Quality & Chronic Disease
Glossary of Related Terms

A

Acute Care - Short-term medical treatment, most often in a hospital, for people who have a severe illness or injury or are recovering from surgery.

American Health Quality Association (AHQA) - An educational, not-for-profit national membership association dedicated to promoting and facilitating fundamental change that improves the quality of health care in America. AHQA represents Quality Improvement Organizations (QIOs) and professionals, sharing information about best practices with physicians, hospitals, and nursing homes. Working together with health care providers, QIOs identify opportunities and provide assistance for improvement.

Agency for Healthcare Research and Quality (AHRQ) – The Nation's lead Federal agency for research on health care quality, costs, outcomes and patient safety. AHRQ is the health services research arm of the U.S. Department of Health and Human Services (HHS), complementing the biomedical research mission of its sister agency, the National Institute of Health. The agency is home to research centers that specialize in major areas of health care research, including clinical practice and technology assessment; health care organization and delivery systems; and primary care. AHRQ is a major source of funding and technical assistance for health services research and research training at leading U.S. universities and other institutions. As a science partner, the agency works with the public and private sectors to build the knowledge base for what works—and does not work—in health and health care and to translate this knowledge into everyday practice and policymaking.

Aligning Forces for Quality: The Regional Market Project (AF4Q) - A national program of the Robert Wood Johnson Foundation (RWJF) designed to help communities across the country improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression and heart disease. The premise of Aligning Forces for Quality is that no single person, group or profession can improve the quality of care without the support of others. Aligning Forces for Quality seeks to drive quality improvement by aligning key forces, including health care providers (physicians/physician groups, nurses, clinics), health care purchasers (employers and insurers) and health care consumers (patients).

Ambulatory Care - Medical care provided on an outpatient basis – therefore, not requiring a person to be admitted to the hospital. Ambulatory care is provided in physicians' offices, clinics, emergency departments, outpatient surgery centers and hospital settings that do not involve a patient staying overnight.

B

Benchmark (Benchmarking) – A way for hospitals and doctors to analyze quality data, both internally and against data from other hospitals and doctors, to identify best practices of care and improve quality.

Best Practices - The most up-to-date patient care interventions, scientifically proven to result in the best patient outcomes and minimize patients' risk of death or complications.

C

Chronic Care Model – A model developed by Edward Wagner and colleagues that provides a solid foundation from which health care teams can operate. The model has six dimensions: community resources and policies; health system organization of health care; patient self-management supports; delivery system redesign; decision support; and clinical information system. The ultimate goal is to have activated patients interact in a productive way with well-prepared health care teams. Three dimensions that are particularly critical to this goal are adequate decision support, which includes systems that encourage providers to use evidence-based protocols; delivery system redesign, such as using group visits and same-day appointments; and use of clinical information systems, such as disease registries, that allow providers to exchange information and follow patients over time.

Chronic Disease - A disease that is long-lasting or recurrent. Examples include diabetes, asthma, heart disease, kidney disease and chronic lung disease.

Clinical Practice Guidelines - A set of systematically developed statements, usually based on scientific evidence, that help physicians and their patients make decisions about appropriate healthcare for specific medical conditions. Clinical practice guidelines briefly identify and evaluate the most current information about prevention, diagnosis, prognosis, therapy, risk/benefit and cost/effectiveness.

Consumer-Driven (or Directed) Care - A form of health insurance that combines a high-deductible health plan with a tax-favored Health Savings Account, Flexible Spending Account or Health Reimbursement Account to cover out-of-pocket expenses. These accounts are "consumer driven" in that they give participants greater control over their own healthcare, allowing individuals to determine on a personal basis how they choose to spend their healthcare account funds.

Consumer Engagement - Consumers must take an active, engaged role to improve the quality of health care in their communities. The program includes a broad range of activities designed to get consumers to take an active role in their own care, from understanding their own conditions and available treatments, to seeking out and making decisions based on information about the performance of health care providers.

Consumers – An individual who uses, is affected by, or who is entitled or compelled to use a health related service.

Coordination of Care - The mechanisms ensuring that the patient and clinicians have access to, and take into consideration, all required information on the patient's conditions and treatments to ensure that the patient receives appropriate healthcare services.

