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Accountable Care Organization	**ACO**	Groups of medical (& maybe behavioral health) providers who band together under one business umbrella; an integrated health system that incorporates many levels of care & assumes responsibility for improving health outcomes of a defined population. The ACO can include hospitals, primary care doctors, specialists, social workers, pharmacists and nurses and the group is paid to care for a group of patients. If the organization can reduce the cost of caring for patients while maintaining their health, it gets to keep & divide some of the savings. If it can't meet quality measures &costs rise, providers may get lower payments. Organizations participating in ACOs will have options to share risk & savings from improved health processes & outcomes. ACOs can be a vehicle for integrating SUD treatment and medical care within the broader system & may be in an even better position to realize cost savings because they may cover larger populations than health homes.
Activities of Daily Living See also IADLs	**ADLs**	Used to assess functional status to determine services or rehabilitation goals at home or in an institutional setting. Basic ADL self-care tasks: ▪ Personal hygiene & grooming ▪ Dressing & undressing ▪ Self feeding ▪ Functional transfers (getting into & out of bed or wheelchair, getting onto or off toilet, etc.) ▪ Bowel & bladder management ▪ Ambulation (walking without use of use of an assistive device -walker, cane, or crutches - or a wheelchair).
Adverse Selection:		Insurance: People with a higher than average need for, or risk of needing, health care are more apt to seek health insurance than healthier people. Health coverage providers/insurers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when more of the less healthy people disproportionately enroll in a risk pool or plan.
Affordable Care Act	**ACA** **PPACA**	Patient Protection and Affordable Care Act of 2010 aka Affordable Care Act aka "Obamacare:" US Federal statute that is principle healthcare reform legislation. Reforms certain aspects of private & public health insurance programs, increases insurance coverage of pre-existing conditions, expands access to insurance to over 30 million more Americans, & increases projected national medical spending while lowering projected Medicare spending, encourages and incents prevention, public health, evidence based practices. Brings many more people under Medicaid – though now that will be left up to each state.
Agency for Healthcare Research and Quality[1]	**AHRQ**	Federal Dept of HHS agency that focuses on health services research & quality measurement, evidence based practices, etc. Also supports research, demonstrations, approaches and methodological work around healthcare IT issues.

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Alternative Quality Contract From Health Affairs	**AQC**	A MA BC/BS contract stipulates a modified **global payment** (fixed payments for the care of a patient during a specified time period) arrangement. It differs from past models of fixed payments or capitation because it explicitly connects payments to achieving quality goals and defines the rate of increase for each contract group's budget over a 5-year period, rather than annual contracts. All groups participating in the AQC earned significant quality bonuses in the 1st year. This arrangement exemplifies the type of experimentation encouraged by the **ACA**.
Bundled Payment[3]		A fixed dollar amount that covers a set of services, defined as an episode of care, for a defined period. Two types are: - Professional & facility charges for a discrete episode of acute care over a defined period; - Professional & facility charges for treatment of a chronic condition over a defined time period. Bundles generally have 3 components: service inclusion criteria, episode time window & patient inclusion/exclusion criteria.
Capitation		A payment method for health care services. The physician, hospital, or other health care provider is paid a contracted rate for each member assigned, referred to as "per-member-per-month" rate, regardless of the number or nature of services provided. Contractual rates are usually adjusted for age, gender, illness, and regional differences.
Care Management		Broad strategy to ensure that patients with complex, high health needs don't fall through cracks in or between systems. Patient engagement, activation & education, wellness promotion, disease prevention, chronic disease management, etc. often within a **Patient Centered Medical Home** environment. Also involves care coordination & ongoing monitoring.
Case Management		Activities that help individuals gain access to & help coordinate (sometimes) a variety of needed services – social, educational, health & other services
Centers for Medicare and Medicaid	**CMS**	Federal Agency responsible for administering both **Medicare** and **Medicaid**. Medicare is federally funded only & Medicaid is state/federal funded.
Cherry picking		When insurance companies offer coverage to young & healthy people but deny coverage to people who are older or sicker. This ability to offer coverage selectively is known in the insurance world as "cherry-picking."
Child and Adolescent Needs and Strengths Tool	**CANS**	Connected with **Children's Behavioral Health Initiative**. **MassHealth** requires use of this standardized clinical information collection tool, known as the CANS, as an information integration and decision support tool; it ensures a standard minimum "scope" of assessment; can help clinicians prioritize issues for treatment planning; can promote clear communication between clinicians and families
Children's Behavioral Health Initiative	**CBHI**	Interagency initiative of Massachusetts EOHHS to strengthen, expand & integrate services into comprehensive community based system of care that families & their children with significant behavioral, emotional & mental

