

APPENDIX M. GLOSSARY

Accountable Care Organization (ACO)

An ACO is a type of payment and delivery reform model that ties provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers form an ACO, which then provides care to a group of patients. The ACO may use a range of different payment models, which include capitation or fee-for-service. The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided.¹

Basic Activities of Daily Living (ADLs)

Basic ADLs are those skills needed in typical daily self-care, such as bathing, dressing, feeding, and toileting.²

Center for Medicare and Medicaid Innovation (Innovation Center)

The Innovation Center identifies, creates, tests, and evaluates new payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. Several of the Innovation Center's models are testing the use of HIT in payment and payment and service delivery models, including the Health Care Innovation Awards and Pioneer Accountable Care Organization models.

Continuity of Care Document (CCD)

The CCD specification is an XML-based markup standard intended to specify the encoding, structure and semantics of a patient summary clinical document for exchange. The CCD specification is a constraint on the Health Level 7 Clinical Document Architecture standard. The patient summary contains a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's health care, covering one or more health care encounters. It provides a means for one health care practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system, or setting to support the continuity of care. Its primary use case is to provide a snapshot in time containing the pertinent clinical, demographic, and administrative data for a specific patient.³

¹ Accountable Care Organizations (ACOs). See http://www.acofp.org/Practice_Management/ACO/Medical_Home/, accessed March 2013.

² Encyclopedia of Nursing and Allied Health, ©2002 Gale Cengage. All Rights Reserved. Full copyright.

³ Continuity of Care Document. See http://en.wikipedia.org/wiki/Continuity_of_Care_Document.

Clinical Document Architecture (CDA)

The CDA is a document markup standard that specifies the structure and semantics of clinical documents. A CDA document is a defined and complete information object that can include text, images, sounds, and other multimedia content. The document can be sent inside a Health Level 7 message and can exist independently, outside a transferring message. The first release of the standard filled an important gap by addressing common and largely narrative clinical notes. It left out certain advanced and complex semantics, both to foster broad implementation and to give time for these complex semantics to be fleshed out within Health Level 7. Being a part of the emerging Health Level 7 version 3 family of standards, the CDA derives its semantic content from the shared Health Level 7 Reference Information Model and is implemented in Extensible Markup Language. The Health Level 7 mission is to develop standards that enable semantic interoperability across all platforms.⁴

Consolidated Clinical Document Architecture (CCDA)

CCDA is a consolidated library of reusable Clinical Document Architecture templates for nine common document types, including the Continuity of Care Document based on a consistent framework of document sections and representation of different types of structured clinical data.⁵ A conceptual view is available at:

http://blogs.gartner.com/wes_rishel/2012/03/19/a-new-approach-to-clinical-interop-in-stage-2-meaningful-use/.

Direct Project

The Direct Project specifies a simple, secure, scalable, standards-based way for participants to send authenticated, encrypted health information directly to known, trusted recipients over the Internet. The Direct Project allows secure communication of health data among health care participants who already know and trust each other and thus is bound by a set of simplifying assumptions. The Direct Project assumes that the sender is responsible for several minimum requirements before sending data, including the collection of patient consent where appropriate.⁶

⁴ Dolin, RH, L Alschuler, C Beebe, PV Biron, SL Boyer, D Essin, and JE Mattison. (2001). The HL7 clinical document architecture. *Journal of the American Medical Informatics Association*, 8(6): 552-569. The National Alliance for Health Information Technology. Available at: U.S. Department of Health and Human Services. Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms. http://healthit.hhs.gov/defining_key_hit_terms, accessed June 4, 2012.

⁵ What is Consolidated CDA? See <http://www.hl7standards.com/blog/2012/03/22/consolidated-cda/>, accessed March 2013.

⁶ NwHIN Direct page. See <http://www.nhindirect.org/>.

