aaPM&R
American Academy of
Physical Medicine and Rehabilitation

Quality Glossary

This glossary explains terms on the Quality Tab of the Website but is not a legal document.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

A

Accountable Care Organizations (ACOs) - Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. *[Centers for Medicare & Medicaid Services]*

Activity - The execution of a task or action by an individual. *[WHO-ICF]*

Activity Limitations - Difficulties an individual may have in executing activities. *[WHO-ICF]*

Affordable Care Act (ACA) - The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will "continue to be rolled out over the next four years." Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions.

Agency for Health Care Policy & Research (AHCPR) - The Nation's lead Federal agency for research on health care quality, costs, outcomes and patient safety

Agency for Healthcare Research & Quality (AHRQ) - Offers health care information, research findings, and data to help consumers, health providers, health insurers, researchers, and policymakers make informed decisions about health care issues

American Congress of Rehabilitation Medicine (ACRM) - Multidisciplinary organization promoting rehabilitation research

American with Disabilities Act of 1990 (ADA) -The Americans with Disabilities Act (ADA) gives civil rights protections to individuals with disabilities that are like those provided to individuals on the basis of race, sex, national origin, and religion. It guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, State and local government services, and telecommunications

American Medical Association (AMA) - Organization of Physicians focused on professional and public health issues

American Occupational Therapy Association (AOTA) – Provides information for consumers and practitioners of Occupational Therapy

American Physical Therapy Association (APTA) -Professional organization fostering advancements in physical therapy practice, research and education

American Speech-Language-Hearing Association (ASHA) - Professional, scientific and credentialing association for speech-language pathologists, audiologists and speech, language and hearing

Appropriate Use Criteria (AUC) - Appropriate Use Criteria (AUC) specify when it is appropriate to use a procedure. An "appropriate" procedure is one for which the expected health benefits exceed the expected health risks by a wide margin.

Authoritative Evidence - Written medical or scientific conclusions demonstrating the medical effectiveness of a service produced by the following:

- Controlled clinical trials, published in peer-reviewed medical or scientific journals;
- Controlled clinical trials completed and accepted for publication in peer-reviewed medical or scientific journals;
- Assessments initiated by CMS;
- Evaluations or studies initiated by Medicare contractors;
- Case studies published in peer-reviewed medical or scientific journals that present treatment protocols. *[Centers for Medicare & Medicaid Services]*

B

Benchmark - In health care refers to an attribute or achievement that serves as a standard for other providers or institutions to emulate. Benchmarks differ from other standard of care goals, in that they derive from empiric data—specifically, performance or outcomes data. For example, a statewide survey might produce risk-adjusted 30-day rates for death or other major adverse outcomes. After adjusting for relevant clinical factors, the top 10% of hospitals can be identified in terms of particular outcome measures. These institutions would then provide benchmark data on these outcomes. For instance, one might benchmark "door-to-balloon" time at 90 minutes, based on the observation that the top-performing hospitals all had door-to-balloon times in this range. In regard to infection control, benchmarks would typically be derived from national or regional data on the rates of relevant nosocomial infections. The lowest 10% of these rates might be regarded as benchmarks for other institutions to emulate. *[Agency for Healthcare Research & Quality]*

Benchmarking - A process of searching out and studying the best practices that produce superior performance. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same service or product (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).

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

Body Functions - Physiological functions of body systems (including psychological functions). *[WHO-ICF]*

Body Structures - Anatomical parts of the body such as organs, limbs and their components. *[WHO-ICF]*

C

Carrier Advisory Committee (CAC) - Committee made up of physicians representing each state specialty society along with the CMS fiscal intermediary medical directors

Commission on the Accreditation of Rehabilitation Facilities (CARF) -An independent, nonprofit organization focused on advancing the quality of rehabilitation CARF provides accreditation services worldwide

Consumer Assessment of Health Plans (CAHPS) -funded by the Agency for Health Care Policy and Research

(AHCPR), a federal agency in the U.S. Department of Health and Human Services (DHHS). The project, begun in 1995, is designed to develop and test survey instruments that can be used to obtain consumer evaluations of their experiences with health plans and services. The "standard survey" that is being developed and evaluated will include questions covering availability of care and providers, continuity of care, and technical quality of care, among other factors. The project also includes the development and testing of methods for providing information to consumers for use in making decisions about which health plan to enroll in. *[Agency for Healthcare Research & Quality]*

Centers for Disease Control and Prevention - An organization that maintains several code sets included in the HIPAA standards, including the ICD-9-CM codes.

Centers of Excellence - Healthcare facilities specially equipped for and specializing in difficult, complex, and expensive tertiary care procedures, such as kidney or other organ transplants, TBI, SCI, or coronary artery bypass surgery.

Centers for Medicare and Medicaid Services (CMS) - The federal agency that runs the Medicare program for the elderly and disabled individuals. In addition, CMS works with the states to run the Medicaid program for low-income individuals.

