAC)

The MHA's state political action committee to support state and federal issues.

Hill-Burton Act

Following World War II, the federal government encouraged the building of hospitals and other health care facilities by providing funds for expansion and development. These funds, made available through the Hill-Burton Construction Act (Titles VI and XVI of the Public Health Service [PHS] Act), spurred the development of community hospitals, nursing homes, public health centers and rehabilitation facilities. In accepting Hill-Burton funds, public and nonprofit medical facilities agreed to make services available to persons in the facilities' service area without discrimination on the basis of race, color, national origin, creed or ability to pay for 20 years following the facilities' completion. Hill-Burton facilities were required to participate in the Medicare and Medicaid programs and they were required to post public notice of their community service obligation.

Hospital-attached Long-Term Care Unit (HLTCU)

A skilled nursing facility that is attached to and operated by an acute-care hospital.

Home Health Agency (HHA)

An organization that coordinates and provides care for services carried out in the patient's home.

Home Health Care

Service provided by health professionals in an individual's place of residence to patients who require short- or long-term intervention by health professionals due to an injury, illness or disabling condition.

Hospice

Care for the terminally ill and their families, either in the patient's home or in an inpatient facility, so that the patient can live as full a life as possible.

Hospital Market Basket

A measure of labor, goods and services that hospitals must purchase to provide care. This measure is used to determine prospective payment system rates.

Hospital Purchasing Service (HPS)

A member-owned purchasing organization that offers health care products at a reduced rate to its members.

Hospitalist

Health care provider, usually a physician, whose entire practice is devoted to treating patients in a hospital setting.

Human Immunodeficiency Virus (HIV)

The virus that causes AIDS.

I

Indemnity Insurance

Traditional health insurance, where the insured is reimbursed for covered expenses without regard to choice of provider. Payment up to a stated limit may be made either to the individual incurring and claiming the expense or directly to providers. (See *Fee-for-Service*.)

Independent Practice Association (IPA)

(See *Health Maintenance Organization*.)

Inpatient

An individual who receives health care services while admitted in a healthcare facility overnight or longer.

Integrated Delivery

The ability to provide comprehensive health care services through a coordinated, client-centered continuum designed to improve the health of people in specified geographic markets within economic limits (e.g., capitation).

Integrated Delivery Network (IDN)

A network of providers, typically including hospitals and physicians, organized to provide comprehensive services to a community in the most efficient way.

Intensive Care Unit (ICU)

The area of a hospital where patients with life-threatening illnesses are closely monitored. Also called Critical Care Unit.

ISO 9000

An internationally recognized quality management system used by organizations to develop and document processes to ensure their facilities meet set quality standards established by the International Organization for Standardization in Geneva, Switzerland. To keep certification current, organizations must be audited regularly by a third party inspector. The ISO 9000 certification process is more demanding than the traditional JCAHO accreditation.

J

The Joint Commission

A private, nonprofit organization whose purpose is to encourage attainment of uniformly high standards of institutional health care.

Joint Operating Agreement (JOA)

A legal business arrangement of two or more parties agreeing to cooperatively manage their existing organizations.

Joint Venture

A contract or agreement forming a legal entity where two or more parties work together on a project and share profits, losses, and control. Joint ventures are usually limited to a single project.

L

Length of Stay (LOS)

The length of a patient's stay in a hospital or other health care facility.

Level of Care or Level of Service

The intensity of services performed for an individual or health care organization.

Licensed Practical Nurse (LPN)

A nursing school graduate who has been licensed by a state; occasional synonym, licensed vocational nurse (LVN).

Living Will

Written instructional directives that indicate the author's wishes for medical treatment should he or she become incapacitated and unable to make medical decisions. (See *Durable Power of Attorney for Health Care*.)

Local Medical Review Policy (LMRP)

Guidelines for public and medical use within a certain geographic area that state which procedures and treatments are reasonable and necessary for different types of conditions and are eligible for insurance coverage.

Long-Term Acute-Care Hospital (LTAC)

A hospital providing specialized care to medically complex patients who usually require an extended hospital stay.

Long-Term Care (LTC)

Health, rehabilitative or personal services provided on a long-term basis for people who are chronically ill, aged, disabled or retarded.

