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Health Care Glossary

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This document is a work in progress. Please email your suggestions for additions to Sukhsimranjit Singh, DRI Postgraduate Fellow ssingh01@hamline.edu. No claim is made that this is a comprehensive catalogue of resources; rather this Glossary has been intentionally limited to commonly used health care terms related to the anticipated themes of the Symposium. We hope the Glossary will be helpful to all those participating, as well as for those with general interest in the field.

AHCPR (Agency for Health Care Policy and Research): Created in December, 1989, this Public Health Service agency within the U.S. Department of Health and Human Services reported to the Secretary. Its mission was to support research designed to improve the outcomes and quality of health care. It became the AHRQ in 1999.¹

AHP (Accountable Health Partnership): An organization of doctors and hospitals that provides care for people organized into large groups of purchasers.

AHP (Accountable Health Plan): “AHPs can be IDSs, MCOs, Health Networks, partnerships or joint ventures between practitioners, providers or payers that would assume responsibility for delivering medical care and managing the funds required to pay for the services rendered. Physicians and other providers would work for, contract with or own these health plans. When an IDS or hospital group or IPA operates one or more health insurance benefit products, or a managed care organization acquires a large scale medical delivery component, it qualifies as an Accountable Health System or Accountable Health Plan.”²

AHRQ (Agency for Healthcare Research and Quality): Formerly the Agency for Health Care Policy and Research (AHCPR), AHRQ’s mission is to support research designed to improve the

¹ Agency for Healthcare Research and Quality, <http://www.ahrq.gov>.

² Pam Pohly’s Net Guide, *Managed Care & Health Care Terminology*, <http://www.pohly.com/terms.html> (last visited Oct. 14, 2007) (providing an extensive glossary of terms).

outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services.³

APDRG: (All Patient Diagnosis Related Groups): “An enhancement of the original DRG’s, designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases.”⁴

Accreditation: The process by which an organization recognizes a provider, a program of study or an institution as meeting predetermined standards. Two organizations that accredit managed care plans are the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO also accredits hospitals and clinics. CARF accredits rehabilitation providers.⁵

Affiliated Provider: A health care provider or facility that is part of the Health Maintenance Organization (HMO) network usually having formal arrangements to provide services to the HMO member.

Beneficiary: “An individual who receives benefits from or is covered by an insurance policy or other health care financing program.”⁶

CAHPS (Consumer Assessment of Health Plans): Funded by AHRQ; it is a five year project to help consumers identify the best health care plans and services for their needs.

CME (Continuing Medical Education): Formal education for health professionals after their degree and full time post-graduate training.

CON (Certificate of Need): A certificate that an individual or organization needs to receive to construct or modify a health facility. Such certificate is also needed if the individual or organization is planning to offer a new or different health service.

Coverage: The guarantee against specific losses provided under the terms of an insurance policy. Coverage is sometimes used interchangeably with benefits.

Deductible: “The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insured will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed-dollar amounts or the value of specified services (such as two days of hospital care or one physician visit.)”⁷

³ AcademyHealth, *Glossary*, <http://www.academyhealth.org/publications/glossary.pdf> (last visited October 14, 2007) (offering a detailed healthcare glossary. Cited extensively throughout this publication, AcademyHealth’s Glossary is a valuable resource for those undertaking healthcare research).

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

EMTALA (The Federal Emergency Medical Treatment and Labor Act): “EMTALA was enacted in response to widespread ‘patient dumping,’ a practice in which patients are transferred from one hospital’s emergency room to another’s for admission.”⁸ EMTALA applies only to hospitals that accept payment from Medicare and operate an emergency department. EMTALA does not require a hospital to offer emergency room services, although some state statutes do and federal tax strongly encourages tax-exempt hospitals to offer such services.⁹

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment): A program mandated by law as part of the Medicaid program. This is a program for eligible children under 21 to ascertain their physical or mental defects. All states in the United States are mandated to impose this initiative.