Certification Commission for Health Information Technology (CCHIT®) - Is an independent, 501(c)3 nonprofit organization with the public mission of accelerating the adoption of robust, interoperable health information technology. The Commission has been certifying electronic health record technology since 2006.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) -A health benefits program that provides authorized in-patient and out-patient care from civilian sources, on a cost-sharing basis. Those eligible are retired military, dependents of active-duty, retired and deceased military

Clinical Indicator - As quantitative measures that can be used to monitor and evaluate the quality of important governance, management, clinical, and support functions that affect patient outcomes *[Agency for Healthcare Research & Quality]*

Clinical Pathway - A patient care management tool that organizes, sequences, and times the major interventions of nursing staff, physicians, and other departments for a particular case type.

Clinical Performance - The degree of accomplishment of desired health objectives by a clinician or healthcare organization.

Clinical Performance Measure - A subtype of quality measure that is a mechanism for assessing the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in the optimal time period.

Clinical Practice Guideline - is defined as "systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances". *[Field MJ, Lohr KN (Eds). Clinical Practice Guidelines: Directions for a New Program, Institute of Medicine, Washington, DC: National Academy Press, 1990.]*

Computerized Physician Order Entry or Computerized Provider Order Entry (CPOE) - A computer-based system used for ordering medications and tests. Some CPOEs have enhanced capabilities for providing physicians with care protocols and other information.

Continuous Quality Improvement (CQI) - A management approach to improving and maintaining quality that emphasizes internally driven and relatively continuous assessments of potential causes of quality defects, followed by action aimed either at avoiding decrease in quality or else correcting it an early stage.

Consensus Statement – A written document that represents the collective opinions of a convened expert panel. The opinions expressed in the Consensus Statement are derived by a systematic approach and a traditional literature review where randomized control trials do not commonly exist. "Suggestions made" in Consensus Statements are derived by this standardized process. *[American College of Chest Physicians (ACCP)]*

Comprehensive Outpatient Rehabilitation Facility (CORF) - A facility that is primarily engaged in providing outpatient rehabilitation for the treatment of Medicare beneficiaries

Criteria - The expected levels of achievement or specifications against which performance can be assessed. *[Centers for Medicare & Medicaid Services]*

Current Procedural Technology (CPT) - A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions. *[Centers for Medicare & Medicaid Services]*

D

Decision Support - Refers to any system for advising or providing guidance about a particular clinical decision at the point of care. For example, a copy of an algorithm for antibiotic selection in patients with community acquired pneumonia would count as clinical decision support if made available at the point of care. Increasingly, decision support occurs via a computerized clinical information or order entry system. Computerized decision support includes any software employing a knowledge base designed to assist clinicians in decision making at the point of care.

Typically a decision support system responds to "triggers" or "flags"—specific diagnoses, laboratory results, medication choices, or complex combinations of such parameters—and provides information or recommendations directly relevant to a specific patient encounter. *[Agency for Healthcare Research & Quality]*

Department of Health and Human Services (DHHS) - The United States government's principal agency for protecting the health of all Americans and providing essential human services

Diagnosis Related Group (DRG) - A patient classification system adopted on the basis of diagnosis consisting of distinct groupings

Drug Enforcement Agency (DEA) - Enforces the controlled substances laws and regulations of the United States

E

Efficiency -The use of resources to get the best value. "The opposite of efficiency is waste" *[Institute of Medicine, Crossing the Quality Chasm, a new Health System for the 21st Century. Committee on Quality of Health Care in America. 2001, Washington, DC: national Academy Press, p.52.]*

Electronic Health Records (EHRs) - EHRs focus on the total health of the patient—going beyond standard clinical data collected in the provider's office and inclusive of a broader view on a patient's care. EHRs are designed to reach out *beyond* the health organization that originally collects and compiles the information. They are built to share information with other health care providers, such as laboratories and specialists, so they contain information from *all the clinicians involved in the patient's care*.

Electronic Medical Records (EMRs) - Are a digital version of the paper charts in the clinician's office. An EMR

contains the medical and treatment history of the patients in one practice.

Environmental Factors - Make up the physical, social and attitudinal environment in which people live and conduct their lives. *[WHO-ICF]*

Episode of Care - The health care services given during a certain period of time, usually during a hospital stay. *[Centers for Medicare & Medicaid Services]*

Eunice Shriver National Institute of Child Health and Human Development (NICHD)-Ensuring that every person is born healthy and wanted, that women suffer no harmful effects from the reproductive process and that all children have the change to fulfill their potential of a healthy and productive life, free of disease and disability

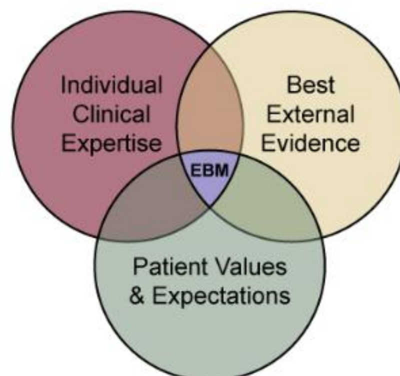
Evidence – The available body of facts or information indicating whether a belief or proposition is true or valid. See Levels of evidence for examples of evidence tables.