Electronic Health Record (EHR)

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.⁷

Electronic Medical Record (EMR)

An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.⁸

Health Information Exchange (HIE)

The electronic movement of health-related information among organizations according to nationally recognized standards.⁹

Health Information Organization (HIEO)

An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.¹⁰

Health Insurance Portability and Accountability Act (HIPAA)

Provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information.¹¹

Instrumental Activities of Daily Living (IADLs)

IADLs refer to skills beyond basic self-care that evaluate how individuals function within their homes, workplaces, and social environments. IADLs may include typical domestic tasks, such as driving, cleaning, cooking, and shopping, as well as other less physically demanding tasks such as operating electronic appliances and handling budgets.¹²

⁷ Continuity of Care Document. See http://en.wikipedia.org/wiki/Continuity_of_Care_Document.

⁸ The National Alliance for Health Information Technology. Available at: Department of Health and Human Services. Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms. See http://healthit.hhs.gov/defining_key_hit_terms, accessed June 4, 2012.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

¹² Encyclopedia of Nursing and Allied Health, ©2002 Gale Cengage. All Rights Reserved. Full copyright.

Interoperability

Interoperability in health care is the ability of different information technology systems and software applications to communicate, to exchange data accurately, effectively and consistently, and to use the information that has been exchanged.¹³

Long-Term and Post-Acute Care (LTPAC)

LTPAC has been used to describe services across the spectrum of care such as including skilled nursing facilities, home care, hospice, long-term acute care hospitals, inpatient rehabilitation facilities, assisted living facilities, medication management, and independent care. There is no standard definition of LTPAC. Some LTPAC services include Long-Term Services and Supports (see below).¹⁴

Long-Term Services and Supports (LTSS)

LTSS are services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS include institutional and community-based services such as skilled nursing facilities, care management, adult day care, home-delivered meals, transportation providers, and other services.

Master Patient Index (MPI)

Individual providers and organizations that treat patients maintain an index of their patients, called a MPI. It contains the patient identifiers and the patient's identifying personal and demographic information. The MPI maintained by organizations are unique only within the organization. It serves as a directory of patients for ready reference, verification, and identification of the patient and patient information.¹⁵

Nationwide Health Information Network (NwHIN)

The NwHIN is the portfolio of nationally recognized services, standards and policies that enable secure Health Information Exchange over the Internet. Often also used as an umbrella term to describe the result of standards harmonization and pilot testing activities led by the U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology.¹⁶

¹³ Informed Medical Decisions Foundation. What is Shared Decision Making? See <http://informedmedicaldecisions.org/what-is-shared-decision-making/>.

¹⁴ LTPAC Health IT Collaborative. See <http://www.ltpachealthit.org/content/about-long-term-and-post-acute-care>.

¹⁵ Appavu, SI. Analysis of Unique Patient Identifier Options. Part 3: Unique Patient Identifier. Available at <http://www.nevhs.bhs.gov/app3.htm>, accessed April 24, 2012.

¹⁶ National eHealth Collaborative. 2012. Information Exchange Roadmap: The Landscape and a Path Forward.

Patient-Centered Care

Patient-centered care is health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.¹⁷

Patient and Consumer Engagement

Patient and consumer engagement is defined as “actions individuals must take to obtain the greatest benefit from the health care services available to them.”¹⁸

Personal Health Record (PHR)

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.¹⁹

Regional Health Information Organization (RHIO)

A health information organization that brings together health care stakeholders within a defined geographic area and governs Health Information Exchange among them for the purpose of improving health and care in that community.²⁰

Self-Management

Self-management is defined as consumer/patient initiative and responsibility for actions to maintain or improve health or manage a condition irrespective of specific clinical relationships.

Shared Care

Also referred to as “shared management of care,” is defined as the patient and the health care provider(s) working as a team, which may also include family/friend/lay caregivers designated by the patient, guided by the preferences and expectations of the patient.

¹⁷ Hurtado, MP, EK Swift, and J Corrigan. 2001. *Envisioning the National Health Care Quality Report*. National Academies Press.

¹⁸ *A New Definition for Patient Engagement: What is Engagement and Why is it Important?* Washington, DC: Center for Advancing Health; 2010.

