HEALTH CARE
TERMS & ABBREVIATIONS

Texas Healthcare Trustees

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SEVENTH EDITION

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Texas Healthcare Trustees

Texas Healthcare Trustees is a statewide association whose members are the governing boards of Texas hospitals, health care systems and health-related organizations. THT provides education and resources for governing board members. Membership includes more than 450 governing boards and represents nearly 4,000 trustees. Founded in 1961, THT is the oldest trustee organization in the country.

Texas Healthcare Trustees partners with Merritt Hawkins, an AMN Healthcare company, on professional development projects that may be beneficial to its members. Merritt Hawkins helps advance THT's mission through various educational forums and resources, including the *Trustee Guidebook,* presentations, white papers, surveys and interactive, web-based resources.

MERRITT HAWKINS
an AMN Healthcare company

Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare. Merritt Hawkins partners with hospitals, medical groups, academic centers and other facilities nationwide to create and carry out effective strategies for physician, physician leader and advanced practitioner recruiting. Using a consultative approach, Merritt Hawkins offers both industry-leading expertise and the comprehensive range of recruiting resources necessary to be successful in today's challenging recruiting market.

Merritt Hawkins has been recognized for its expertise by publications ranging from The Wall Street Journal and Fortune to Modern Healthcare, Hospitals & Health Networks, HealthLeaders and numerous others. Merritt Hawkins' physician surveys and white papers are industry benchmarks that are continuously cited and referenced by health care organizations, media outlets, academic centers and policy institutes nationwide. Merritt Hawkins' executives are selected to speak before dozens of health care professional organizations annually, including various trustee organizations, and have presented expert testimony before the Congress of the United States on multiple occasions.

The leader in its field, Merritt Hawkins sets the standard for physician recruiting expertise, resources and effectiveness.

Academic Medical Center
An entity operating in affiliation with a medical school and one or more teaching hospitals to provide undergraduate and graduate medical education and research.

Accountable Care Organization (ACO)
A network of physicians, hospitals and other health care providers who voluntarily share financial and medical responsibility for providing coordinated high-quality care to Medicare patients. The Patient Protection and Affordable Care Act incentivizes the creation of ACOs.

Accreditation
An independent assessment and review process of a health care organization to demonstrate the organization's compliance in meeting specific criteria or nationally held standards. Accreditation agencies include The Joint Commission, the National Committee for Quality Assurance and DNV Healthcare.

Accrual Accounting
Accounting method that recognizes a revenue or expense at the time services are rendered, regardless of when cash is actually exchanged.

Acquisition
Obtaining a majority of an organization's ownership or assets by cash or other compensation.

Activities of Daily Living (ADL)
Self-care activities such as dressing, bathing, cooking and shopping, which serve as a measurement of an individual's functional status. Used to evaluate independent living ability and to assess an individual's need for long-term or acute care.

Actuary
An accredited professional who measures, monitors and analyzes the financial consequences of risk. Actuaries calculate predictable health risks and rates and help set health insurance premiums.

Acute Care
A level of care given to treat an individual's physical or mental condition, usually requiring immediate intervention and constant medical attention, equipment and personnel.

Acute-Care Hospital
An inpatient hospital where an admitted patient receives short-term treatment (fewer than 30 days) for severe injury, illness or urgent medical condition or recovers from surgery.

Administrative Services Only (ASO)
A group health insurance program for large employers where the employer assumes all the financial risk of coverage but hires a third party to provide administrative services, such as claims processing and employee communications.

Administrative Services Organization
An arrangement in which an employer hires a third party to perform administrative services such as claims processing and billing; the employer bears the risk for claims.

Admission
Formal process allowing entry of a patient into a hospital or other health care setting for the purpose of providing treatment.

Admission, Discharge, Transfer (ADT) System
Software application used by hospitals and other health care facilities to track patients from the point of arrival to departure by transfer, discharge or death.

Admitting Privileges
Permission granted to a physician (M.D./D.O.), dentist or podiatrist to admit patients to a particular hospital or health care facility for the provision of diagnostic services or treatment.

Advance Beneficiary Notice (ABN)
Written notice given by health care provider or supplier to a fee-for-service beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity.

Advance Directive
A legal document, recognized under Texas law, in which an individual specifies preferences concerning end-of-life care in the event he or she becomes incapacitated or is unable to make decisions. Advance directives take three forms: Directive to Physicians, Out-of-Hospital Do-Not-Resuscitate Order and Medical Power of Attorney.