Evidence-based clinical practice -An approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best. *[Gray JAM. 1997. Evidence-based healthcare: how to make health policy and management decisions. London: Churchill Livingstone.]*

Evidence-based health care - The conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors. [*Cochrane AL. Effectiveness and Efficiency : Random Reflections on Health Services. London: Nuffield Provincial Hospitals Trust, 1972. Reprinted in 1989 in association with the BMJ. Reprinted in 1999 for Nuffield Trust by the Royal Society of Medicine Press, London (temporarily out of print; new edition scheduled for early 2013).]*

Evidence based medicine - The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. *[Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. 1996. Evidence based medicine: what it is and what it isn't. BMJ 312: 71–2]*

The Evidence-based Medicine Triad *[Source: Florida State University, College of Medicine]*



F

Functional Independence Measure (FIM®) -Provides a uniform system of measurement for disability based on

the International Classification of Impairment, Disabilities and Handicaps; measures the level of a patient's disability and indicates how much assistance is required for the individual to carry out activities of daily living

Functional Outcome Measure – Health status measures that go beyond traditional physiological assessments. By incorporating a multidimensional definition of health that encompasses physical, psychological and social aspects, functional outcome measures can capture the broader impact of disease and treatment on life from a patient's own perspective. *[National Resource Center for Health and Safety]*

G

Grades of Recommendation *[Levels of Evidence and Grades of Recommendation, Oxford Centre for Evidence-Based Medicine]*

A	Consistent level 1 studies
B	Consistent level 2 or 3 studies ***or*** extrapolations from level 1 studies
C	Level 4 studies ***or*** extrapolations from level 2 or 3 studies
D	Level 5 studies ***or*** troubling inconsistent or inconclusive studies of any level

H

Healthcare Common Procedural Coding System (HCPC) - A medical code set, selected for use in HIPAA transactions, that identifies health care procedures, equipment, and supplies

Health Care Quality - The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. *[Institute of Medicine, Medicare: A Strategy for Quality Assurance, ed. Lohr K. Vol. 2. 1990, Washington, DC: National Academy Press.]*

The Institute of Medicine further defines quality as having the following properties or domains:

- Effectiveness. Relates to providing care processes and achieving outcomes as supported by scientific evidence.
- Efficiency. Relates to maximizing the quality of a comparable unit of health care delivered or unit of health benefit achieved for a given unit of health care resources used.
- Equity. Relates to providing health care of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care.
- Patient centeredness. Relates to meeting patients' needs and preferences and providing education and support.
- Safety. Relates to actual or potential bodily harm.
- Timeliness. Relates to obtaining needed care while minimizing delays.

Health Care Quality Improvement Program (HCQIP) - A program, which supports the mission of CMS, to assure health care security for beneficiaries. The mission of HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to improving quality, monitoring and improving quality of care, communicating with beneficiaries and health care providers, practitioners, and plans to promote informed health choices, protecting beneficiaries from poor care, and strengthening the

infrastructure.

Applicable Programs

1. Ambulatory Surgical Center Quality Reporting
2. E-Prescribing Incentive Program
3. End Stage Renal Disease Quality Improvement Program
4. Home Health Quality Reporting
5. Hospice Quality Reporting
6. Hospital Acquired Condition Payment Reduction (ACA 3008)
7. Hospital Inpatient Quality Reporting
8. Hospital Outpatient Quality Reporting
9. Hospital Readmission Reduction Program
10. Hospital Value-Based Purchasing
11. Inpatient Psychiatric Facility Quality Reporting
12. Inpatient Rehabilitation Facility Quality Reporting
13. Long-term Care Hospital Quality Reporting
14. Medicare and Medicaid EHR Incentive Program for Eligible Professionals
15. Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs
16. Medicare Shared Savings Program
17. Medicare Physician Quality Reporting System (PQRS)
18. Physician Compare
19. Physician Feedback
20. Value-Based Modifier Program
21. Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting

Health Maintenance Organization (HMO) - A type of health insurance plan usually contracting with primary care physicians to be the gatekeeper of health care.

Health Plan Employer Data and Information Set (HEDIS) - A set of core performance measures designed by participating managed health plans and employers to respond to employers' needs to understand the value of their healthcare and to hold plans accountable for performance. HEDIS is sponsored by the National Committee for Quality Assurance. *[National Committee for Quality Assurance (NCQA)]*

HIPAA - Health Insurance Portability and Accountability Act. A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another, HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage, and you think it is based on past or present health.