Long-Term Care Facility (LTCF)

Any residential health care facility that administers health, rehabilitative or personal services for a prolonged period of time.

M

Major Diagnostic Category (MDC)

A broad classification of diagnoses assigned to a patient.

Managed Care

A method of health care delivery used by health care organizations, such as HMOs, to “manage” or coordinate what is spent on health care by closely monitoring how physicians and other medical professionals treat patients. Patients are assigned a “gatekeeper” with whom they can discuss problems and who has the authority to decide whether the patient should be referred to a specialist or receive diagnostic tests.

Managed Care Organization (MCO)

An organization of health care providers, such as physicians and hospitals, formed to enhance efficiency of work performed, e.g. HMOs, PPOs, etc.

Management Information System (MIS)

An information system, usually electronic, designed to collect, store and transmit data to aid management in planning and directing the operations of an organization.

Management Services Organization (MSO)

Organization that, for a fee, provides physician groups with such management services as group purchasing, billing and other financial activities, and assistance with insurance and staffing issues.

Market Basket Index

A weighted average of individual price and wage indices, each of which measure the price movement of a particular cost item or group of items.

Master of Science in Nursing (MSN)

A person holding a master’s degree in nursing.

Master of Social Work (MSW)

A person holding a master’s degree in social work.

Medicaid

State and federally funded program that pays for medical services to low-income residents who meet certain requirements. Federal funding varies annually, based on a formula related to each state’s per capita income.

Medical Savings Account (MSA)

A savings plan whereby pre-tax dollars can be used for health care expenses, providing an incentive for reduced use of health care services.

Medically Necessary

A term used to describe the supplies and services provided to diagnose and treat a medical condition in accordance with the standards of good medical practice and the medical community. An example of a service that is not medically necessary is that part of a stay in a facility determined by a case manager to be excessive. It may be considered excessive because the stay was too long or appropriate care is available in a less costly or more efficient setting.

Medicare

A federally funded program that pays for medical services to residents over age 65 and the permanently disabled. Coverage is divided into two components. Part A covers services such as hospitalization and post-hospital skilled nursing facility care, while Part B deals with physicians’ services, medical and surgical services and supplies, diagnostic tests, and clinical laboratory services.

Medicare Cost Reports

Reports submitted by hospitals that provide services to Medicare beneficiaries. These reports are a condition of participation in the program and contain detailed hospital data, including financial statements and utilization information.

Medigap

A Medigap policy is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn’t cover.

Medicare Part D

Medicare Part D is a federal program to subsidize the costs of prescription drugs for those who are currently on Medicare. It is not part of the “original” Medicare program and is administered by private insurance who are then reimbursed by CMS.

Medicare Payment Advisory Commission (MedPAC)

The Medicare Payment Advisory Commission was created under the Balanced Budget Act of 1997 to advise the US Congress on Medicare payment policies and other policy issues affecting Medicare and the broader health system. It replaced the Physician Payment Review Commission (PPRC) and the Prospective Payment Assessment Commission (ProPAC), which previously acted as health policy advisors to Congress.

Member

A person eligible to receive benefits from a health maintenance organization or insurance policy. Also called an “enrollee,” the term includes both those who have enrolled or “subscribed” and their eligible dependents.

Merger

The blending of two or more hospitals or other entities so that only one company survives as a legal entity. (See *Consolidation*.)

Morbidity

Departure from a state of well-being, either physiological or psychological; illness.

Morbidity Rate

The number of cases of an illness (morbidity) in a population divided by the total population considered at risk for that illness.

Mortality

Death, as in expected mortality (the predicted occurrence of death in a defined population during a specific time interval).

Mortality Rate

The number of people who die during a specific time period divided by the total population.

Multihospital System

A corporate body that owns and/or manages multiple entities including hospitals, long-term care facilities, other institutional providers and programs, physician practices, and/or insurance functions. Also called health system, health care system, or network.

N

National Committee for Quality Assurance (NCQA)

Nonprofit organization that accredits managed care organizations such as HMOs.

National Institutes of Health (NIH)

The agency of the Department of Health and Human Services responsible for most of its medical research programs and related functions.