Advanced Practice Registered Nurse (APRN)
A clinical professional who received advanced training and education in his or her field, often a master's or doctorate, who may serve as a primary care provider. The term includes nurse practitioners, clinical nurse specialists, nurse anesthetists and nurse midwives.

Adverse Event
An undesirable medical occurrence resulting in unintended physical or psychological harm to the patient caused by an act of commission or omission, rather than by the underlying disease or condition of the patient. This term is associated with the phrase "never events."

Affiliation
Agreement or partnership between two or more otherwise independent hospitals, programs or providers. An affiliated hospital allows doctors to practice and admit patients. Doctors can be affiliated with more than one hospital. Affiliation also refers to a hospital and insurance plan contract wherein the hospital agrees to provide benefits to the plan's members.

Affordable Care Act (ACA)
Formally known as the Patient Protection and Affordable Care Act, or informally as Obamacare, this federal legislation was signed into law in 2010. The ACA refers to two separate pieces of legislation, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Key provisions of the ACA are to increase access to quality, affordable health insurance, lower the uninsured rate, increase industry efficiency and lower health care costs.

Agency for Healthcare Research and Quality (AHRQ)
Public health service agency within the U.S. Department of Health and Human Services. AHRQ's mission is to support research designed to improve the outcomes and quality of health care, reduce costs, address patient safety and medical errors, and broaden access to effective services.

All Patient Refined Diagnosis Related Groups (APR-DRG)
Classification system that categorizes patients according to their reason for admission, severity of illness and risk of mortality.

Allied Health Professional
A professionally trained non-physician health care provider who provides a range of diagnostic, technical and therapeutic health care services to patients. Allied health professionals include paramedics, physician assistants, certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, registered nurses and a variety of other medical team members. Allied health professionals comprise almost 60 percent of the health care workforce.

Allowable Costs
The maximum amount covered for a service under health insurance benefits. The contracted allowable amount may not cover the full amount charged by a health care provider in which case the patient/consumer may have to pay the difference.

Allowable Expenses
Necessary and reasonable expenses that an insurer will cover. Also referred to as eligible expenses.

All-Payer System
A system in which all third-party payers of health care bills, including the government, private insurers, large companies or individuals, pay the same rates for health care services at the amount set by the government. Maryland's all-payer system for hospital services is the most well-known.

Ambulatory Care
Medical care provided on an outpatient basis that may be delivered in a hospital, physician's office, clinic or other facility.

Ambulatory Patient Group (APG)
A classification for outpatient services and procedures. Approximately 7,000 services and procedures are classified into about 300 procedure groups. Unlike diagnosis related group (DRG) reimbursement for inpatient care, where medical events are condensed into one diagnostic related group, an outpatient visit can combine several different APGs.

Ambulatory Payment Classification
Method of paying outpatient facilities for services for the Medicare program.

Ambulatory Surgical Center (ASC)
A licensed facility that operates to provide surgical procedures, pain management and some diagnostic services in an outpatient setting.

American College of Healthcare Executives (ACHE)
An international professional society of health care executives who lead hospitals, health care systems and other health care organizations. ACHE provides the Fellow of the American College of Healthcare Executives (FACHE) designation, signifying certification in health care management, and also offers health care education.

American Hospital Association (AHA)
Professional association, representing more than 5,000 hospitals nationally, that shapes and influences federal legislation and regulation to improve the ability of its members to deliver quality health care.

Ancillary Services
Supplemental services that support the diagnosis and treatment of a patient (i.e., diagnostic services, home health care, physical therapy and occupational therapy).

Annual Payment Update
Annual adjustment to Medicare reimbursement rates for hospitals and other health care providers based on inflation. Hospitals can receive their full annual payment update by meeting the requirements of the Reporting Hospital Quality for Annual Payment Update initiative.

Anti-Kickback Statute
A criminal statute that prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate federal health care program business.

Anti-Trust Laws
State and national laws that prohibit health care and other providers from price fixing or developing monopolies that would prevent consumers from having choices of costs and services.

Any Willing Provider
A health care provider that complies with an insurer's preferred provider terms and conditions for participation in the provision of services through a health benefit plan.

Area Health Education Center (AHEC)
Partnership between health and educational institutions, the purpose of which is to improve the supply, distribution, quality, use and efficiency of health care personnel in specific medically underserved areas.

Area Wage Index
A component of the Medicare payment calculation intended to account for geographic differences in labor and benefits costs.