HIPAA also:

- limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage;
- usually gives you credit for health coverage you have had in the past;
- may give you special help with group health coverage when you lose coverage or have a new dependent; and
- Generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

Home Health Agency (HHA) - Companies that provide short-term skilled nursing or rehabilitative services to homebound persons

I

Impairments - Problems in body function or structure such as a significant deviation or loss. *[WHO-ICF]*

Implementation Science – The study of methods to promote the integration of research findings and evidence into healthcare policy and practice. It seeks to understand the behavior of healthcare professionals and other stakeholders as a key variable in the sustainable uptake, adoption, and implementation of evidence-based interventions.

Inappropriate Utilization - Utilization of services that are in excess of a beneficiary's medical needs and condition (overutilization) or receiving a capitated Medicare payment and failing to provide services to meet a beneficiary's medical needs and condition (underutilization). *[Centers for Medicare & Medicaid Services]*

Inpatient Rehabilitation Facility (IRF) - A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients

Institute of Medicine (IOM) - An organization within the National Academy of Sciences that acts as an advisor in health and medicine and conducts policy studies relevant to health issues. The IOM was chartered in 1970 by National Academy of Science to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the health of the public. The IOM is an advisor to federal government on issues of medical care, research, and education

Instrumental Activities of Daily Living (IADL) - Refers to daily self-care activities within an individual's place of residence

International Classification of Diseases (ICD) - The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes.

International Classification of Functioning, Disability and Health (ICF) - The International Classification of Functioning, Disability and Health, known more commonly as ICF, is a classification of health and health-related domains. These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation.

International Society of Physical and Rehabilitation Medicine (ISPRM) - Scientific and educational international society for practitioners in the field of physical and rehabilitation medicine

The Joint Commission - An organization that evaluates and accredits healthcare organizations and programs in the United States. The Joint Commission is an independent, not-for-profit organization. A hospital is accredited by the Joint Commission if it meets certain quality standards. These checks are done at least every 3 years. Most hospitals take part in these accreditations.

K

Knowledge Translation - A dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve health, provide more effective health services and products and strengthen the health care system.

L

Length of Stay (LOS) - A term commonly used to measure the duration of a single episode of hospitalization. Inpatient days are calculated by subtracting day of admission from day of discharge.

Levels of Evidence

***JBJS/AAOS Evidence Table -** The preferred table utilized by the Evidence Committee to help standardize the review of evidence and establish levels of evidence for Academy work products

*Levels of Evidence for Primary Research Question

Types of Studies

	Therapeutic Studies- Investigating the Results of Treatment	Prognostic Studies- Investigating the Outcome of Disease	Diagnostic Studies-Investigating a Diagnostic Test	Economic & Decision Analyses-Developing an Economic or Decision Model
Level I	1. Randomized controlled trial a. Significant difference b. No significant difference but narrow confidence intervals 2. Systematic review[2] of Level-I randomized controlled trials (studies were homogeneous)	1. Prospective study[1] 2. Systematic review[2] of Level-I studies	1. Testing of previously developed diagnostic criteria in series of consecutive patients (with universally applied reference "gold" standard) 2. Systematic review[2] of Level-I studies	1. Clinically sensible costs and alternatives; values obtained from many studies; multiway sensitivity analyses 2. Systematic review[2] of Level-I studies
Level II	1. Prospective cohort study[3] 2. Poor-quality randomized controlled trial (e.g., <80% follow-up) 3. Systematic review[2] a. Level-II studies b. nonhomogeneous c. Level-I studies	1. Retrospective study[4] 2. Study of untreated controls from a previous randomized controlled trial 3. Systematic review[2] of Level-II studies	1. Development of diagnostic criteria on basis of consecutive patients (with universally applied reference "gold" standard) 2. Systematic review[2] of Level-II studies	1. Clinically sensible costs and alternatives; values obtained from limited studies; multiway sensitivity analyses 2. Systematic review[2] of Level-II studies
Level III	1. Case-control study[5] 2. Retrospective cohort study[4] 3. Systematic review[2] of Level-III studies		1. Study of nonconsecutive patients (no consistently applied reference "gold" standard) 2. Systematic review[2] of Level-III studies	1. Limited alternatives and costs; poor estimates 2. Systematic review[2] of Level-III studies
Level IV	Case series (no, or historical, control group)	Case series	1. Case-control study 2. Poor reference standard	No sensitivity analyses
Level V	Expert opinion	Expert opinion	Expert opinion	Expert opinion

Other examples of Evidene Tables include:

- Oxford Centre for Evidence-Based Medicine 2011 Levels of Evidence
- AHA Evidence Classification
- American Academy of Neurology – (Definitions for Classification of Evidence: Appendix 9)

Local Coverage Determination (LCD)

- An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). The difference between LMRPs and LCDs is that LCDs consist only of "reasonable and necessary" information, while LMRPs may also contain category or statutory provisions.

- The final rule establishing LCDs was published November 11, 2003. Effective December 7, 2003, CMS's contractors will begin issuing LCDs instead of LMRPs. Over the next 2 years (until December 31, 2005) contractors will convert all existing LMRPs into LCDs and articles. Until the conversion is complete, for purposes of a 522 challenge, the term LCD will refer to both 1.) Reasonable and necessary provisions of an LMRP and, 2.) an LCD that contains only reasonable and necessary language. Any non-reasonable and

necessary language a contractor wishes to communicate to providers must be done through an article.