National Rural Health Association (NRHA)

A national trade association representing rural hospitals, rural health clinics and other rural health care providers.

Network

A group of hospitals, physicians, other providers, insurers, and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their community. (See *Integrated Delivery Network*.)

Nonprofit Hospital

A non-taxable hospital that operates on a not-for-profit basis under the ownership and control of a private corporation. Usually owned by a community, church or other organization concerned with community services and resources, nonprofit hospitals use earnings to improve their facilities and services. (See *Tax-Exempt Nonprofit Health Organization*.)

Nurse Anesthetist (CRNA)

A registered nurse who is qualified by special training to administer anesthesia in collaboration with a physician or dentist and who can assist in the care of patients who are in critical condition. (See *Advanced Practice Nurse*.)

Nurse Practitioner

A registered nurse who has completed additional training beyond basic nursing education and provides primary health care services in accordance with state nurse practice laws or statutes. (See *Advanced Practice Nurse*.)

Nurse Midwife

A registered nurse that has received special training to examine expectant mothers and perform or assist in routine labor and delivery of normal infants. (See *Advanced Practice Nurse*.)

O

Obstetrics-Gynecology (OB-GYN)

The science and surgical specialty devoted to the study and care of pregnancies, obstetrics, and women's sexual hormones and organs.

Occupational Safety and Health Administration (OSHA)

The federal agency responsible for promulgating rules, setting health and safety standards, and overseeing enforcement, whether by direct federal effort or by relying on state enforcement programs.

Occupational Therapist (OT)

A therapist who evaluates the self-care, work and leisure skills of a client and plans and implements social and interpersonal activities to develop, restore and/or maintain the client's ability to accomplish activities of daily living and necessary occupational tasks.

Office of Management and Budget (OMB)

An organization within the US executive office that develops the president's proposed federal budget for submission to Congress, monitors the established budget and its execution, and provides executive oversight in areas such as procurement and regulation.

Omnibus Budget Reconciliation Act (OBRA)

A bill presented annually on the federal budget that outlines new programs and program changes reflected in the federal budget.

Operating Room (OR)

Hospital suite in which surgery requiring anesthesia is performed.

Outcome Measures

Measures of the effectiveness and quality of medical care that would assist purchasers in shopping for high-quality service.

Out-of-Area Benefits

The coverage allowed to members of a health maintenance organization for emergency situations outside of the prescribed geographic area of the HMO.

Outpatient

An individual who receives health care services without being admitted to a health care facility.

Outpatient Prospective Payment System (OPPS)

A determined payment rate for a Medicaid outpatient procedure regardless of services rendered or the intensity of the services.

ORYX

A performance measurement initiative of the Joint Commission on Accreditation of Healthcare Organizations that aims to increase the relevance of accreditation and support improvement efforts in accredited organizations in a flexible and affordable manner.

P

Participating Provider

A health care provider who participates through a contractual arrangement with a health care service contractor, HMO, PPO, IPA or other managed care organization.

Patient Advocate

An individual who investigates and mediates patients' problems and complaints in relation to a health care provider's services.

Patient Focused Care

A concept of patient care where health care providers are cross-trained, enabling greater coordination of care with fewer employees.

Payer

An organization (such as the federal government for Medicare or a commercial insurance company) or person who directly reimburses health care providers for their services.

Peer Review

Review of a health professional's performance of clinical professional activities by peers through formally adopted written procedures.

Peer Review Organization or Professional Review Organization (PRO)

An organization with which the Medicare program and hospitals contract for quality and utilization review of services covered by the program.

Periodic Interim Payment (PIP)

A regular payment made by a carrier to a hospital, home health agency or skilled nursing facility that approximates anticipated revenue and is adjusted periodically to conform to actual revenues to assure predictable cash flow.

Performance Improvement

The continuous study and adaptation of functions and processes to increase the probability of achieving desired outcomes and better meet the needs of patients and other users of services. (See *Total Quality Management, Quality Improvement, and Quality Assurance.*)

Pharmacogenomics

The use of genetic information to tailor pharmaceuticals to specific patients.