Assignment of Benefits
An agreement or arrangement between a beneficiary and an insurance company by which a beneficiary requests the insurance company to pay the health benefit payment directly to the physician or medical provider.

Assisted Living Facility
A housing alternative for the elderly or those with disabilities who need assistance with activities of daily living such as dressing, bathing or cooking, but do not require intensive medical or nursing care. Additional services, such as medication administration, also may be available.

Associate Degree in Nursing (A.D.N.)
A two-year degree in the field of nursing usually earned at a junior or community college that provides opportunities to work in entry-level nursing positions.

Attending Physician
A physician who is on the medical staff of a hospital or health care facility and who is legally responsible for the care provided to a given patient. A patient's attending physician also is regarded as a person's private physician if that physician cares for the person on an individual and/or outpatient basis.

Average Daily Census (ADC)
Average number of hospital inpatients per day over a given period. Calculated by dividing the total number of patient days during a given period by the number of calendar days in that period.

Average Length of Stay (ALOS)
Refers to the average number of days that patients spend in a hospital. Calculated by dividing the sum of inpatient days by the number of admissions and discharges during a specified period of time.

Bachelor of Science in Nursing (B.S.N.)
Four-year degree awarded by an accredited college or university that allows an individual to become a registered nurse after passing a licensure examination.

Bad Debt
Debt that is unlikely to be paid or that is not collectible.

Balance Billing
The practice of a health care provider billing a patient for the difference between what the patient's health insurance reimburses and what the provider charges.

Bed Days
A bed day is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

Benchmarking
Measurement of products, services and practices used against major competitors or industry leaders to create normative or comparative standards. Benchmarking can be used to evaluate quality of care.

Beneficiary
Person designated as eligible to receive proceeds or benefits under a will, trust or insurance policy.

Benefit Levels
The maximum amount a health insurance company agrees to pay for a specific covered benefit.

Benefit Package
A description of health care services and supplies an insurer, government agency or health plan covers for a group or individual under the terms of a contract.

Billed Charges
The gross billed amount or retail price for specific services delivered by a health care provider.

Block Grant
A set amount of federal funds awarded to a state or local government with minimal requirements on how the funds should be used.

Blood Stream Infection
A common quality metric, a bloodstream infection occurs when bacteria enter the bloodstream through a wound or infection, or through a surgical procedure or injection.

Board Certified
The process by which a health care professional demonstrates mastery in a specific area of practice through written, practical or simulation-based testing.

Board Eligible
Description for a health care professional who has completed licensure requirements for a medical specialty or subspecialty but has not yet passed the required examination.

Brain Death
Irreversible loss of brain activity, including involuntary activity necessary to sustain life.

Bundled Billing
A cost control method that charges a set price for all medical services associated with select procedures, such as a knee replacement or heart attack.

Bundled Payment
A single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment. Payments are made to the provider on the basis of expected costs for clinically defined episodes that may involve several practitioner types, settings of care, and services or procedures over time.

Business Associate
A person or entity that provides services for a covered entity that involves the use or disclosure of protected health information.

C. Diff
The toxin-producing bacteria *clostridium difficile* that can result from cross-contamination in care settings; those most at risk are older adults who take antibiotics.

Capital Asset
Tangible or intangible property with a life of over one year that contributes to the functioning of a business and is not intended for sale during the normal course of business.

Capital Expense
Expenditure that is spent to acquire or improve a long-term asset.

Capitation
Method of payment for health services in which a hospital, physician or provider is paid a fixed amount for each patient regardless of the services provided.

Case Management
Collaborative process to coordinate the assessment, planning and facilitation of care for selected patients.

Case Manager
A non-physician professional who provides an array of services to assist individuals and families with complicated health or medical situations in the most effective way possible.

Case Mix
Various types of patients categorized by disease related groups, severity of illness or other indicators; used as a tool for managing and planning health care services.

Catastrophic Illness
A severe illness, typically considered life-threatening, that requires extensive treatment and hospitalization.

Catheter-Associated Urinary Tract Infection (CAUTI)
An infection that occurs when bacteria enters the urinary tract through a urinary catheter.

Census
Number of patients admitted to a health care facility who receive care over a given period of time.

Centers for Disease Control and Prevention (CDC)
The federal agency within the U.S. Department of Health and Human Services that serves as the central point for consolidation of disease control and prevention data, health promotion and public health programs.

Centers for Medicare & Medicaid Services (CMS)
The federal agency within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs, Children's Health Insurance Program, and the federal insurance exchange; determines provider certification requirements; and establishes reimbursement policies and formulas for these programs.