		health needs obtain services needed to succeed in home, school & community. Intended to increase timely access to appropriate services, expand array of services, reduce health disparities, promote clinical best practice, establish integrated behavioral health system across state agencies, & more.
Children's Health Insurance Program	**CHIP**	Provides health coverage to nearly 8 million children in families with incomes too high to qualify for Medicaid, but can't afford private coverage. Signed into law in 1997, CHIP provides federal matching funds to states to provide this coverage. Its name then was State Children's Health Insurance Program (SCHIP). Like Medicaid, CHIP is administered by the states, but is jointly funded by the federal government and states. The Federal matching rate for state CHIP programs is typically about 15 percentage points higher than the **Medicaid** matching rate for that state (i.e. a State with a 50% Medicaid FMAP has an "enhanced" CHIP matching rate of 65%). Every state administers its own CHIP program with broad guidance from CMS.
Children's Health Insurance Program Reauthorization Act of 2009	**CHIPRA**	This US 2009 legislation provided states with significant new funding, new programmatic options, & a range of new incentives for covering children through **Medicaid** & **CHIP**. The intent is to support states in developing efficient & effective strategies to identify, enroll, & retain health coverage for uninsured children who are eligible for Medicaid or CHIP but are not enrolled. CHIPRA provided flexibility to states to expand health care coverage to children who need it, & tasked the Secretary of HHS with developing standards by which states can measure the quality of the care that children are receiving. U.S. Census Bureau data showed that, in 2008, the uninsured rate among children was at the lowest level since 1987. Most are eligible for Medicaid & CHIP but not enrolled. Administrative barriers can still make it difficult & many families either don't know about Medicaid or CHIP or mistakenly believe their children are not eligible. Some CHIPRA features to help states & communities boost participation rates: - New Express Lane Eligibility option that allows states to enroll children in Medicaid or CHIP based on information available through other programs & data bases. - Outreach funding dedicated to promoting effective enrollment & renewal strategies. - A first-of-its-kind payment incentive for states to offset some of the costs associated with states' success in covering more children. - An option for states to verify US citizenship through data matches with Social Security Administration to reduce coverage losses and delays. - Automatic eligibility for newborns whose mothers are covered through Medicaid and CHIP.
Community-Based Acute Treatment	**CBAT**	Mental health services in a staff-secure setting on a 24 hour basis, with sufficient clinical staffing to insure child/adolescent safety, while providing intensive therapeutic services. These can include (but not limited to) daily

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		medication monitoring, psychiatric assessment, nursing, **specialing** as needed, individual, group & family therapy, cast management, family assessment & consultation, discharge planning and psychological testing as needed. May be an alternative to or transition from Inpatient services.
Community Health Centers From MA League of CHC site	**CHCs**	Started in 1965 in Massachusetts, the state's 50 community health center organizations provide care to 1 of every 9 people (nearly 800,000 state residents) through more than 280 access sites across the state. CHCs offer primary, preventive and dental care, as well as mental health, substance abuse and other community-based services to anyone in need regardless of insurance status or ability to pay. Not all offer all services. Nationally there are over 1,000 health centers that serve more than 16 million people. Most **Federally Qualified Health Centers** (FQHCs) are CHCs but not all CHCs are FQHCs
Community Tenure		Time in the community for people released from psychiatric hospitalization; time in the community between admissions or instead of hospitalizations; a measure of clinical improvement (**AHRQ**). Longer 'community tenure' can indicate increased community connections, better functionality in work/school in support of recovery.
Consumer Assessment of Healthcare Providers and Systems [1]	**CAHPS®**	**AHRQ** program that asks consumers & patients to report on & evaluate their experiences in healthcare. There is also a hospital version known as HCAHPS® which is used to adjust payments to hospitals based on performance as part of the Hospital Value Based Purchasing Program.
Current Procedural Terminology (CPT).	**CPT**	This code set, maintained by the AMA through its CPT Editorial Panel, describes medical, surgical, & diagnostic laboratory & radiological services performed as part of patient care in offices, clinics, or hospitals. It's designed to communicate uniform information about medical services & procedures among physicians, coders, patients, accreditation organizations, & payers for administrative, financial, and analytical purposes. CPT coding identifies specific services rendered and is usually accompanied by an ICD diagnosis code. CPT is currently identified by the **Centers for Medicare and Medicaid Services (CMS)** as Level 1 of the **Health Care Procedure Coding System.** It is updated every fall.
Custodial Care		"Unskilled" care that basically provides assistance with Activities of Daily Living for people who can't take care of them on their own. May be provided in the home or in a nursing home. Usually not covered by insurance.
Data Segmentation Initiative	**DSI**	Health IT: The goal of this program is to produce a pilot project that will allow providers to share portions of an electronic medical record while not sharing others, such as information related to substance abuse treatment, which is given heightened protection under the law. The technology could potentially be used to give patients choice over what health information is shared by providers electronically. Started in coordination with **ONC** in 2011, this appears to be an open forum *via* wiki.

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Diagnosis Related Group	**DRG**	System to classify hospital stays into groups so hospital benefits for specific diagnostic stays can be determined prospectively (ahead of time). DRGs are assigned by a "grouper" program based on **ICD (International Classification of Diseases)** diagnoses & procedures, age, sex, discharge status, and the presence of complications or co-morbidities. DRGs have been used in the US since 1982 to determine how much Medicare pays a hospital for each diagnosis group, since patients within each category are similar clinically and expected to use the same level of hospital resources. Some outliers are recognized. Developed even earlier in New Jersey.
Direct Gateway		Health IT: The Commonwealth is preparing to deploy a "Direct Gateway" by October, 2012 that will allow any provider in the state to send a secure message, such as a clinical summary, to any other provider in the state. Significantly, the Direct Gateway can be used to send messages to and from providers that do not have electronic health records, which is potentially a very important development for behavioral health providers.
Direct Project [1]		Health IT: Developed by the **NHIN Exchange**; seeks to create a simple secure, scalable, standards-based way to transmit health information from a sender to a trusted recipient via the internet. Embraced by **HIE** vendors; protocols have already been used to transmit information.
Disproportionate Share Hospital	**DSH** **Some say 'dish'**	Payments made by a state's **Medicaid** and/or by the **Medicare** program to hospitals designated as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments these hospitals receive for providing inpatient care to Medicaid/Medicare beneficiaries. Low income hospitals tend to be in dense urban areas or in isolated rural areas. Medicaid: States have some discretion in determining how much eligible hospitals receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute
Diversionary Services		Per DMH, those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community.
Domain		ACO term: The way CMS categorizes 65 quality metrics. Scores will be the basis for determining shared savings. The 5 domains • Patient/aregiver experience (7 measures) • Care coordination (16 measures) • Patient safety (2 measures) • Preventive health (9 measures) • At-risk population/frail elderly health (31 measures) focus on diabetes, heart failure, coronary artery disease, hypertension, chronic obstructive pulmonary disorder-COPD and frail elderly.