Physical Therapist (PT)

An individual trained, licensed in, or practicing physical therapy.

Physician Assistant (PA)

A trained, licensed individual who performs tasks that might otherwise be performed by physicians or under the direction of a supervising physician.

Physician-Hospital Organization (PHO)

An entity sponsored and jointly governed by a hospital and a subset of its medical staff to negotiate and serve managed care contracts and achieve administrative efficiencies.

Physician Management Company (PMC)

An organization that provides physicians and physician groups with access to capital, information systems, group purchasing power, and management expertise. May also establish management services organizations to develop relationships with physicians.

Physician Organization (PO)

Group of physicians representing various specialties or a single specialty which negotiates on behalf of its physician members to accept managed care or discounted fee-for-service contracts. Also called multispecialty group or independent practice association (IPA).

Point-of-Service Plan (POS)

A model that combines features of both health maintenance organizations and traditional insurance. Enrollees decide at the time care is needed whether to use a doctor who is in the network or one who is not. Copayments and fee schedules are typically larger when a doctor outside the network is chosen.

Political Action Committee (PAC)

A body formed to collect and distribute contributions to political candidates.

Portable Benefits

A comprehensive set of health services that follow an individual regardless of his or her employment status.

Preauthorization

A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed.

Pre-existing Condition

A medical condition existing prior to the effective date of insurance coverage. Federal legislation passed in 1996 states that workers who are covered by group insurance policies cannot be excluded from coverage for more than 12 months due to a pre-existing medical condition. Such limits can be placed only on conditions treated or diagnosed within the six months prior to enrollment in an insurance plan. Insurers cannot impose new pre-existing condition exclusions for workers with previous coverage.

Preferred Provider Organization (PPO)

A type of health plan that features elements of fee-for-service and managed care. The PPO contracts with networks of providers who agree to provide services and be paid negotiated rates. Enrollees have lower copays and/or improved benefits if they see physicians and hospitals on the preferred list, which is created by insurance companies or employers.

Preventive Care

Comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well-person care.

Primary Care

Basic health care; a branch of medicine that accentuates the point when a patient first seeks assistance in a health care system and the treatment of simpler, more common illnesses and injuries.

Primary Diagnosis

The illness or injury causing most of the patient's inpatient stay.

Principal Diagnosis (PDX)

After study, the diagnosis determined to be the major cause of a patient's admittance to the hospital. This may or may not be same as the primary diagnosis.

Principal Procedure

The required procedure performed to treat a patient's primary diagnosis.

Procedural Code

A statistical code system designed to communicate procedural data to insurance companies or other third-party payers.

Professional Corporation (PC)

A legal entity whose shareholders must be licensed members of the same profession, such as medicine or dentistry. A PC provides limited liability for its professional stockholder(s) and allows for corporate ownership of equipment.

Prospective Payment System (PPS)

The Medicaid hospital payment system that sets payments in advance for the provision of the service.

Prospective Review

Part of the quality assurance process where possible hospitalization is reviewed, prior to admission, to determine appropriateness and medical necessity of the proposed level of care. (See *Quality Assurance*.)

Provider Service Organization (PSO)

Organizations that provide community-based health care delivery systems as an alternative to fee-for-service insurance plans. (See *Community Care Networks*.)

Provider Sponsored Network (PSN)

Formal affiliation of health care providers offering a full range of health care services with strong roots in the community.

Q

Quality Assessment (QA)

A system by which the quality of care is studied through a combination of data interpretation and peer review.

Quality Assurance (QA) or Quality Management (QM)

An organized program of activities intended to assure the quality of care provided in a medical setting or program. Includes quality assessment and corrective actions to remedy any deficiencies identified. (See *Total Quality Management*, *Quality Improvement*, and *Performance Improvement*.)

Quality Improvement

A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement. (See *Total Quality Management*, *Quality Assurance*, and *Performance Improvement*.)

R

Reasonable and Customary Charges

Amounts charged by health care providers that are consistent with charges by similar providers for similar services in a given locale.

Referral Authorization

Approval of a request for a health plan member to receive medical services or supplies from specialists and/or providers outside of the participating medical group.