ERISA (The Employee Retirement Income Security Act of 1974): ERISA provides its beneficiaries with a positive right to sue to recover denied benefits, while also imposing fiduciary obligations on plan fiduciaries. ERISA’s primary role throughout the 1980’s and 1990’s was deregulatory, as its preemptive provisions repeatedly blocked state common law actions against health plans as well as state attempts at plan regulation.¹⁰

HMO (Health Maintenance Organization): This is a broad term that generally refers to any organized plan other than a traditional health insurance company that provides for an individual’s health care. Some plans are very tightly structured so that all care is provided by the HMO’s employees in the HMO’s hospitals or clinics, while other plans are cooperative agreements among independent doctors, hospitals and other health care providers.¹¹

IDS (An Integrated delivery system): IDS is a vehicle in which an enumerated list of health care services are provided to enrollees while implementing cost and quality control mechanisms designed to create efficiencies. IDSs are formed for a variety of reasons:

1. to create a contracting force in the marketplace;
2. to increase market leverage and access to both the provider and IDS;
3. to maintain a level of autonomy and control where the IDS is provider owned;
4. to boost profit margins by controlling access and cost; and
5. to apportion or otherwise control risks associated with the delivery of health care.¹²

IPA (Independent Practice Association): “The independent practice association is typically a physician-organized entity that contracts with payers on behalf of its members physicians. The typical IPA negotiates contracts with insurers and pays physicians on a fee-for-service basis with a withhold. Physicians may maintain significant business outside IPA, join multiple IPA’s,

⁸ BARRY R. FURROW, ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 538 (5th ed. 2004).

⁹ *Id.*

¹⁰ *Id.* at 644.

¹¹ DELILAH BRUMMET FLAUM & DIANE J. ROMZA-KUTZ, *An Overview of Managed Care Organizations: Sorting Out the Alphabet Soup*, in MANAGED CARE LIABILITY (Am B. Ass’n 1996). See also MANAGED CARE LIABILITY: EXAMINING RISKS AND RESPONSIBILITIES IN A CHANGING HEALTH CARE SYSTEM (David L. Leitner, ed. Tort and Insurance Practice Section, Am. B. Ass’n 1997) (examining and elaborating upon contemporary healthcare policy).

¹² *Id.*

retain ownership of their own practices, and typically continue in their traditional style of practice.”¹³

Informed Consent: “The doctrine that a consent effective as authority to form therapy can arise only from the patient’s understanding of alternatives to and risks of the therapy is commonly denominated ‘informed consent.’”¹⁴

JCAHO (Joint Commission on Accreditation of Healthcare Organizations): A national private, nonprofit organization whose purpose is to encourage the attainment of uniformly high standards of institutional medical care. Establishes guidelines for the operation of hospitals and other health facilities and conducts survey and accreditation programs.¹⁵

MCO (Managed Care Organization): A health plan that seeks to manage care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis.

Managed Care: “A body of clinical, financial and organizational activities designed to ensure the provision of appropriate health care services in a cost-efficient manner. Managed care techniques are most often practiced by organizations and professionals that assume risk for a defined population (e.g. health maintenance organizations.)”¹⁶

Medical Error: The failure of a planned action to be completed as intended (error of execution) or the use of a wrong plan to achieve an aim (error of planning).¹⁷ Medical error is a major source of iatrogenesis-disease or illness induced by medical treatment or diagnosis. Such iatrogenesis has also been characterized as medical misadventure.¹⁸

PCCM (Primary Care management): The use of a primary care physician to manage the use of medical or surgical care. PCCM programs usually pay for all care in a free for service basis.

PCP (Primary Care Provider): A generalist physician (family practice, general internal medicine, general pediatrics, and sometimes obstetrics/gynecology for female patients) who provides primary care services.¹⁹

PHO (Physician-Hospital Organization): A legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives. Doctors maintain ownership of their practices and agree to accept managed care patients according to the terms of

¹³ FURROW, ET AL., *supra* note 8 at 908.

¹⁴ See, e.g., Jon R. Waltz & Thomas W. Scheunemann, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970) (providing early analysis of the professional standard of informed consent).

¹⁵ AcademyHealth, *supra* note 3.

¹⁶ *Id.*

¹⁷ Ohio Hospice & Palliative Care Organization, *Health Care Glossary* http://www.ohpco.org/health_care_glossary.htm (last visited October 14, 2007).

¹⁸ FURROW, ET AL., *supra* note 8 at 27.