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Dual Eligibles or Duals		People who are both eligible for **Medicare** (disabled or 65+ or ESRD) and eligible for **Medicaid** (low income). Because both program rules and benefits are not coordinated, there may be overlap or leave gaps; some rules may contradict each other, etc. Massachusetts has a relatively recent Medicaid waiver to coordinate services and reimbursements for disabled Dual Eligibles between ages 18 & 64.
Electronic Medical Record/Electronic Health Record	**EMR/EHR**	Health IT: A computerized medical record of each patient's care; tests, visits, surgeries, diagnoses, prescriptions etc. in an organization that delivers care, such as a hospital or physician's office. Electronic medical records may be part of a local stand-alone health information system that allows storage, retrieval and modification of records or part of a larger system-wide set of records. There is some consensus that EMRs can reduce several types of errors, such as those related to prescription drugs, to preventive care, and to tests and procedures. Alerts remind clinicians of intervals for preventive care and track referrals and test results. Clinical guidelines for disease management have a demonstrated benefit when accessible within the electronic record during the process of treating the patient. There are multiple EMR vendors that have not been at all similar making any changes of systems difficult. Some organizations have different EMRs for emergency departments, inpatient floors and for various departments or clinics. Efforts are underway in many settings to consolidate records so that the care of the patient is much better coordinated allowing multiple health care providers to see the same record. This does raise privacy issues, especially with mental health and SUD treatment records and access in discussions about integrated care.
Entitlement		A federal program (like **Medicare** or **Medicaid**) which provides financial benefits, or goods & services, to an indefinite number of beneficiaries. They have legal rights to those benefits or services when eligibility requirements are met. Congress has little or no discretion on how much money to appropriate; some entitlements have permanent appropriations determined by formulas written into law. Not subject (or less subject) to yearly budget whims of the Congressional party in power.
End Stage Renal Disease	**ESRD**	When a person's kidneys stop working to the point where they need dialysis or a transplant, they are said to have permanent kidney failure or End Stage Renal Disease. Patients of any age with ESRD were added to **Medicare** as an eligible group in 1972.
Emergency Services Program	**ESP**	Provides mental health crisis management intervention and stabilization services in Massachusetts through 4 service components – **Mobile Crisis Intervention (MCI)** services for youth, adult mobile services, ESP community based locations, and community crisis stabilization (CCS) services for ages 18 and over. All services can be accessed through a toll free number.
Fair Share Contribution	**FSC**	MA state health insurance legislation (Chapter 58 of the Acts of 2006)

www.mass.gov		enacted in April, 2006 contained new obligations for MA employers. Among the provisions was the requirement for certain employers to make a "Fair Share Contribution" (FSC) to the Commonwealth Care Trust Fund if they do not make a "fair and reasonable" contribution to the health insurance costs for their employees at levels specified by regulation – an amount per employee per year. The EOHHS MA Division of Health Care Finance & Policy promulgates the regulations related to determining an employer's liability for FSC, including regulations defining the "Primary Test" and the "Secondary Test," which determine whether a fair and reasonable contribution has been made. The Division of Unemployment Assistance is responsible for collecting the Fair Share Contribution. MA employers subject to unemployment insurance law who employ eleven or more full-time equivalent employees must file an annual Fair Share Contribution report as well as the Employer Health Insurance Responsibility Disclosure (HIRD) report.
Fee for Service	**FFS**	A method of paying a fee for each unit of health care service provided by a physician or credentialed staff. Many services have levels built in for either time or complexity (sometimes both).
Federal Insurance Contributions Act	**FICA**	Social Security payroll taxes are deducted through this authority. (This does not apply to MA state employees or the Commonwealth as an employer.) Employee and employer each pay 6.2% up to a specified annual max. Self employed people pay the full 12.4% FICA In the past contributions toward Medicare Part A were also lumped under FICA. They are now deducted (1.45% of all wages) on a separate line.
Federally Qualified Health Center From HRSA website	**FQHC**	A reimbursement designation from the Bureau of Primary Health Care (**Health Resources and Services Administration - HRSA**) and **CMS** of the US Dept of Health and Human Services. FQHCs are community-based organizations that provide comprehensive primary care and preventive care, that can include health, oral, and mental health / substance abuse services to persons of all ages, regardless of ability to pay or health insurance status. FQHCs (also known as **Community Health Centers**, Migrant Health Centers, and 330 Funded Clinics) are a critical part of the health care safety net. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. (FQHC Look-Alikes are entities that operate and provide services consistent with all statutory, regulatory, and policy requirements that apply to section 330-funded health centers, but do not receive funding under section 330.) They were initially started to provide comprehensive health services to the medically underserved with the intent to reduce patient loads on hospital emergency rooms. Since then their mission has expanded to provide primary care services in underserved urban & rural communities, particularly for the underserved, underinsured, & uninsured, including migrant workers and for non-U.S. citizens. In return FQHCs receive consideration from the Fed. Gov't in the form of a cash grant, cost-based reimbursement for their Medicaid patients, and free malpractice coverage. Most FQHCs are CHCs but not all CHCs are FQHCs