Referral Physician

A physician who has a patient referred to him by another source for examination, surgery, or to have specific procedures performed, usually because the referring source cannot adequately provide the needed service.

Referring Physician

A physician who sends a patient to another source for examination, surgery, or to have specific procedures performed, usually because the referring physician cannot adequately provide the needed service.

Registered Nurse (RN)

One who has graduated from a college or university program of nursing education and has been licensed by the state.

Resource-Based Relative Value Scale (RBRVS)

Method of reimbursement for physicians in Medicare cases that weights different services based on their relative complexity, resource use, and cost.

Resource Utilization Group (RUG)

A classification for nursing home patients whose resident information is similar and who have a certain per diem reimbursement rate.

Restructuring

Reorganization to facilitate management of new functions or demands.

Retrospective Review

A part of the quality assurance process that reviews patient care, after hospital discharge, to determine quality, necessity, and appropriateness of care. (See *Quality Assurance*.)

Rural Health Clinic (RHC)

A health care organization that is in compliance with the federal Rural Health Clinics Act. RHCs must be located in a medically underserved area or a health professions shortage area, use physician assistants and/or nurse practitioners to deliver services, provide preventive services, and be licensed by the state.

Rural Referral Center

Hospitals located in rural areas that meet certain criteria to be paid the Medicare prospective payment system's urban rate, adjusted by the rural wage index. Qualifying criteria include such things as having at least 275 beds and a minimum volume of discharges annually.

S

Sentinel Event

A term used by the Joint Commission on Accreditation of Healthcare Organizations to define an adverse patient occurrence in an accredited facility.

Service Area

The geographical area in which a managed care plan is licensed to provide health care services to its members; or the region served by a hospital or other health care provider.

Severity Adjustment

Classification of patients by severity-of-illness data to allow for meaningful comparison of performance and quality among organizations and practitioners.

Skilled Nursing Facility (SNF)

A facility primarily engaged in providing skilled nursing care that has an organized professional staff of physicians and registered nurses. A patient may be admitted to an SNF after discharge from an acute-care hospital.

Sole Community Provider

Health care facility located in an isolated area that serves as the only source of emergency, outpatient, and inpatient care in the region. These facilities receive a special designation from the Centers for Medicare and Medicaid Services (CMS) and a different payment formula that provides for greater reimbursement.

Stark Laws

Provisions inserted by Rep. Fortney “Pete” Stark (D-CA) in the OBRA '89 and OBRA '93 amendments that, subject to certain exceptions, prohibit physicians from referring Medicare and Medicaid patients to clinical laboratories or other ancillary care services in which they have an ownership interest or from which they receive any type of compensation.

Subacute Care

Health services provided to patients who are not in an acute or severe stage of illness, but who require more medical care than they would receive in a long-term care setting.

Subscriber

An individual who meets a health plan’s eligibility requirements, enrolls in the health plan, and accepts the financial responsibility for any premiums, copayments, or deductibles.

T

Taxable For-Profit Health Organization

A hospital or other health care provider whose revenues are subject to federal and state taxation. For-profits are not required to pursue charitable purposes, are relatively unrestricted in providing compensation and benefit packages to physicians and other employees, are able to raise capital through the issuance of public securities, and are subject to securities laws. (Compare with *Tax-Exempt Nonprofit Health Organization*.)

Tax-Exempt Nonprofit Health Organization

A hospital or other health care provider that is generally exempt from federal and state income taxes (except unrelated business income tax) and state and local property and sales taxes. Nonprofits may raise capital through charitable contributions, low-interest loans and municipal bonds and can use tax-exempt bond financing. They are generally not subject to securities laws. Value of compensation, benefits and ownership interests offered to physicians, employees, suppliers and contractors is limited. (Compare with *Taxable For-Profit Health Organization*.)

Teaching Hospital

A facility that has been approved to participate in residency training by the Accreditation Council for Graduate Medical Education and/or has a residency or internship program(s) approved by the American Osteopathic Association and/or is a member of the Council of Teaching Hospitals.

Telehealth Reimbursement

Provided under the Balanced Budget Act of 1997, a means of Medicare payment to providers for certain telemedicine consultations for patients living in rural areas.