Local Medical Review Policy (LMRP) - An administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment

Long-Term Acute Care Hospital (LTAC) - Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit.

Long-term Care - A variety of services that help people with their medical and non-medical needs over a period of time.

M

Maintenance of Certification (MOC) - A process of continuous professional development to maintain time limited professional licenses.

Meaningful Use (MU) - In a health information technology (HIT) context, defines the use of electronic health records (EHR) and related technology within a healthcare organization. Achieving meaningful use also helps determine whether an organization will receive payments from the federal government under either the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program.

Measure - A standard: a basis for comparison; a reference point against which other things can be evaluated; “they set the measure for all subsequent work.” v. To bring into comparison against a standard. *[National Quality Forum]*

- Measures drive improvement. Teams of healthcare providers who review their performance measures are able to make adjustments in care, share successes, and probe for causes when progress comes up short — all on the road to improved patient outcomes.
- Measures inform consumers. As a growing number of measures are publicly reported, consumers are better able to assess quality for themselves, and then use the results to make choices, ask questions, and advocate for good healthcare. Some providers now post performance measures on their websites, and consumers can consult national sources such as HospitalCompare.gov and NursingHomeCompare.gov.
- Measures influence payment. Increasingly, private and public payers use measures as preconditions for payment and targets for bonuses, whether it is paying providers for performance or instituting nonpayment for complications associated with NQF’s list of “Serious Reportable Events.” *[National Quality Forum]*

Measure Type - CMS refers to the domain of quality that a measure assesses:

- **Process**: Refers to a measure that focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.
- **Outcome**: Refers to a measure that assesses the results of health care that are experienced by patients
- **Intermediate Outcome**: Refers to a measure which aims to meet specific thresholds of health outcomes.
- **Structure**: Refers to a measure that assesses aspects of the health care infrastructure that generally are broad in scope, system wide (for example, staffing level).
- **Efficiency**: Refers to a measure of cost of care associated with a specified level of health outcome.
- **Patient Perspective**: Refers to a measure which focuses on a patient’s report concerning observations of and participation in health care.
- **Cost/Resource Use**: Refers to broadly applicable and comparable measures of health services counts (in terms of units or dollars) applied to a population or event (broadly defined to include diagnoses, procedures, or encounters). A resource use measure counts the frequency of defined health system resources; some may further apply a dollar amount (for example, allowable charges, paid amounts, or standardized prices) to each unit of resource use—that is, monetizes the health service or resource use units.

- **Composite:** Refers to a measure which contains two or more individual measures, resulting in a single measure and a single score. Composite measures may be composed of one or more process and/or one or more outcome measures
  [Centers for Medicare & Medicaid Services]

Meta-Analysis - Methods focused on contrasting and combining results from different studies, in the hope of identifying patterns among study results, sources of disagreement among those results, or other interesting relationships that may come to light in the context of multiple studies.*[Greenland S, O' Rourke K: Meta-Analysis*]

Medically Necessary - Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor. *[Centers for Medicare & Medicaid Services]*

Medicare Administrative Contractors (MAC) - A company that processes claims for Medicare

Medicare Ambulatory Care Indicators for the Elderly (MACIE) - Reflects important aspects of routine care for health conditions that are common to the Medicare population, while also maintaining consistency with contemporary methods for performance measurement

Medicare Coverage Advisory Committee (MCAC) - Provides advice on scientific, clinical practice, and ethical questions regarding Medicare coverage issues

Medicare Payment Advisory Committee (MedPAC) - The Medicare Payment Advisory Commission is an independent Congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program.

Medicare Provider Analysis and Review file (MedPAR) -Contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals and skilled nursing facilities (SNF)

Medicare Prescription Drug, Improvement and Modernization Act of 2003(MMA) - Established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries

Minimum Data Set (MDS) - *Part* of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes

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

N

National Center for Medical Rehabilitation Research (NCMRR) - Development of scientific knowledge needed to enhance the health, productivity, independence and quality of life of people with disabilities

National Committee for Quality Assurance (NCQA) - A non-profit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Set

(HEDIS) data reporting system

National Drug Code (NCD)- Is a unique product identifier used in the United States for drugs intended for human use.

National Institute on Aging (NIA) - Leads a broad scientific effort to understand the nature of aging and to extend the health, active years of life.

National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) - *S*upports research into the causes, treatment, and prevention of arthritis, musculoskeletal and skin diseases.