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Federal Medical Assistance Percentage	**FMAP**	Statutory term for the federal **Medicaid** matching rate—or share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 76% depending upon a state's per capita income; on average, across all states, the federal government pays 57 % of the costs of Medicaid.
Formulary		Preferred drug list: A list of prescription drugs covered by a particular drug benefit plan. Patients pay varying co-pays for drugs that are on formulary. Patients must pay a larger percentage of the cost of the drug - sometimes 100% - for drugs not on the formulary, Formularies vary between drug plans and differ in the breadth of drugs covered & costs of co-pay & premiums. Most formularies cover at least one drug in each drug class, & encourage generic substitution.
FQHC Look-Alike From HRSA website		These health centers do not receive grants under Section 330 but are determined by the US Secretary of the Dept of Health and Human Services to meet requirements for receiving a grant based on the HRSA recommendations. FQHC Look-Alikes receive cost-based reimbursement for their Medicaid services – but no free malpractice coverage.
Global Payment		An all-inclusive payment per enrollee for a defined scope of services, regardless of how much care is actually provided; reimbursement of health care providers (such as hospitals and physicians) based on expected costs for clinically-defined episodes of care. Seen by some as 'a middle ground' between fee-for-service reimbursement (providers are paid for each service rendered to a patient) & capitation (providers are paid a 'lump sum' per patient regardless of how many services the patient receives). Unlike capitation, this payment may also involve multiple providers or even types of providers. To minimize problems from capitation-like payments Blue Cross Blue Shield of MA **alternative quality contract (AQC**), which combines a health status–adjusted global payment with performance incentives for meeting quality and safety benchmarks.
Health Savings Account	**HSA**	Created in 2003 so individuals covered by high-deductible (usually commercial) health plans could receive tax-preferred treatment of money saved for medical expenses. These accounts are a component of "consumer-driven health care" and are favored mostly by those with high incomes; tax-advantaged medical savings accounts available to US taxpayers enrolled in a high-deductible health plan. Funds contributed to an account are not subject to federal income tax at the time of deposit. Unlike a flexible spending account, funds roll over and accumulate year to year if not spent. HSAs are owned by the individual, which differentiates them from company-owned Health Reimbursement Arrangements (HRA) that are an alternate tax-deductible source of funds paired with standard health plans. HSA funds may currently be used to pay for qualified medical expenses at any time without federal tax liability or penalty. Beginning in early 2011

		over the counter medications cannot be paid with HSA dollars without a doctor's prescription[1]. Withdrawals for non-medical expenses are treated very similarly to those in an individual retirement account in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier.
Healthcare Common Procedure Coding System	**HCPCS** **Some say** "hick picks"	The Healthcare Common Procedure Coding System is a set of health care procedure codes based around the American Medical Association's **Current Procedural Terminology (CPT)**. This system provides a standardized coding system for describing the specific items and services provided in the delivery of health care. Such coding is necessary for Medicare, Medicaid, and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner. Initially, use of the codes was voluntary, but with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) use of the HCPCS for transactions involving health care information became mandatory. HCPCS includes 2 levels of codes: • Level I is numeric and consists of the AMAs Current Procedural Terminology (CPT); and • Level II codes are alphanumeric & primarily include non-physician services such as ambulance services & prosthetic devices, & represent items &supplies & non-physician services not covered by CPT codes (Level I). There are also dental codes which may be part of Level 1.
Healthcare Effectiveness Data and Information Set[1]	**HEDIS**	Primary measurement tool of the **NCQA**; consists of 76 measures across 5 domains of care in areas such as asthma medication use, breast cancer screening, comprehensive diabetes care, immunization status, & identifying and addressing tobacco use & substance use disorders. 90% of health plans use HEDIS as a quality measurement and reporting tool.
Health Information Exchange	**HIE**	Health IT: The process of reliable and interoperable electronic health-related information sharing conducted in a manner that protects the confidentiality, privacy, and security of the information. The development of widespread HIEs is quickly becoming a reality. Health Information Organizations (HIOs) oversee HIE. For HIOs to function, they must be able to use nationally recognized standards to enable interoperability, security and confidentiality, & to ensure authorization of those who access the information. The HIE implementation challenge will be to create a standardized interoperable model that is patient centric, trusted, longitudinal, scalable, sustainable, and reliable. HIEs, enabled by technology, are expected to improve the quality of care and patient safety and reduce healthcare costs.
Health Information Technology	**HIT**	Health IT: "…the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making" (Brailer, & Thompson, 2004). Widespread use of health IT is seen as a way to improve the quality of health