Core Measures - Specific clinical measures that, when viewed together, permit a robust assessment of the quality of care provided in a given focus area, such as acute myocardial infarction (AMI).

D

Disease Management - An approach designed to improve the health and quality of life for people with chronic illnesses by keeping their conditions from getting worse.

E

Effective Care - Services that are of proven value and have no significant tradeoffs. The benefits of the services so far outweigh the risks that all patients with specific medical needs should receive them. These services, such as beta-blockers for heart attack patients, are

backed by well-articulated medical theory and strong evidence of efficacy, determined by clinical trials or valid cohort studies.

Electronic Health Record - A computerized medical file that contains the history of a patient's medical care.

Evidence-based Medicine - The wise and careful use of the current, best available scientific research and practices with proven effectiveness in daily medical decision making, including individual clinical practice decisions, by well-trained, experienced clinicians. Evidence is at the heart of developing performance measures for the most common and costly health conditions. The measures allow consumers to compare medical providers to learn which ones routinely offer the highest quality, safest, and most effective care.

F

Fee Schedule - A complete listing of fees used by health plans to pay doctors or other providers.

Fee-for-Service - An arrangement under which patients or a third party pay physicians, hospitals, or other health care providers for each encounter or service rendered.

G

Group Health Plan - A health plan that provides health coverage to employees, former employees and their families, and is supported by an employer or employee organization.

H

Health Information Technology - The use of computers, software programs, electronic devices and the Internet to store, retrieve, update and transmit information about patients' health.

Health Plan Employer Data and Information Set (HEDIS) Measures - A set of health care quality measures designed to help purchasers and consumers determine how well health plans follow accepted care standards for prevention and treatment. Formerly known as the Health Plan Employer Data Information Set.

I

Informed Decision Making (IDM) - A process that occurs when patients understand the nature of the disease or condition being addressed; understand the clinical service including benefits, risks, limitations, alternatives, and uncertainties; consider their own preferences and values; participate in decision-making at the level they desire; and make decisions consistent with their own preferences and values or choose to defer a decision until a later time.

Inpatient Care - The delivery of healthcare services to a person who has been admitted to a hospital or other health facility for a period of at least 24 hours.

Institute of Medicine (IOM) - A not-for-profit organization and honorific membership organization that works outside the framework of government to ensure scientifically informed analysis and independent guidance on matters of biomedical science, medicine and health. The Institute provides unbiased, evidence-based, and authoritative information and advice

concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large. IOM's book on quality and safety, *Crossing the Quality Chasm: A New Health System for the 21st Century*, partially funded by the Foundation, reported that a huge divide exists between the care we should receive and the care that we do get. The Quality Chasm introduces the notion that health care needs to take a page from industry and use its engineering improvement methods to aim for top quality, efficiency, and safety. The report lays out six goals that would become akin to a mantra for the quality improvement movement. Care should be "safe, effective, patient-centered, timely, efficient, and equitable." IOM's 2003 landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrates the reality and effect of health disparities and quality-of-care differences for persons of racial and ethnic minorities.

J

Joint Commission - A private, not-for-profit organization that evaluates and accredits hospitals and other healthcare organizations providing home care, behavioral healthcare, ambulatory care and long-term care services.

K

L

M

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

Misuse - Occurs when an appropriate process of care has been selected but a preventable complication occurs and the patient does not receive the full potential benefit of the service. Avoidable complications of surgery or medication use are misuse problems. A patient who suffers a rash after receiving penicillin for strep throat, despite having a known allergy to that antibiotic, is an example of misuse. A patient who develops a pneumothorax after an inexperienced operator attempted to insert a subclavian line would represent another example of misuse.

N

National Committee on Quality Assurance (NCQA) - A private, not-for-profit organization dedicated to improving health care quality through measurement, transparency and accountability. NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. The organization has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what's important, how to measure it, and how to promote improvement.