Central Line-Associated Bloodstream Infection (CLABSI)
An infection that occurs when bacteria enters the bloodstream through a central venous catheter, also known as a central line.

Certificate of Need (CON)
Requirement for a health care organization to obtain permission before expansions, construction, acquisitions, major equipment purchases, the addition of beds and the addition of new services can occur. Texas does not have a CON process for hospitals.

Charge Master
A hospital's comprehensive list of procedures and supplies billable to a patient or health insurance provider.

Charges
The dollar amount billed by a health care facility or provider for services provided.

Charity Care
The unreimbursed cost to a hospital for providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent.

Children's Health Insurance Program (CHIP)
A joint state-federal insurance program under Title XXI of the Social Security Act that provides low-cost health coverage to children from birth through age 18. CHIP is for families who earn too much money to qualify for Medicaid but cannot afford private health insurance. In Texas, CHIP covers children in families with incomes above Medicaid eligibility levels up to 200 percent of the federal poverty level.

Chronic Condition
A health condition or disease that is recurring or has long-lasting effects that may result in long-term care needs. Examples include cancer, diabetes, hypertension (high blood pressure), high cholesterol and stroke.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
A federal health plan, now known as TRICARE, that allows active-duty military personnel, retired military personnel under age 65 and their dependents to receive government-subsidized health care from civilian providers.

Claims
A formal request submitted to a health insurer requesting payment for health care services provided to a patient by a health care facility or provider.

Clean Claim
A claim submitted by a health care provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy that includes required data elements for timely processing.

Clinic
An outpatient medical facility. A clinic may be associated with a hospital.

Clinical Laboratory Improvement Amendments (CLIA)
CLIA regulations include federal standards applicable to all U.S. facilities or sites that test human specimens for health assessment or to diagnose, prevent or treat disease. Requires clinical laboratories to be certified by their state and CMS before they can accept human samples for diagnostic testing. The FDA, CMS and CDC oversee CLIA.

Clinical Quality Measure (CQM)
A tool that helps assess and track the quality of health care services and providers. CQMs evaluate various aspects of patient care, including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and clinical guidelines.

Closed Formulary
A list of preferred drugs covered by a pharmacy benefits management program or a managed care plan, often offered at a lower copayment. A non-formulary drug may be covered if it is determined the drug is medically necessary.

Closed Panel
A managed care plan in which those covered seek care from a primary care provider, contracted to provide services, who also has control over referrals to other physicians in or outside of the managed care plan.

Coinsurance
A form of cost-sharing. Refers to the amount (calculated as a percentage) a health insurance policy requires the insured to pay for health care services after the insured has met his or her deductible.

Commission on Graduates of Foreign Nursing Schools (CGFNS)
An internationally recognized authority on credentials evaluation and verification pertaining to the education, registration and licensure of nurses and health care professionals across the world. The CGFNS program is designed for first-level general or registered nurses who have been educated in another country and wish to work as professional nurses in the U.S.

Community Benefit
The unreimbursed cost to a hospital of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research and subsidized health services. Community benefits do not include the cost to the hospital of paying taxes or other governmental assessments.

Community Health Information Network (CHIN)
Web-based network that permits the electronic exchange of clinical, financial and administrative information among unaffiliated health care entities in order to improve the efficiency and delivery of health care in a community. Also known as community health management information system.

Community Health Needs Assessment
An assessment conducted by health care organizations to identify gaps in health care services, populations with special/unique needs, health problems in the community and barriers to accessing health care services and to estimate projected future needs.

Community Hospitals
Non-federal, acute-care general and specialty hospitals.

Community Rating
A concept that prevents health insurers from varying premiums based on an individual's age, gender, health status or other factors.

Compliance
The act of meeting specified standards, policies, procedures, laws or regulations.

Computerized Physician Order Entry (CPOE)
Process of electronic entry in which physicians directly enter medication orders or care instructions for a patient.

Comorbidities
One or more conditions or diseases co-occurring with a primary disease or disorder.

Concurrent Review
Review of appropriateness of health care, the setting and the progress of discharge plans as they are being provided.

Conditions of Participation (CoPs)
Standards designated by CMS that hospitals and critical access hospitals must comply with in order to participate in the Medicare and Medicaid programs.