		care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.
Health Information Technology for Economic and Clinical Health Act [1] funded by ARRA	**HITECH**	Health IT: Required the federal government to take a leadership role in encouraging meaningful use of health IT; this increased expectations for HER functionality - including quality measurement. The Act invested $20B for health IT infrastructure and for **Medicare** and **Medicaid** incentives to encourage doctors and hospitals to become meaningful users. It also included a State Health Information Exchange Cooperative Agreement program to foster health info exchange--**EHR** information sharing across institution ands communities. Key goal is ensuring that EHRs can share information to further care coordination, patient centered care, cost savings and other goals. Interoperability is a building block of this type of exchange.
Health Resources and Services Administration HRSA website	**HRSA**	U.S. DHHS Agency and primary Federal agency for improving access to health care services for uninsured, isolated or medically vulnerable. Grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers and children (**FQHCs, CHCs,** etc.). They train health professionals and improve systems of care in rural communities. HRSA oversees organ, bone marrow and cord blood donation. It supports programs that prepare against bioterrorism, compensates individuals harmed by vaccination, and maintains databases that protect against health care malpractice and health care waste, fraud & abuse.
Independent Living and Long Term Services and Supports	**LTSS**	Variety of services & supports to help people with disabilities meet their daily needs for assistance & improve quality of their lives – while staying out in the community. Assistance with ADLs, support for everyday tasks – IADLs like laundry, shopping, etc.
Instrumental Activities of Daily Living	**IADLs**	Ability to handle IADLs allow people to remain in the community: ▪ Housework ▪ Taking medications as prescribed ▪ Managing money ▪ Shopping for groceries or clothing ▪ Use of telephone or other form of communication ▪ Using technology (as applicable) ▪ Transportation within the community
International Classification of Diseases From CDC website	**ICD**	There are 2 related classifications of diseases with similar titles, & a third classification on functioning and disability. • The International Classification of Diseases (ICD) is the classification used to code and classify mortality data from death certificates. • The International Classification of Diseases, Clinical Modification is used to code & classify morbidity data from the inpatient and outpatient records, physician offices, & most National Center for Health Statistics surveys.
International Classification of	**ICD-9-CM**	ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization** in the United States.

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Diseases, Ninth Revision, Clinical Modification **While US hospitals use ICD-9 procedure codes most physicians use the CPT codes. Both hospitals & physicians use ICD-9 diagnosis codes.		ICD-9-CM consists of: • a tabular list containing a numerical list of the disease code numbers; • an alphabetical index to the disease entries; and • a classification system for surgical, diagnostic, and therapeutic procedures The National Center for Health Statistics (NCHS) and **CMS** are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM. US providers, insurers and others that use, bill with, pay and collect data using these codes have been struggling toward conversion to ICD-10 - which requires changing computer systems, forms, etc. The federal government has finalized a 1-year delay in the compliance deadline for the nationwide conversion to ICD-10 code sets A delay, first proposed in April, will move the compliance deadline to Oct. 1, 2014. The WHO completed work on ICD-10 in 1992 and much of the world has used that coding system since the late 1990's and efforts are going toward ICD-11.
Managed Care		Managed care tried to change health care financing by changing the incentives. Fee-for-service health care encourages provision of health care services. In managed care, doctors and other health care providers make a profit by providing only the services absolutely necessary in treating patients and by maintaining the health of its members. Funding method is most often **capitation**. Managed care combines health insurance and service provision into one organization, taking the insurance approach further. For a fixed fee (usually per patient per month), the managed care company agrees to provide a package of services. With a fixed amount of money for the task, providers are incentivized to conserve funds. The motivation to contain costs is strong because the market advantage lies in offering lower costs in exchange for restricted options. A chief characteristic of managed care is the use of a panel or network of health care providers to provide care to enrollees. These usually include: • A network of designated doctors and health care facilities, which furnish an array of health care services to enrollees • Explicit standards for selecting providers • Formal utilization review and quality improvement programs • Emphasis on preventive care • Financial incentives to encourage enrollees to use care efficiently Patients going outside plan networks would have to pay the full cost of care. These networks may reduce costs by negotiating favorable fees from providers, selecting cost effective providers, and creating financial incentives for providers to practice more efficiently. Most people think of health maintenance organizations (HMO) when hearing about Managed Care. This name was given to prepaid group practices around 1970 & which emphasized health promotion and prevention. HMOs grew when Congress enacted the Health Maintenance Organization Act of

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		1973. This legislation promised start-up grants and loans to HMOs that offered at least a minimum level of benefits, charged premiums based on community-wide health care costs, and met criteria for federal certification. It also required every business with more than 50 employees to offer enrollment in federally qualified HMOs as a benefit option whenever such HMOs existed in the area. From http://aspe.hhs.gov/Progsys/forum/basics.htm & Wikipedia There are other models such as Preferred Provider Organizations where patients are incentivized to use providers in the preferred network but can go outside it in exchange for higher copays or other variations on shared payment. Some for-profit entities changed the managed care concept to one of restraining care – even necessary care - in favor of profits.
Managed Care Entities	**MCE**	Term used in **MassHealth** materials
MA Patient Centered Medical Home Initiative	**PCMH**	3-year multi-payer EOHHS demonstration in MA with 46 primary care practices. They receive TA to help them develop teams, re-focus their work into **PCMH**s. Some also receive enhanced payment to incentivize changes.
MassHealth		The name given to **Medicaid** in Massachusetts
The Massachusetts Child Psychiatry Access Project	**MCPAP**	An interdisciplinary healthcare initiative that assists primary care providers (PCPs) who treat children and adolescents for psychiatric conditions.
Massachusetts eHealth Institute	**MeHI**	Health IT: A division of the Massachusetts Technology Collaborative, is leading the state's efforts to further innovation in health IT across the Commonwealth. MeHI, established by an act of the Legislature, is the state's entity for health care innovation, technology, and competitiveness and is responsible for advancing the dissemination of health information technology throughout Massachusetts, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange. It recently launched a "Last Mile" program to help provider organizations and their electronic health record (EHR) vendors connect to the statewide HIE. The Massachusetts eHealth Collaborative (MAeHC) is conducting a brief survey to help HIE project leaders to understand the current and planned adoption of EHRs in the Commonwealth, to identify those EHR vendors that have a large number of Massachusetts customers on their products, and to identify how the "Last Mile" program can most effectively and efficiently help healthcare providers connect to the statewide HIE. MAeHC is reaching out to member organizations that serve Behavioral Health professionals for help distributing the survey and reaching providers.