National Institute for Clinical Excellence (United Kingdom) (NICE) - Developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service

NIDRR National Institute of Disability and Rehabilitation Research (NIDRR) - Conducts comprehensive and coordinated programs of research and related activities to maximize the full inclusion, social integration, employment and independent living of disabled individuals of all ages

National Institute of Health (NIH) - The primary federal agency for conducting and supporting medical research

National Medicare Education Program (NMEP) - Help educate beneficiaries about their Medicare program benefits, health plan choices, supplemental health insurance, beneficiary rights, responsibilities, and protections, and health behaviors

National Opinion Research Center (NORC) - Conducts survey research in the public interest for government agencies, educational instructions, private foundations, nonprofit organizations and private corporations

National Quality Forum (NQF) A private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. The mission of the NQF is to improve American healthcare through endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and, efficient.

National Science Foundation (NSF) - Independent U.S. government agency responsible for promoting science and engineering through programs that invest money in research and education projects in science and engineering

O

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

Outcome- of care is a health state of a patient resulting from health care.

Outcome Measures - Assess performance on a broader scale. Outcome measures gauge the comprehensive result of multiple health care services provided to an individual. An outcome measure can be used to assess quality of care to

the extent that health care services influence the likelihood of desired health outcomes. Outcome-based measures of quality reflect the cumulative impact of multiple processes of care. Outcome measures may suggest specific areas of care that may require quality improvement, but further investigation is typically necessary to determine the specific structures or processes that should be changed. *[Agency for Healthcare Research & Quality]*

Outpatient Rehabilitation Facility (ORF) - Facility where one receives treatment and education regarding an injury or illness on an outpatient basis

P

Pain - An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. *[International Association for the Study of Pain (IASP)]*

Paralyzed Veterans of America (PVA) - Advocates on behalf of veterans of the armed forces who have experienced spinal cord injury or dysfunction. Includes news, resources for vets and their families, and chapter information

Participation - Involvement in a life situation. *[WHO-ICF]*

Participation Restrictions - Problems an individual may experience in involvement in life situations. *[WHO-ICF]*

Patient Protection & Affordable Care Act (PPACA)- The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will "continue to be rolled out over the next four years." Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions.

Patient-Centered Medical Home (PCMH) - A team based health care delivery model led by a physician, P.A., or N.P. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. *[American College of Physicians; American Academy of Family Physicians]*

Patient Registry - An organized system that used observational study methods to collect uniform data (clinical and other); Evaluates specified outcomes for a population defined by a particular disease, condition, or exposure, and that Serves a predetermined scientific, clinical or policy purpose. [*Derived from: Gliklich RE, Dreyer NA: Registries for Evaluating patient Registries: A User's Guide: AHRQ publication No. 07-EHC001. Rockville, (patient registry)]*

Pay for Performance (P4P) - A direct financial reward model or quality bonus; incentive and reward models where there are direct provider dollars at stake for quality improvement. Refers to the general strategy of promoting quality improvement by rewarding providers (meaning individual clinicians or, more commonly, clinics or hospitals) who meet certain performance expectations with respect to health care quality or efficiency

Patient-Centered Outcomes Research Institute (PCORI) - Is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment and care options available, and the science that supports those options.

Performance - can be defined in terms of patient outcomes but is more commonly defined in terms of processes of

care (e.g., the percentage of eligible diabetics who have been referred for annual retinal examinations, the percentage of children who have received immunizations appropriate for their age, patients admitted to the hospital with pneumonia who receive antibiotics within 6 hours). Pay-for-performance initiatives reflect the efforts of purchasers of health care—from the federal government to private insurers—to use their purchasing power to encourage providers to develop whatever specific quality improvement initiatives are required to achieve the specified targets. Thus, rather than committing to a specific quality improvement strategy, such as a new information system or a disease management program, which may have variable success in different institutions, pay for performance creates a climate in which provider groups will be strongly incentivized to find whatever solutions will work for them.

Performance Improvement Projects - Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PHPs choosing or prescribed by the State. *[Centers for Medicare & Medicaid Services]*

Physician's Consortium for Performance Improvement (PCPI) – is a national, physician-led program dedicated to enhancing quality and patient safety. The ongoing mission of the PCPI is to align patient-centered care, performance measurement and quality improvement.

Process Improvement - A methodology utilized to make improvements to a process through the use of continuous quality improvement methods. *[Centers for Medicare & Medicaid Services]*

Process Measure - Assesses a health care service provided to, or on behalf of, a patient. Process measures are often used to assess adherence to recommendations for clinical practice based on evidence or consensus. To a greater extent than outcome measures, process measures can identify specific areas of care that may require improvement. *[Agency for Healthcare Research & Quality]*

Performance measurement - Measurement of adherence to recognized standards of quality. Performance measurement may take place at the national, system, institution, or individual provider level, and it includes measures of process and outcome. *[Agency for Healthcare Research & Quality]*

Physician Payment Review Commission (PPRC) - Formed to advise the U.S. Congress on methods used to pay physicians for services to Medicare beneficiaries

Physician Quality Reporting System (PQRS) - A volunteer quality reporting program created by CMS in 2007 (known as PQRI until 2011). Physicians are evaluated on their quality of care by confirming specific services were rendered to patients who met predetermined criteria. Practices will be reimbursed for successful participation by their physicians through 2014, after which significant penalties for non-participation will be imposed. It is currently a pay-for-reporting program, but is anticipated to pave the way for future pay-for-performance initiatives by validating the clinical performance measures involved.