Conflict of Interest
A situation in which a person has a duty to more than one person or organization but cannot do justice to the actual or potentially adverse interests of both parties.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law allowing an employee and his or her dependents to continue to receive employer-sponsored health insurance coverage for a limited period of time after his or her employment ends, hours are reduced or another qualifying event occurs that disqualifies him or her from receiving health insurance as an employee benefit. The employee must pay the full premium plus two percent to continue the coverage.

Consumer-Directed Health Plans
Health plans with high deductibles accompanied by a consumer-controlled savings account for health care services. The two types of savings accounts are health savings accounts and health reimbursement arrangements.

Consumer Price Index (CPI)
Measure of change in prices over time paid by consumers for a market basket of consumer goods and services. Consumers are made up of all urban consumers and urban wage earners. The CPI is used to make changes in the federal income tax structure and cost-of-living wage adjustments.

Consumer Price Index, Medical Care Component
One of eight major components in the Consumer Price Index. Within this component are two medical care classifications: medical care commodities and medical care services that include prescription drugs and medical supplies, eyeglasses and eye care, professional services, and hospital services.

Continuous Quality Improvement (CQI)
Approach to quality management that emphasizes the organization and systems rather than the individual. This method empowers employees to continually improve work processes by identifying problems, implementing and monitoring corrective actions, and demonstrating or measuring improvement.

Continuum of Care
An integrated system of care providing comprehensive services ranging from preventive and ambulatory services to acute- and long-term care and rehabilitative services.

Contractual Allowance
The negotiated difference between what an insurance company will pay according to its contract and what a hospital or health care provider bills for a service or procedure.

Copayment (co-pay)
Cost-sharing arrangement in which an insured person pays a fixed amount for a specified service, such as prescription drugs or physician office visit. The insured typically is responsible for payment at the time the health care service is rendered.

Core Measures
Standardized quality measures selected to align reporting and improve patient care. The measures were established by CMS, The Joint Commission, payers and health care providers. Core measures are linked to pay for performance.

Corporate Practice of Medicine (CPOM)
State law that prohibits physicians in Texas from entering into partnerships, employee relationships, fee splitting or other situations with non-physicians where the practice of medicine is directed by, controlled by or fee-shared with non-physicians.

Cost Shifting
Occurs when an individual, group or government underpays for a health care service resulting in higher costs or charges for an individual who is privately insured.

Cost-to-Charge Ratio
The ratio of a hospital's operating costs (total expenses excluding bad debt) to its charges (gross patient revenue and other operating revenue).

Covered Entity
Defined by HIPAA as health plans, health care clearinghouses and health care providers who electronically transmit any type of health information.

Covered Lives
The total number of participants and beneficiaries in a health plan or covered by an insurer.

Credentialing and Privileging
Process by which a hospital obtains, verifies and assesses the qualifications of a practitioner and determines the scope of practice for him or her to provide services in the hospital. Credentials are documented evidence of licensure, education, relevant training and experience, or other qualifications. The criteria for granting privileges is determined by the hospital, is specific to that facility, and is based on credentials, practice history and performance.

Credentials Verification Service (CVS)
Provides data collection and background screenings and verifies records and credentials of a doctor or other health care practitioner seeking to provide services within a hospital.

Critical Access Hospital (CAH)
A rural community hospital that receives 101 percent of reasonable costs for reimbursement of inpatient and outpatient services for Medicare patients. The U.S. Department of Health and Human Services requires hospitals designated as a CAH to have no more than 25 inpatient beds; maintain an annual average length of stay of no more than 96 hours for acute inpatient care; offer 24-hour, 7-day-a-week emergency care; and be located in a rural area at least a 35-mile drive away from any other hospital or CAH.

Current Procedural Terminology (CPT) Codes
List of medical, surgical and diagnostic services associated with a unique identifying code used to report health care services and procedures to payers for reimbursement. It is designed to communicate standardized information about services and procedures among physicians, coders, patients, accreditation organizations and payers.

Data Use Agreement (DUA)
A legally binding agreement between entities regarding the transfer or use of personally identifiable data. DUAs serve to outline the terms and use of the data.

Deductible
Amount of expense an insured individual must pay for health care services, typically in a calendar year, before the health plan will pay for covered services.

Deemed Status
An accreditation given to a hospital once it is determined it meets Conditions of Participation or Conditions for Coverage, allowing the hospital to receive reimbursement from Medicare or Medicaid. Deemed status is received through a national accrediting organization that CMS has authorized as a deeming authority.

De-identified Data
Health information in which all identifiers have been removed and there is no reasonable basis to believe that the information can be used to identify a specific individual.