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		MeHI is one of 62 federally-designated Regional Extension Centers (REC) and is the designated REC for the Commonwealth of Massachusetts. These are modeled after the USDA extension centers around the country offering technical assistance and pointing to available resources.
Meaningful use		Health IT: The meaningful use rule is part of a coordinated set of regulations to help create a private, secure 21st-century electronic health information system. In June 2010, Dept of HHS issued a rule that laid out a process for the certification of electronic health records, so that providers could be assured their **EHRs** are capable of meaningful use. The department also issued still another regulation that lays out the standards & certification criteria that EHRs must meet in order to be certified. Finally, realizing that the privacy & security of EHRs are vital, the DHHS has worked to safeguard privacy and security by implementing new protections contained in the **HITECH** legislation. The meaningful use rule strikes a balance between acknowledging the urgency of adopting EHRs to improve our health care system & recognizing the challenges that adoption will pose to health care providers. The process is being "…calibrated to reflect both the capacities of providers who face a multitude of real-world challenges and the maturity of the technology itself. DHHS has also established a nationwide network of Regional Extension Centers to help providers adopt qualified EHRs & making meaningful use of them
Measure Applications Partnership [1]	**MAP**	Public-private partnership convened by the **National Quality Forum - NQF**- which provides advice to US Dept. of Health and Human Services on quality measures for public reporting, performance-based payment programs and other purposes. The group encouraged alignment of public and private sector efforts so performance measurement and measure selection is balanced across stakeholders[2]
Medicaid		Federal/State funded program providing medical assistance and benefit programs for people at certain low income levels. Reimbursement for certain basic services is required and for others it is optional and up to the state (though much more complex). Medicaid in Massachusetts is known as MassHealth. Massachusetts has **CMS** waivers that allow for some of its health reform programs and options. Medicaid is administered by states and funded with state and federal funds.
Medicaid Waivers		Section 1115 waivers give states flexibility to design and improve their Medicaid and **CHIP** programs. Waivers let states test new or existing ways to deliver and pay for program coverage 1915(b) Waivers are one of several options available to states that allow the use of Managed Care in the Medicaid Program. When using 1915(b), states have four different options: • [1915(b)(1)] - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid

		benefits • [1915(b)(2)] - Allow a county or local government to act as a choice counselor or enrollment broker) to help people pick a managed care plan • [1915(b)(3)] - Use the savings that the state gets from a managed care delivery system to provide additional services • [1915(b)(4)] - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation) 1915(c) Home and Community Based (HCBS) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.
Medicare		Federal health insurance for people 65+, people under 65 with certain disabilities, and people with End Stage Renal Disease.
Medicare Part A		Financed by payroll contributions (now broken out of **FICA**). There is no premium for most beneficiaries. Hospital & SNF (not long term care) coverage, some hospice. Deductible & copays kick in only after relatively long stays.
Medicare Part B		Outpatient physician, X-Ray, Lab, medical equipment, etc.coverage. Funded thru premiums & general tax revenue based on a complex formula. Penalties apply if not applied for on time. Premium is now income based – higher income people have higher premiums. Administered regionally by health plans/insurers such as Blue Cross/BlueShield.
Medicare Part C		Medicare Managed Care (Uses funding from A&B premium dollars. Premiums go to private health plans) aka Medicare Advantage Plans
Medicare Part D		Prescription Drug Coverage – restrictions apply. Formulary. Additional premium. Doughnut hole - no coverage when certain limits are reached, then benefits available after certain out of pocket amounts spent.
Mobile Crisis Intervention	**MCI**	DMH - Service provided by local **Emergency Services Providers (ESPs)**; Short-term (up to 72 hours), mobile, on-site, face-to-face crisis intervention; Therapeutic response to a **MassHealth**-enrolled child's mental health crisis by trained crisis professionals; available in in any setting where the child is naturally located, including home, school, childcare centers, respite settings; Provides follow-up to other services.