Telemedicine/Telehealth

The use of real-time video transmissions and stored electronic data to facilitate health care delivery between distant locations.

Temporary Assistance for Needy Families (TANF)

A federal welfare program providing block grants to states for time-limited assistance to low-income families with dependent children. TANF replaces the Aid to Families with Dependent Children program. Medicaid eligibility will continue to be determined using former AFDC standards.

Tertiary Care

Medical care requiring a setting outside of the routine, community standards; care to be provided within a regional medical center having comprehensive training, specialists, and research training.

Title XVIII

Medicare program. (See *Medicare*.)

Title XIX

Medicaid program. (See *Medicaid*.)

Total Quality Management (TQM)

A continuous quality improvement management system directed by top management that empowers employees and focuses on systemic, rather than individual, employee problems. (See *Quality Improvement*, *Quality Assurance*, and *Performance Improvement*.)

U

Uncompensated Care

Care given for which payment is not received, or for which only a portion of the cost is reimbursed.

Unemployment Compensation (UC)

A federal program administered and operated by the state that carries out the state's unemployment compensation insurance system, which provides wage replacement benefits to persons who are temporarily unemployed.

Universal Services Fund (USF)

A pool of grant money available to health care providers and nonprofit organizations for the purpose of supporting telecommunications activities (including telemedicine).

USIS Immunization Registry**Utah CheckPoint**

Utah Premium Partnership Program (UPP)

A premium subsidy program offered through the Utah Dept. of Health to assist in making health insurance more affordable for working individuals and families who do not currently have health insurance.

Utah PricePoint**Utah Primary Care Network (PCN)****Utilization**

The frequency with which a benefit is used — for example, 3,200 doctors' office visits per 1,000 HMO members per year.

Utilization Management (UM)

A hospital department that manages the patient flow in a facility.

Utilization Review (UR)

Evaluation of the necessity, appropriateness and efficiency of the use of medical services and facilities.

V

Visiting Nurse Association (VNA)

A nonprofit health agency that provides nursing services in the home, using nurses and other personnel as home health aides trained to give bedside personal care.

W

Wage Index

A means of adjusting hospital payments for local labor costs. The Centers for Medicare and Medicaid Services (CMS) uses the adjusted wage index to determine reimbursement to hospitals for Medicare patients. In urban areas where hospitals tend to hire more specialists, the labor costs may appear high; whereas in rural areas where it may be difficult to hire specialists, the labor costs appear artificially low.

Work Force Redesign

The process of evaluating and restructuring the traditional roles and functions of health care workers. This process includes issues such as patient contact, scope of practice and cross training.

Workers' Compensation (WC)

Provides state-mandated insurance coverage for work-related injuries and disabilities.

World Health Organization (WHO)

A specialized agency of the United Nations generally concerned with health and health care.

X

Xenotransplantation

The use of non-human (usually pig) organs in human transplant operations.

Y

APPENDIX A

Acronym Guide

A

AAHP	American Association of Health Plans
AAPCC	Adjusted Average Per Capita Cost
AARP	American Association of Retired Persons
ACHE	American College of Healthcare Executives
ADN	Associate Degree in Nursing
AFDC/ADC	Aid to Families with Dependent Children
AG	Attorney General
AHA	American Hospital Association
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
AMA	American Medical Association
AMCRA	American Managed Care and Review Association
ANA	American Nurses Association
AONE	American Organization of Nurse Executives
APG	Ambulatory Payment Classification
APG	Ambulatory Patient Group
APN	Advanced Practice Nurse
ASC	Administrative Services Contract or Ambulatory Surgical Center

B

BBA	Balanced Budget Act of 1997
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BBRA**BCBSU** Blue Cross Blue Shield of Utah**BSN** Bachelor of Science in Nursing**C****CAH** Critical Access Hospital**CAP** Contract Administration Process**CBC** Citizens for Better Care**CBO** Congressional Budget Office**CCU** Critical Care Unit**CDC** Centers for Disease Control and Prevention**CEO** Chief Executive Officer**CFO** Chief Financial Officer**CHAMPUS** Civilian Health and Medical Program of the Uniformed Services**CHE** Certified Healthcare Executive**CHIN** Community Health Information Network**CMS** Centers for Medicare & Medicaid Services**COB** Coordination of Benefits**COBRA** Consolidated Omnibus Budget Reconciliation Act of 1985**COHE** College of Osteopathic Healthcare Executives**CON** Certificate of Need**COO** Chief Operating Officer**COP** Conditions of Participation**CPI** Consumer Price Index