Department of State Health Services/ Texas Department of State Health Services (DSHS/TDSHS)
An agency of the Texas Health and Human Services System. TDSHS provides prevention and preparedness activities, family and community health services, mental health services, substance abuse prevention, and regulation of health professionals and maintains records including birth and death certificates and health statistics.

Diagnosis Related Group (DRG)
A patient classification system by diagnosis or procedure into major diagnostic categories containing specific diseases, disorders or procedures for the purposes of determining payment of hospital charges.

Discharge
Release of a patient from a provider's care, often referring to the date when a patient leaves a hospital, either returning home or transferring to another facility.

Discharge Planning
Evaluation of a patient's medical needs and recommendations of appropriate care after discharge from an inpatient setting.

Disproportionate Share (DSH) Adjustment
Provides a percentage increase in Medicare payment to hospitals that care for a disproportionate share of Medicaid patients and low-income, uninsured individuals.

DNV Healthcare Inc.
A national accreditation organization with deeming authority from CMS to evaluate and monitor the quality of care provided in hospitals and other health care institutions and to provide accreditation to those institutions.

Do-Not-Resuscitate (DNR) Out-of-Hospital (OOH)
An advance directive that allows an individual to refuse certain life-sustaining treatments in any setting outside of a hospital. This advance directive must be issued with an individual's attending physician.

Doctor of Nursing Practice (D.N.P.)
A degree focused on nursing practice that is an alternative to a research-focused doctoral degree (Ph.D.).

Drug Formulary
List of prescription drugs, both generic and brand name, covered by an insurance plan.

Dual Eligible
Describes individuals who are eligible for both Medicare and Medicaid benefits, including low-income seniors and younger people with disabilities.

Durable Medical Equipment (DME)
Any equipment such as hospital beds, walkers and oxygen equipment that provide therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses.

Duty of Care
Taking the care and exercising the judgment that any reasonable and prudent person would exhibit in the process of making informed decisions, including acting in good faith consistent with what a member of the board truly believes is in the best interest of the organization.

Duty of Loyalty
A standard that calls upon the board and its members to consider and act in good faith to advance the interest of the organization. It incorporates a duty to disclose situations that may present a conflict of interest as well as a duty to avoid competition with and appropriation of the assets of the organization.

Duty of Obedience
A standard that requires obedience to the organization's mission, bylaws and policies, as well as honoring the terms and conditions of other standards of appropriate behavior such as laws, rules and regulations.

Electronic Claim
A claim submitted by a health care provider to an insurer or third-party payer via technology that meets electronic filing requirements prescribed by HIPAA.

Electronic Data Interchange (EDI)
Computer-to-computer exchange of data and documents using a standardized format. Common health care uses of this technology include claims submission and payment, eligibility determination, and referral authorization.

Electronic Health Record (EHR)
Digital record of health information to be shared with providers responsible for a patient's care. EHRs are designed to go beyond standard clinical data and include past medical history, vital signs, progress notes, diagnoses, medications, immunization dates, allergies, lab data and imaging reports. The record also may contain other relevant information, such as insurance information, demographic data, and even data imported from personal wellness devices.

Electronic Medical Record (EMR)
A digital record of health-related information on an individual that can be created, gathered, managed and consulted by authorized clinicians and staff within a health care organization.

Emergency Department/Emergency Room (ED/ ER)
A department that provides immediate emergency medical care on a 24-hour basis for acutely ill or injured persons who present without an appointment by their own means or by an ambulance.

Emergency Medical Treatment and Labor Act (EMTALA)
Federal law that requires emergency departments to screen and stabilize individuals who present to an ER, regardless of their ability to pay.

Emergency Preparedness Plan
A framework to manage natural disasters, major incidents or mass casualty events that require assessment and treatment of patients who need emergency medical care. Hospitals, communities and/or regions have plans that may include additional staff, evacuation and/or sheltering in place. These plans typically are practiced at least annually through simulated disasters.

Employee Retirement Income Security Act (ERISA)
A federal law that sets minimum standards for pension plans in private industry. ERISA plans are retirement plans offered by employers that allow individuals to set aside funds during their working lives for future retirement. ERISA does not require any employer to establish a pension plan. It only requires that those who establish plans must meet certain minimum standards.

Endowment Fund
A fund set up where the original investment is maintained to provide income for general or restricted use(s), as specified by the donor, institution or program.

Episode of Care
Health care services provided to a patient with a specific medical problem within a set period of time.