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National Committee for Quality Assurance **From NCQA site**	**NCQA**	Private, not-for-profit organization dedicated to improving health care quality; central driver for health care system improvements & elevating health care quality in the national agenda. Its seal is a widely recognized symbol of quality. Organizations using the seal in advertising & marketing materials must first pass a rigorous, comprehensive review & must annually report on their performance. That seal is a reliable indicator that an organization is well-managed & delivers high quality care & service for consumer and employer purchasers. Health plans in every state, the DC & Puerto Rico are NCQA accredited. These plans cover 109 million or 70.5% of all Americans enrolled in health plans. NCQA has helped build consensus around important health care quality issues thru work with large employers, policymakers, doctors, patients & health plans. Quality standards & performance measures for a broad range of health care entities have been developed, including identifying & addressing addiction. Annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use results to set improvement agendas for the next year. Accredited health plans today face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas to earn NCQA's seal of approval. More stringent standards are being developed. These standards will promote the adoption of strategies to improve care, enhance service and reduce costs, such as paying providers based on performance, leveraging the Web to give consumers more information, disease management and physician-level measurement.
Nationwide Health Information Network Exchange[1]	**NHIN**	Health IT: Set of standards, services, & policies that enable secure HIE over the internet to encourage information exchange. In 2009 the network served 500 hospitals and more than 4,000 provider organizations nationwide.
National Quality Forum **From NQF site**	**NQF**	Not for profit, private sector standard-setting organization whose efforts center on the evaluation & endorsement of standardized performance measurement. In collaboration with a diverse group of member healthcare stakeholders, NQF works to improve the quality of American healthcare by infusing daily health practices with higher standards and routine measures of how & when patients' needs are being effectively and efficiently met. NQF evaluates & endorses tools for standardized performance measurement, including: performance measures that assess structure, process, outcomes, & patient perceptions of care; preferred practices that suggest a specific process that, when executed effectively, lead to improved patient outcomes; & frameworks that provide a conceptual approach to organizing practices.
Office of the National Coordinator for Health IT **From ONC website**	**ONC**	Health IT: In the Office of the Secretary for the US DHHS, ONC is the principal Federal entity charged with coordination of nationwide efforts to implement & use the most advanced health IT & the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, & legislatively mandated in the **Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009**.

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		ONC's mission includes: • Promoting development of a nationwide Health IT infrastructure that allows for electronic use and exchange of information that: o Ensures secure & protected patient health information o Improves health care quality o Reduces health care costs o Informs medical decisions at the time/place of care o Includes meaningful public input in infrastructure development o Improves coordination of care & information among hospitals, labs, physicians, etc. o Improves public health activities & facilitates early identification/rapid response to public health emergencies o Facilitates health and clinical research o Promotes early detection, prevention, & management of chronic diseases o Promotes a more effective marketplace o Improves efforts to reduce health disparities • Providing leadership in the development, recognition, & implementation of standards & the certification of Health IT products; • Health IT policy coordination; Strategic planning for Health IT adoption & health information exchange; and • Establishing governance for the **Nationwide Health Information Network**.
Patient Portals or personal health records	**PHR**	Technologies that allow patients to access their health information & facilitate patient reported data. Use to-date is low. They vary in ownership & amount/types of information available. Health-related online applications that allow patients to interact & communicate with their healthcare providers, such as physicians and hospitals. Portal services are usually available on the Internet 24/7. Some patient portal applications are stand-alone web sites purchased by healthcare providers. Other portal applications are integrated into the provider's existing web site. Or some are modules added onto an existing electronic medical record system. All variations allow patients to interact with their medical information *via* the Internet & all must deal with security/privacy issues. Lines between an **EMR**, a personal health record, and a patient portal in some settings have begun to blur.
Patient Protection and Affordable Care Act of 2010		aka Affordable Care Act aka "Obamacare:" US Federal statute that is principle healthcare reform legislation. Reforms certain aspects of private & public health insurance programs, increases insurance coverage of pre-existing conditions, expands access to insurance to over 30 million more Americans, & increases projected national medical spending while lowering projected **Medicare** spending, encourages and incents prevention, public health, evidence based practices.
Patient Self Management		Activated patient/consumer who possesses skills to manage their own care, collaborate with providers and manage their health.
Person Centered Medical Home	**PCMH**	The PCMH focus is on 5 main elements: Care that is Comprehensive, Patient Centered, Coordinated, Accessible and Safe/quality. The PCMH is

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AKA **Patient Centered Medical Home or Health Home**		accountable for meeting most of each patient's physical & mental health care needs, including prevention and wellness, acute care, and chronic care. A team of care providers might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Smaller practices may build virtual teams linking themselves and their patients to community providers and services. Partnering with patients/families requires understanding & respect for each patient's unique needs, culture, values, and preferences; active support for patients in learning to manage and organize their own care. PCMHs are expected to coordinate care across all parts of the broader health care system, including specialty care, hospitals, home health care, & community services and supports - critical during transitions between sites of care. Short waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, & alternative methods of communication such as email & telephone care are also needed. A commitment to quality, ongoing improvement; use of evidence-based medicine & clinical decision-support tools to guide shared decision making, performance measurement & improvement, patient satisfaction, & population health management. PCMHs must also focus on IT, payment reform, & workforce development. See http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home for PCMH principles
Physician Consortium for Performance Improvement[1]	**PCPI**	A subgroup of the American Medical Assn - AMA - one of the leading US quality measure developers. Identifies, develops, tests & implements measures & is a leading force in enabling use of measures in **EHRs**. In 2008 this group developed clinical performance measures on screening and brief counseling for tobacco use & for unhealthy alcohol use along with other behavioral issues.
Program of All-Inclusive Care for the Elderly	**PACE**	Comprehensive service delivery and financing that integrates medical and long term services under **Medicare** & **Medicaid**. Program intent is to keep people who meet skilled nursing facility level of care criteria at home. Limited to PACE service areas.
Program of Assertive Community Treatment www.mass.gov	**PACT**	DMH - A multi-disciplinary team approach to providing acute, active, ongoing, & long-term community-based psychiatric treatment, assertive outreach, rehabilitation & support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope & empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community & are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.
Registries		A registry is a list of all the patients in a practice who share some characteristic, such as a certain condition or medication regimen. By tracking patients by a disease state (like diabetes), physicians can better