¹⁹ AcademyHealth, *supra* note 3.

a professional services agreement with the PHO. The PHO serves as a collective negotiating and contracting unit.²⁰

POS (Point of Service): Overlaying the HMO and PPO structure are POS plans. These are considered hybrids or outgrowths of traditional HMO and PPO delivery systems. These plans have primary physicians which may be reimbursed on a captivated type basis and often combine such payment with withholds.

PPA (Preferred Provider Arrangement): Selective contracting with a limited number of health care providers, often at reduced or pre-negotiated rates of payment.

PPO (Preferred Provider Organization): A second long-standing type of IDS is a PPO. This incentive encourages the enrollee to receive health care services from a designated panel of “preferred” providers which have contracted with the PPO.²¹

Peer Review: Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers).

Primary Payer: “The insurer obligated to pay losses before any liability is assumed by other, secondary insurers. Medicare, for instance, is a primary payer with respect to Medicaid.”²²

Utilization Review: Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. In a hospital, utilization review includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices both on a concurrent and retrospective basis. Utilization review can be done by a peer review group or a public agency.²³

Voluntary Reporting: A medical error reporting system where the reporter chooses to report an error in order to prevent similar errors from occurring in the future.²⁴

²⁰ FURROW, ET AL., *supra* note 8 at 909, also defined as, “The physician-hospital organization is an organization that contracts with payers on behalf of the hospital and its affiliated physicians. The organization is responsible for negotiating health plan contracts, and in some cases, conducting utilization review, credentialing, and quality assurance.” *Id.*

²¹ *Id.* at 5.

²² AcademyHealth, *supra* note 3.

²³ *Id.*

²⁴ *Id.*

Additional Resources for Health Care Terminology

Book

VERGIL SLEE, DEBORA SLEE & H. JOACHIM SCHMIDT, SLEE'S HEALTH CARE TERMS (4th ed. 2001)

Web-Resources

AcademyHealth publishes the basic Glossary of health care terms.

Available at: <http://www.academyhealth.org/publications/glossary.htm>

American Association for Respiratory Care maintains Health care Glossary.

Available at: <http://www.aarc.org/advocacy/resources/glossary.html>

Blue Cross Blue Shield Association has a Healthcare Coverage Glossary webpage.

Available at: <http://www.bcbs.com/coverage/glossary/>

Cigna publishes a user friendly Glossary.

Available at: <http://www.cigna.com/glossary/glossary.html>

The Delaware Healthcare Association has compiled a Glossary of Health Care Terms and Acronyms.

Available at: <http://www.deha.org/> (click "Health Care Professional Resources." On the intervening page, click "Glossary")

Glossary of Terms in Managed Health Care: A collection of the definitions of commonly used terms in the medical provider, hospital and managed care industries.

Available at: <http://www.pohly.com/terms.html>

Glossary of 'Natural Health Care' Terms provides a rich source online.

Available at: <http://www.nwhealth.edu/healthyu/liveNaturally/gloss.html>

Minnesota Department of Health maintains a commonly used Health Care Terms Glossary.

Available at <http://www.health.state.mn.us/clearinghouse/glossary.htm>

Postdoctoral Scholars at Stanford University maintains specific Glossary of Health Care terms.

Available at: http://postdocs.stanford.edu/benefits/health_terms_glos.html

Ohio Hospice and Palliative Care Organization have a Glossary of Health Care Terms; which was last updated on 16/1/2007.

Available at: http://www.ohpco.org/health_care_glossary.htm

Ohio Hospital Association maintains a useful body of Glossary and Acronyms of Health Care terms.

Available at: <http://www.ohanet.org/publications/glossary.htm>

UW School of Public Health and Community Medicine, Health Services Library Information Center has a Glossary of Health Care and Health Care Management Terms.

Available at: <http://depts.washington.edu/hsic/resource/glossary.html>

United States Department of Justice carries a webpage containing important terms in Health Care Glossary.

Available at: http://www.usdoj.gov/atr/public/health_care/204694/appendixc.htm

University of Illinois at Chicago maintains a Health Care Glossary.

Available at: <http://www.uic.edu/sph/cade/abcmco/basics/gloss.html>

United States Department of Health and Human Services maintains an exclusive glossary section for Managed care terms.

Available at: <http://aspe.os.dhhs.gov/Progsys/Forum/mcobib.htm>