D

DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DNR	Do-Not-Resuscitate
DO	Doctor of Osteopathy
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DVS	Director of Volunteer Services

E

ED	Emergency Department
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
EPA	Environmental Protection Agency
EPG	Episodic Payment Group
EPO	Exclusive Provider Organization
ER	Emergency Room
ERISA	Employee Retirement Income Security Act
ETG	Episodic Treatment Group

F

FACHE	Fellow of the American College of Healthcare Executives
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FDA	Food and Drug Administration
FFS	Fee-for-Service
FMG	Foreign Medical Graduate
FQHC	Federally Qualified Health Center
FRG	Function Related Group
FTC	Federal Trade Commission
FY	Fiscal Year

G

GHAA	Group Health Association of America
GME	Graduate Medical Education
GP	General Practitioner

H

HEDIS	Health Plan Employer Data and Information Set
HFMA	Healthcare Financial Management Association
HHA	Home Health Agency
HHS	Health and Human Services, Department of
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HLTCU	Hospital-attached Long-Term Care Unit
HMO	Health Maintenance Organization
HPS	Hospital Purchasing Service

I

ICU	Intensive Care Unit
IDN	Integrated Delivery Network
IPA	Independent Practice Association

J

JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JOA	Joint Operating Agreement

L

LMRP	Local Medical Review Policy
LOS	Length of Stay
LPN	Licensed Practical Nurse
LTAC	Long-Term Acute-Care Hospital
LTC	Long-Term Care
LTCF	Long-Term Care Facility

M

MCO	Managed Care Organization
MD	Doctor of Medicine
MDC	Major Diagnostic Category
MedPAC	Medicare Payment Advisory Commission
MIS	Management Information System
MSA	Medical Savings Account
MSN	Master of Science in Nursing
MSO	Management Services Organization

MSW Master of Social Work

N

NCQA National Committee for Quality Assurance

NIH National Institutes of Health

NRHA National Rural Health Association

O

OB-GYN Obstetrics-Gynecology

OBRA Omnibus Budget Reconciliation Act

OMB Office of Management and Budget

OPPS Outpatient Prospective Payment System

OR Operating Room

ORYX A JCAHO initiative (*listed as ORYX*)

OSHA Occupational Safety and Health Administration

OT Occupational Therapist

P

PA Physician Assistant

PCN Primary Care Network

PAC Political Action Committee

PDx Principle Diagnosis

PC Professional Corporation

PHA Participating Hospital Agreement

PHO Physician-Hospital Organization

PIP	Periodic Interim Payment
PMC	Physician Management Company
POS	Point-of-Service Plan
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRO	Peer Review Organization or Professional Review Organization
PSN	Provider Sponsored Network
PSO	Provider Service Organization
PSO	Patient Safety Organization
PT	Physical Therapist

Q

QA	Quality Assessment or Quality Assurance
QHP	Quality Health Plan
QIO	Quality Improvement Organization
QM	Quality Management

R

RBRVS	Resource-Based Relative-Value Scale
RHIO	Rural Health Information Organization
RHC	Rural Health Clinic
RN	Registered Nurse
RUG	Resource Utilization Group

S

SCHIP	State Children's Health Insurance Program
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SNF Skilled Nursing Facility

T

TANF Temporary Assistance for Needy Families

TQM Total Quality Management

U

UDOH Utah Department of Health

UHA Utah Hospitals & Health Systems Association

UHIN Utah Health Information Network

UM Utilization Management

UPP Utah Premium Partnership for Health Insurance

UR Utilization Review

USF Universal Services Fund

USIIS Utah Statewide Immunization Information System

V

VNA Visiting Nurse Association

W

WC Workers' Compensation

WHO World Health Organization

APPENDIX B

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