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		organize patient care. Registries can go further & produce detailed reports on both individuals & patient populations. They can provide reminders (e.g. to check a patient's hemoglobin A1c level) & also ID patients who aren't receiving a certain level of care. Seen as a key element in collecting & tracking how well practices are meeting treatment goals.
Risk adjustment		Use of patient level information to explain variation in healthcare spending, resource utilization & health outcomes for a fixed interval of time --e.g. a year -- OR use of information to calculate the expected health expenditures of individual patients over a fixed interval of time OR payment based on observable characteristics of the patient. A way to try to predict resource use for individuals/determine best payment formula for **capitated** payments for a given individual.
Serious Mental Illness **From NAMI website**	**SMI**	Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others & daily functioning; conditions that often result in a diminished capacity for coping with the ordinary demands of life. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) & borderline personality disorder. Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.
Skilled Nursing Facility	**SNF**	Facility that provides skilled nursing or rehabilitation staff (RNs, physical and occupational therapists, speech –language therapists and/or audiologists) & services to treat, manage, observe and evaluate care. Focus is care to restore function – usually relatively short term.
Specialing		DMH term - Therapeutic services provided in a variety of 24-hour settings on a one-to-one basis to provide for individual's safety. Constant attendance of a professional staff member on a disturbed patient to protect the patient from harming the self or others and to observe the patient's behavior.
State Children's Health Insurance Program	**SCHIP**	See **Children's Health Insurance Program**
State Health Policy Consortium/Behavioral Health Data Exchange Consortium		National: Established March, 2010 through an HHS contract with RTI International, the SHPC works to facilitate groups of states in resolving policy issues to enable the interstate exchange of electronic health information. Groups of 3 or more states can apply for support services--virtual & in-person meeting resources, policy and legal research, & technical & business architecture expertise -- related to approved multistate Consortium activities. It does not appear that Massachusetts is part of a group of states yet.

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		As of May 2012, over 28 states have been involved in a wide variety of collaborative projects that tackle cutting-edge questions related to interstate exchange in the areas of consent management, disaster preparedness & response, exchange of behavioral health data, regional trust anchors to support HISP connectivity and centralized Direct provider directories, and engaging **HIE**s & the vendor community in the reuse of interfaces, documentation and other assets related to the development of HIE & **HIT** infrastructure.
Statewide Quality Advisory Committee **www.mass.gov**	**SQAC**	Charged with making recommendations for how health care providers, facilities & provider groups report publicly on health care quality. The committee will make its selection from existing state & national quality measures & provide recommendations on which ones Massachusetts should adopt as standard measures for health care quality
Stop-loss		Stop-loss is insurance coverage for businesses that self-fund, or self-insure, their own employee health benefit plans. These employers pay employees' health claims from their own dedicated accounts rather than pay an insurer & contract with companies (third-party administrators) to administer the health plan for each employee. Most large companies are self-insured. By self-funding, businesses take on the risk of employee health care expenses and may save some administrative costs. Stop-loss is a layer of protection should health claims exceed a certain threshold. There are two types of stop-loss: - Specific stop-loss covers extreme losses for a covered individual. For example, an employee has a catastrophic illness or injury with extraordinary medical bills. Specific stop-loss coverage would kick in when the bills exceed a certain level defined in the policy. - Aggregate stop-loss coverage protects employers when total claims by the entire group exceed a certain level, such as 125% of the cost of projected claims.
The Joint Commission	**TJC**	The nation's largest health care accreditation body; accredits more than 19,000 health care organizations & programs in the US. This year TJC included (voluntary) substance abuse and tobacco as new core measures as indicators of an inpatient hospital organization's performance. These measures can inform onsite accreditation activities and facility reporting.
Transition Care Unit **www.mass.gov DMH**	**TCU**	DMH - A community-based therapeutic program offering high levels of supervision, structure & intensity of service within an unlocked setting. The program serves children & adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care & no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.

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Wraparound		DMH - Structured team-based process for developing & implementing individualized Care Plans for youth; process is facilitated by a Care Coordinator (MA or BA clinician); strong emphasis on working in partnership with family & youth: engagement, respect, collaboration, promoting youth & family "voice and choice;" Process must be culturally informed to be effective; A powerful approach to engaging families, & to making gains that can be sustained in the long run; Especially appropriate for youth/families with complex needs &/or multiple service providers/systems

1. Quality Measurement Enabled by Health IT: Overview, Possibilities And Challenges, www.AHRQ.gov

2. David Blumenthal and Marilyn Tavenner. The "Meaningful Use" Regulation for Electronic Health Records. N Engl J Med 2010; 363:501-504August 5, 2010

3. Michael Bailit and Megan Burns. Issue Brief: Bundled Payment Across the US Today: Status of Implementatino and Operational Findings. Healthcare Incentives Improvement Institute

Learn More

SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/

The Commonwealth Fund (not Massachusetts) http://www.commonwealthfund.org/

Patient Centered Primary Care Collaborative http://www.pcpcc.net/