Preferred Provider Organization (PPO) - A medical insurance plan in which members receive more coverage if they choose health care providers approved by or affiliated with the plan

Private Fee-for-Service (PFFS) - *A* Medicare Advantage (MA) health plan, offered by a State licensed risk bearing entity, which has a yearly contract with the Centers for Medicare & Medicaid Services (CMS) to provide beneficiaries with all their Medicare benefits, plus any additional benefits the company decides to provide

Program of All-Inclusive Care for the Elderly (PACE) - A special type of health plan that provides all the care and

services covered by Medicare and Medicaid as well as additional medically necessary care and services based on needs as determined by an interdisciplinary team.

Prospective Payment System (PPS) - A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount

Q

Quality - Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results. *[Centers for Medicare & Medicaid Services]*

Quality Assurance (QA) - A program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked. *[Centers for Medicare & Medicaid Services]*

Quality Improvement Organization - Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for Service plans, and ambulatory surgical centers. *[Centers for Medicare & Medicaid Services]*

Quality improvement (QI) **-** The attainment, or process of attaining, a new level of performance or quality that is superior to any previous level of quality. *[Agency for Healthcare Research & Quality]*

R

Recovery Audit Contractors (RAC)- Detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments and are paid based on what they recover.

Registry – See Patient Registry

Relative Value Scale Update Committee (RUC) - Expert physician panel in developing relative value recommendations to CMS

Relative Value Scale Update Committee (RUG) - Expert physician panel in developing relative value recommendations to CMS

Relative Value Units (RVUs) - RVUs reflect the relative level of time, skill, training and intensity required of a physician to provide a given service. *[Merritt Hawkins]*

Resources Based Relative Value Scale (RBRVS) - Used to determine how much money medical providers should be paid

Risk adjustment - In performance measurement, the use of severity of illness measures, such as age, to estimate the risk (the measurable or predictable chance of loss, injury, or death) to which a patient is subject before receiving a health care intervention. The purpose of risk adjustment is to ensure that comparisons of performance measures across organizations are fair and that observed differences are due to variation in provision of care rather than differences in patient populations served. *[Agency for Healthcare Research & Quality]*

S

Skilled Nursing Facility (SNF) - A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services

Social Security Administration (SSA) - Pay retirement, disability, and survivors benefits to workers and their families and administer the Supplemental Security Income Program

Social Security Disability Income (SSDI) - A federal assistance program for disabled people who have paid Social Security taxes or are dependents of people who have paid

State Health Insurance Program (SHIP) -State agency that is in charge of the state's Medicaid programs

Strength of Evidence - This applies to more than just the results of your review, although your review will obviously contribute greatly to the overall body of knowledge on its topic. It is how strong the overall case for the use or cessation of use for the intervention is. The strength of evidence relating to your review question is determined by factors both within your review and external to your review. *[Cochrane Collaboration]*

Sustainable Growth Rate (SGR) - A method currently used by the Centers for Medicare and Medicaid Services (CMS) in the United States to control spending by Medicare on physician services

Systematic Review - A systematic review attempts to identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria to answer a given research question. Researchers conducting systematic reviews use explicit methods aimed at minimizing bias, in order to produce more reliable findings that can be used to inform decision making. *[Cochrane Library]*

T

U

Utilization - The extent to which a given group uses a particular service in a specified period. Although usually expressed as the number of services used per year per 100 or per 1000 persons eligible for the service, utilization rates may be expressed in other ratios.

Underuse - The failure to provide a health care service when it would have produced a favorable outcome for a patient. Standard examples include failures to provide appropriate preventive services to eligible patients (e.g., Pap smears, flu shots for elderly patients, screening for hypertension) and proven medications for chronic illnesses (steroid inhalers for asthmatics; aspirin, beta-blockers, and lipid-lowering agents for patients who have suffered a recent myocardial infarction). *[Agency for Healthcare Research & Quality]*

V

Value - Value of care as a measure of specified stakeholder's (such as an individual patient's consumer organization's payer's providers, governments or society's) **preference-weighted assessment** of a particular combination of

quality and cost of care performance. *[AQA principles of "efficiency" Measures April 2006*.]

Value or Value-Based Purchasing: A policy adopted by healthcare payers (e.g., the Center for Medicare and Medicaid Services [CMS] and private insurers) and Congress combining benefits in quality with lower costs. For example, studies have shown wide regional variation in care utilization throughout the United States, yet higher utilization does not necessarily lead to higher quality. In this case, higher utilization would be considered to have low value

Value Based Payer Modifier (VBP): VBP is part of CMS' drive to transform itself from a passive payer to an active purchaser of quality health care. The VBP is an effort to reward high-quality care delivered at low cost by penalizing low-quality care delivered at high cost.