Ethics Committee
A group of individuals, usually comprising an administrator, one or more physicians, a chaplain, a community representative and an ethicist, formed to help patients and families reach informed decisions and work with health care providers in order to make complex and difficult decisions regarding moral issues (i.e., end-of-life care).

Evidence-Based Medicine (EBM)
Integration of individual clinical expertise with the best available external clinical evidence from systematic research for use in making decisions about the care of individual patients and/or the delivery of appropriate health care services.

Excess Bed Capacity
Greater hospital bed availability than patients receiving care or treatment.

Exclusive Provider Organization (EPO)
Arrangement in which health care services must be obtained by the insured from doctors and hospitals within an established network. If members go outside of the network, no benefits are payable or the patient is responsible for a higher percentage of the charge.

Explanation of Benefits
A statement provided by a health insurance company to covered individuals stating what medical treatment and/or services were paid for on their behalf.

External Quality Review Organization (EQRO)
An external independent entity that conducts an annual review of the quality of services and care provided to enrollees in Medicaid and CHIP managed care plans. In Texas, the EQRO is the Institute for Child Health Policy at the University of Florida.

False Claims Act
Federal law that imposes liability on persons and companies that defraud government programs.

Federal Fiscal Year (FFY)
The federal government's accounting period that begins Oct. 1 and ends Sept. 30 of each calendar year. Fiscal years are referred to by the calendar year in which they end.

Federal Medical Assistance Percentage (FMAP)
Amount paid by the federal government to match state Medicaid spending based on a formula taking into account the state's per capita income relative to the nation. By law, the FMAP cannot be lower than 50 percent.

Federal Poverty Level (FPL)
A measure of income determined annually by the U.S. Department of Health and Human Services. The FPL is used to determine eligibility for certain programs and benefits (i.e., Medicaid).

Federal Register
A federal publication issued daily from the National Archives and Records Administration that contains federal agency final and proposed regulations and public notices.

Federally Qualified Health Center (FQHC)
Outpatient clinics that qualify for enhanced reimbursement under Medicare and Medicaid. The main purpose is to provide care to an underserved area or population. FQHCs include federally supported health centers, migrant health centers, health care for the homeless centers, public housing primary care centers, outpatient health programs and certain outpatient Indian providers.

Fee-for-Service (FFS)
Payment method in which each specific service provided to a patient is associated with a corresponding fee to be paid to the provider.

Fee Schedule
A list of fee maximums for specified medical services and procedures used to reimburse a physician and/or other providers on a fee-for-service basis. Medicare has a fee schedule for doctors who treat beneficiaries. Insurance companies have fee schedules that determine what they will pay under their policies.

Fiduciary Relationship
Relationship in which an individual or organization has an explicit or implicit obligation to act on behalf of another person's or organization's interests. A physician has such a relation with his/her patient, and a hospital trustee has one with a hospital.

Fiscal Year (FY)
A period that a company or government uses for accounting purposes and calculating financial statements. The fiscal year may or may not be aligned with the calendar year.

Freestanding Ambulatory Care Center
A licensed facility, separate from a hospital, that provides medical and surgical outpatient care.

Freestanding Emergency Center (FEC) or Freestanding Emergency Room
A licensed facility, separate from a hospital, that is equipped and staffed to provide primary care and medical care for injuries and illnesses, including those that are life-threatening. Freestanding ERs are owned by physicians, hospitals or other entities.

Freestanding Urgent Care Center
A facility owned by a physician, separate from a hospital, that provides primary care and treatment for injury or illness that requires immediate care but is not severe enough to require an ER visit. These centers are not equipped to treat medical emergencies, nor are they structured to provide follow-up care.

Full-Time Equivalent Employee (FTE)
Calculated by taking the total number of hours worked divided by the maximum number of compensable hours in a period. FTEs are units equivalent to employees (i.e., one FTE is equal to one employee working full-time).

Gainsharing
A financial collaboration that sets up a system in which participants receive benefits they achieve resulting from either productivity gains, increased efficiency or decreases in costs. Physicians participating in gainsharing arrangements will have a financial stake in controlling hospital costs.

Gatekeeper
A health care professional who controls a patient's entry into the health care system and coordinates, manages and authorizes all health care services provided to a covered beneficiary. May be a nurse, social worker, physician assistant or primary care physician.

Gatekeeper PPO
A point-of-service plan that requires members to choose a primary care physician and to use doctors and other providers in a network or face higher out-of-pocket costs.