National Quality Forum (NQF) - A shared sense of urgency about the impact of health care quality on patient outcomes, workforce productivity, and health care costs prompted leaders in the public and private sectors to create the NQF as a mechanism to bring about national change. NQF is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. Established as a public-private partnership, the NQF has broad participation from all parts of the health care system, including national, state, regional and local groups representing consumers, public and private

purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries and organizations involved in health care research or quality improvement. Together, the organizational members of the NQF work to promote a common approach to measuring health care quality and fostering system-wide capacity for quality improvement. Quality improvement measures endorsed by the NQF are considered the gold standard.

O

Outcome - Result of a process, including outputs, effects and impacts.

Outpatient Care - Medical or surgical care that does not include an overnight hospital stay.

Overuse - Providing a process of care in circumstances where the potential for harm exceeds the potential for benefit. Prescribing an antibiotic for a viral infection like a cold, for which antibiotics are ineffective, constitutes overuse. The potential for harm includes adverse reactions to the antibiotics and increases in antibiotic resistance among bacteria in the community. Overuse can also apply to diagnostic tests and surgical procedures.

P

Patient-Centered Care - Care that considers patients' cultural traditions, their personal preferences and values, their family situations and their lifestyles. Responsibility for important aspects of self-care and monitoring is put in patients' hands—along with the tools and support they need. Patient centered care also ensures that transitions between different health care providers and care settings are coordinated and efficient. When care is patient-centered, unneeded and unwanted services can be reduced.

Patient Registry - A patient database maintained by a hospital, doctors' practice or health plan that allows providers to identify their patients according to disease, demographic characteristics and other factors. Patient registries can help providers better coordinate care for their patients, monitor treatment and progress and improve overall quality of care.

Patient Satisfaction - A measurement that obtains reports or ratings from patients about services received from an organization, hospital, physician or healthcare provider.

Pay for Performance - A method for paying hospitals and physicians based on their demonstrated achievements in meeting specific health care quality objectives. The idea is to reward providers for the quality—not the quantity—of care they deliver.

Payers - The entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan or an HMO.

Performance Measures - Sets of established standards against which health care performance is measured. Performance measures are now widely accepted as a method for guiding informed decision making as a strong impetus for improvement.

Preference–Sensitive Care - Treatments that involve significant tradeoffs affecting the patient's quality and/or length of life. Decisions about these interventions – whether to have them or not, which ones to have – ought to reflect patients' personal values and preferences, and ought to be made only after patients have enough information to make an informed choice. At times, the scientific evidence on the main outcome – survival – is quite good; in other cases, the evidence is much weaker.

Preventive care - Healthcare services that prevent disease or its consequences. It includes primary prevention to keep people from getting sick (such as immunizations), secondary prevention to detect early disease (such as Pap smears) and tertiary prevention to keep ill people or those at high risk of disease from getting sicker (such as helping someone with lung disease to quit smoking).

Price Transparency - The ability of consumers to know what it will cost to receive a given healthcare service at a variety of outlets.

Primary Care - Basic or general healthcare traditionally provided by doctors trained in: family practice, pediatrics, internal medicine and occasionally gynecology.

Providers – A professional engaged in the delivery of health services, including physicians, dentists, nurses, podiatrists, optometrists, clinical psychologists, etc. Hospitals and long term care facilities are also providers. The Medicare program uses the term "provider" more narrowly, to mean participating institutions: hospitals, skilled nursing facilities, home health agencies, etc.

Public Reporting – Information about physician and physician group performance that consumers can use to compare the performance of local physicians/physician groups is critical for improvement. The expectation is that a comparative public report of the communities' physicians' performance in treating people with chronic illnesses will motivate and improve performance.

Purchasers - An entity that not only pays the premium for healthcare costs, but also controls the premium dollar before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Q

Quality (of Care) - A measure of the ability of a doctor, hospital, or health plan to provide services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Good quality healthcare means doing the right thing at the right time, in the right way, for the right person and getting the best possible results. According to the mantra for the quality improvement movement, care should be "safe, effective, patient-centered, timely, efficient and equitable."

Quality Improvement - The goal of quality improvement is for patients to receive the appropriate care at the appropriate time and place with the appropriate mix of information and supporting resources. Quality improvement tools range from those that simply make recommendations but leave decision-making largely in the hands of individual physicians (e.g., practice guidelines) to those that prescribe patterns of care (e.g., critical pathways). Typically, quality improvement efforts are strongly rooted in evidence-based procedures and rely extensively on data collected about processes and outcomes.