Veterans Health Administration (VHA) - The Veterans Health Administration is America's largest integrated health care system

W

World Health Organization (WHO) - An organization that maintains the International Classification of Diseases (ICD) medical code set.

Work Relative Value Unit (wRVU) - A measure of value used in the United States Medicare reimbursement formula for physician services

X
Y
Z

Abbreviations

ACO – see Accountable Care Organizations
ACA – see Affordable Care Act
ACRM – see American Congress of Rehabilitation Medicine
ADA – see American with Disabilities Act of 1990
AHRQ – see Agency for Healthcare Research & Quality-formerly
AHCPR – see Agency for Health Care Policy & Research
AMA – see American Medical Association
AOTA – see American Occupational Therapy Association
APTA – see American Physical Therapy Association
ASHA – see American Speech-Language-Hearing Association
AUC – see Appropriate Use Criteria
CAC – see Carrier Advisory Committee
CAHPS – see Consumer Assessment of Health Plans
CARF – see Commission on the Accreditation of Rehabilitation Facilities
CCHIT® - see Certification Commission for Health Information Technology
CDC - see Centers for Disease Control and Prevention
CHAMPUS – see Civilian Health and Medical Program of the Uniformed Services
CMS – see Centers for Medicare and Medicaid Services
CORF – see Comprehensive Outpatient Rehabilitation Facility
CPOE – see Computerized Physician Order Entry or Computerized Provider Order Entry
CPT – see Current Procedural Technology
CQI – see Continuous Quality Improvement
DEA – see Drug Enforcement Agency
DHHS – see Department of Health and Human Services
DRG – see Diagnosis Related Group
EHR – see Electronic Health Records
EMR – see Electronic Medical Records
FIM®- see Functional Independence Measure
HCPC – see Healthcare Common Procedural Coding System
HCQIP – see Health Care Quality Improvement Program Health Plan Employer Data and Information Set
HEDIS – see Health Plan Employer Data and Information
HHA – see Home Health Agency
HIPAA - see Health Insurance Portability and Accountability Act.
HMO – see Health Maintenance Organization
IADL – see Instrumental Activities of Daily Living
ICD – see International Classification of Diseases
ICF - see International Classification of Functioning, Disability and Health
IOM – see Institute of Medicine
IRF – see Inpatient Rehabilitation Facility
ISPMR – see International Society of Physical and Rehabilitation Medicine
LCD – see Local Coverage Determination
LOS – see Length of Stay
LMRP - see Local Medical Review Policy
LTAC - see Long-term Acute Care Hospital
MAC – see Medicare Administrative Contractors

MACIE – see Medicare Ambulatory Care Indicators for the Elderly
MCAC – see Medicare Coverage Advisory Committee
MDS – see Minimum Data Set
MedPac – see Medicare Payment Advisory Committee
MedPar – see Medicare Provider Analysis and Review file
MMA – see Medicare Prescription Drug, Improvement & Modernization Act of 2003
MOC – see Maintenance of Certification
MU – see Meaningful Use
NCD – see National Drug Code
NCMRR-see National Center for Medical Rehabilitation Research
NCQA – see National Committee for Quality Assurance
NIA – see National Institute on Aging
NIAMS – see National Institute of Arthritis and Musculoskeletal and Skin Diseases
NICE – see National Institute for Clinical Excellence (United Kingdom)
NICHD – see Eunice Shriver National Institute of Child Health and Human Development
NIDRR – see National Institute of Disability and Rehabilitative Research
NIH – see National Institute of Health
NMEP – see National Medicare Education Program
NOMS – see National Outcomes Measurement System.
NORC – see National Opinion Research Center
NQF – see National Quality
NSF – See National Science Foundation
ORF – See Outpatient Rehabilitation Facility
P4P – see Pay for Performance
PACE – see Program of All-Inclusive Care for the Elderly
PCMH – see Patient-Centered Medical Home
PCORI – see Patient-Centered Outcomes Research Institute
PCPI – see Physician's Consortium for Performance Improvement
PFFS – see Private Fee-for-Service
PPACA – see Patient Protection & Affordable Care Act
PPO – see Preferred Provider Organization
PPRC- see Physician Payment Review Commission
PPS – see Prospective Payment System
PQRS – see Physician Quality Reporting System
PVA – see Paralyzed Veterans of America
QA – see Quality Assurance
QI – see Quality improvement
RAC – see Recover Audit Contractors
RBRVS – see Resources Based Relative Value Scale
RSA – see Rehabilitation Services Administration
RUC – see Relative Value Scale Update Committee
RUG – see Resource Utilization Group
RVU – see Relative Value Units
SGR – see Sustainable Growth Rate
SHIP – see State Health Insurance Program
SME – see Subject matter Expert
SNF – see Skilled Nursing Facility

SSA – see Social Security Administration
SSDI – see Social Security Disability Income
UPIN – Unique Physician Identification Number
VBP – see Value Based Payer Modifier
VHA – see Veterans Health Administration
WHO – see World Health Organization
wRVU – see Work Relative Value Unite