¹⁹ The National Alliance for Health Information Technology. Available at: Department of Health and Human Services. Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms. See http://healthit.hhs.gov/defining_key_hit_terms, accessed June 4, 2012.

²⁰ Ibid.

Shared Decision-Making (SDM)

SDM is a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences.²¹

Standards

Published statement on a topic specifying the characteristics, usually measurable, that must be satisfied or achieved to comply with the standard; technical, functional, or performance-based, in this context.²²

Standards and Interoperability (S&I) Framework

The S&I Framework was adopted by the Office of the National Coordinator for Health Information Technology to harmonize interoperability specifications that support national health priorities. It is a robust network of providers, vendors, and experts from both the public and private sectors with a focus on providing tools, services, and guidance to facilitate the exchange of health information.

Virtual Health Record (VHR)

The Health Information Exchange interventions identified in this study referred to a VHR as a comprehensive electronic health record that was accessed using a secure browser.

²¹ Informed Medical Decisions Foundation. What is Shared Decision Making? See <http://informedmedicaldecisions.org/what-is-shared-decision-making/>.

²² The National Alliance for Health Information Technology. Available at: Department of Health and Human Services. Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms. See http://healthit.hhs.gov/defining_key_hit_terms, accessed June 4, 2012.

LONG-TERM AND POST-ACUTE CARE PROVIDERS ENGAGED IN HEALTH INFORMATION EXCHANGE: Final Report

Files Available for This Report

MAIN REPORT

Executive Summary <http://aspe.hhs.gov/daltcp/reports/2013/HIEengagees.shtml>
HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.pdf>

APPENDIX A. SELECTED PROGRAMS AND INITIATIVES THAT SUPPORT CARE COORDINATION AND INFORMATION EXCHANGE FOR PERSONS RECEIVING LTPAC/LTSS

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendA>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageA.pdf>

APPENDIX B. FRAMEWORK TO CHARACTERIZE HEALTH INFORMATION EXCHANGE TO SUPPORT CARE COORDINATION FOR PERSONS RECEIVING LTPAC/LTSS

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendB>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageB.pdf>

APPENDIX C. ENVIRONMENTAL SCAN AND LITERATURE REVIEW SOURCES

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendC>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageC.pdf>

APPENDIX D. PROMISING COMPONENTS AND INTERVENTIONS TO REDUCE READMISSIONS

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendD>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageD.pdf>

APPENDIX E. SUMMARY OF LITERATURE ON HEALTH INFORMATION EXCHANGE OUTCOMES AND RELATED MEASURES

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendE>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageE.pdf>

APPENDIX F. EXAMPLES OF COMMUNITY-BASED CARE TRANSITION PROGRAM WITH LTPAC/LTSS PARTICIPATION

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendF>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageF.pdf>

APPENDIX G. HEALTH INFORMATION EXCHANGE INTERVENTIONS AND ACTIVITIES IDENTIFIED THAT SUPPORT CARE COORDINATION FOR PERSONS RECEIVING LTPAC/LTSS

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendG>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageG.pdf>

APPENDIX H. SITE VISIT SUMMARY: RUSH UNIVERSITY MEDICAL CENTER, CARE TRANSITIONS PROGRAM, BRIDGE PROGRAM

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendH>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageH.pdf>

APPENDIX I. SITE VISIT SUMMARY: BEACHWOOD HOMES

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendI>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageI.pdf>

APPENDIX J. SITE VISIT SUMMARY: EASTERN MAINE HEALTH SYSTEM, EASTERN MAINE HOME CARE

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendJ>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageJ.pdf>

APPENDIX K. SUMMARY OF INFORMATION ROUTINELY EXCHANGED BY THE THREE SITES VISITED, BY CARE COORDINATION FUNCTION

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendK>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageK.pdf>

APPENDIX L. STANDARDS AVAILABLE TO SUPPORT HEALTH INFORMATION EXCHANGE OF LONG-TERM AND POST-ACUTE CARE DATA

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendL>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageL.pdf>

APPENDIX M. GLOSSARY

HTML <http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendM>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/HIEengageM.pdf>