Quality Indicator - An agreed-upon process or outcome measure that is used to determine the level of quality achieved. A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or achievement of quality goals.

Quality Measures - A mechanism to assign a quantity to quality of care by comparison to a criterion.

R

Racial Disparities - Differences in the delivery of health care, access to health care services and medical outcomes based on ethnicity, geography, gender and other factors that do not include socioeconomic status or insurance coverage. Understanding and eliminating the causes of health disparities is an ongoing effort of many groups and organizations.

Rapid Cycle Change - A quality-improvement method that identifies, implements and measures changes made to improve a process or a system. At the onset, the team sets an outcome measure based on the system's goals. Improvement occurs through small, rapid PDSA (Plan, Do, Study, Act) cycles to advance practice change. This model requires aiming at a specific area to change; planning changes on the basis of sound science, theory, and evidence; piloting several changes with small patient groups; measuring the effects of changes; and acting according to the data. The fundamental concept of rapid-cycle improvement is that healthcare processes — once defined, in place, and in effect — should be continually improved by instituting a constant cycle of innovations or improvements.

Report Card – An assessment of the quality of care delivered by health plans. Report cards provide information on how well a health plan treats its members, keeps them healthy, and gives access to needed care. Report cards can be published by States, private health organizations, consumer groups or health plans.

Right Care - Treatments that, according to evidence-based guidelines, are effective and appropriate for a given condition. Indicators used to define right care are often grouped into two categories: prevention and chronic care.

S

Self-Management - The ability of the individual to have the necessary knowledge, attitudes and skills to manage their health problem or disorder on a day-to-day basis. It is a skill that enables individuals, and their families, to make improved use of existing health services, as well as make choices surrounding healthcare providers, medication, diet, exercise, and other lifestyle issues that protect or damage health.

Sentinel Event - Any unexpected event in a health care setting that causes death or serious injury to a patient and is not related to the natural course of the patient's illness.

Standard of Care - The expected level and type of care provided by the average caregiver under a certain given set of circumstances. These circumstances are supported through findings from expert consensus and based on specific research and/or documentation in scientific literature.

Supply-Sensitive Care - The excess procedures, hospital admissions, and doctor visits that are driven by the supply of doctors and hospital resources rather than by need.

T

Transparency – The process of collecting and reporting healthcare cost, performance and quality data in a format that can be accessed by the public and intended to improve the delivery of services and ultimately improve the healthcare system as a whole.

U

Underuse - Refers to the failure to provide a health care service when it would have produced a favorable outcome for a patient. Standard examples include failures to provide appropriate preventive services to eligible patients (e.g., Pap smears, flu shots for elderly patients,

screening for hypertension) and proven medications for chronic illnesses (steroid inhalers for asthmatics; aspirin, beta-blockers, and lipid-lowering agents for patients who have suffered a recent myocardial infarction).

V

Value Exchange - A multi-stakeholder organization that has taken clear action in its community to convene community purchasers, health plans, providers and consumers to advance quality Health Care. HHS selected the following communities as Chartered Value Exchanges: Wisconsin Healthcare Value Exchange, Madison, Wis.; Healthy Memphis Common Table, Germantown, Tenn.; Greater Detroit Area Health Council, Detroit, Mich.; Niagara Health Quality Coalition, Williamsville, N.Y.; Oregon Health Care Quality Corporation, Portland, Ore.; Pittsburgh Regional Health Initiative, Pittsburgh, Pa.; Puget Sound Health Alliance, Seattle, Wash.; Utah Partnership for Value-driven Health Care, Salt Lake City, Utah; Louisiana Health Care Quality Forum, Baton Rouge, La.; Maine Chartered Value Exchange Alliance, Scarborough, Maine; Minnesota Healthcare Value Exchange, St. Paul, Minn.; Massachusetts Chartered Value Exchange, Watertown, Mass.; Alliance for Health, Grand Rapids, Mich.; New York Quality Alliance, Albany, N.Y.

Value Purchasing - A broad strategy used by some large employers to get more value for their health care dollars by demanding that health care providers meet certain quality objectives or supply data documenting their use of best practices and quality treatment outcomes.

W

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Z