Generally Accepted Accounting Principles (GAAP)
A framework of guidelines for financial accounting, including the standards, conventions and rules accountants follow in recording and summarizing transactions and in the preparation of financial statements.

Generic Drugs
Prescription drugs that have the same active-ingredient formula as brand-name drugs and are identical in dosage, safety, strength, route of administration, quality and intended use. Generic drugs are less expensive than the brand-name drug.

Geographic Adjustment Factor
An adjustment to a provider's Medicare reimbursement rate based on estimated operating expenses in different geographic areas.

Global Payment
A fixed payment given to health care providers for clinically defined services provided to patients in a given period of time.

Governing Body
Legal entity responsible for hospital policy, organization, management and quality of care. The governing body provides oversight and is accountable to the owner(s) of the hospital, the community, local government or shareholders. Also called the governing board, board of trustees or board of directors.

Government Accountability Office (GAO)
An independent non-partisan agency that investigates how the federal government spends taxpayer money by reviewing federal financial transactions, examining the expenditure of appropriations of federal agencies, and reporting to the U.S. Congress.

Graduate Medical Education (GME)
Any type of formal medical education such as internships, residencies, subspecialties and fellowship programs that leads to state licensure and board certification.

Group Model HMO
HMO that contracts with one or more multi-specialty groups to provide medical services, at a negotiated rate, to beneficiaries.

Group Practice
A type of health maintenance organization in which physicians organize to provide medical care, consultation, diagnosis and/or treatment through the joint use of equipment and personnel. Income and expenses are pooled together and shared.

Grouper
A computer software program that uses clinical and other information to classify medical cases into the proper Diagnosis Related Group based on International Classification of Diseases.

Health and Human Services/Texas Health and Human Services Commission (HHSC)
A federal and state agency, respectively, that administers all programs related to health and human services, including Medicaid and CHIP.

Health Information Technology (HIT)
The exchange and management of health information in an electronic multi-system environment. Information is shared among patients, consumers, health care providers, payers and quality monitors. Health information technology includes electronic health records, personal health records, e-prescribing and other programs.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Federal law that governs the transmission, privacy and security of health information. The law also includes administrative simplification provisions aimed at improving the efficiency and effectiveness of the health care system. Additionally, HIPAA protects individuals' rights to health coverage as a result of preexisting conditions, when they change or lose jobs, and other circumstances.

Health Maintenance Organization (HMO)
Organization that provides a wide range of comprehensive health care services for a specified group at a fixed, periodic payment.

Health Plan
Any entity or organization that provides for or pays for health care services for an individual or group of people.

Health Plan Employer Data and Information Set (HEDIS)
Set of standardized performance measures focusing on quality, access, patient satisfaction, membership, utilization and finances developed by the National Committee on Quality Assurance and used in the majority of health plans to measure and compare performance on important dimensions of care and service.

Health Professional Shortage Area
Geographic area, population or facility designated by the federal government as having shortages of primary care, dental or mental health care providers.

Health Resources and Services Administration (HRSA)
Division of the U.S. Department of Health and Human Services created to improve access to health care services for people who are geographically isolated, have special needs or are medically vulnerable. HRSA also focuses on developing a skilled and innovative workforce.

Health Savings Account (HSA)
A medical savings account designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis. Funds contributed to an account are not subject to federal income tax at the time of deposit. They often are paired with high-deductible health insurance policies.

Healthcare Facilities Accreditation Program (HFAP)
Nationally recognized accreditation authority with deeming authority from CMS to survey all hospitals and other health care facilities for compliance with the Medicare Conditions of Participation and Coverage.

Healthcare Financial Management Association (HFMA)
Professional association of health care finance leaders.

Home Health Care
Health care services provided in a patient's home rather than a hospital or other institutional setting, including nursing care, social services, and physical, speech or occupational therapy.

Horizontal Integration
A strategy creating a network of complementary or similar types of providers, such as a multi-organization system composed of acute-care hospitals. May be used as a competitive strategy by some hospitals and systems to control the geographic distribution of health care services.

HOSPAC
The political action committee of the Texas Hospital Association that supports candidates for state and federal public office who express willingness to work with Texas hospitals on priority health care issues.

Hospice
An organized program of holistic care for the terminally ill that emphasizes caring and comfort of spiritual and emotional needs as opposed to curing, and that may include inpatient care, home care, respite care and family support. A hospice may be a freestanding facility, a unit of a hospital or other institution, or a separate program of a hospital, agency or institution.

Hospital-Acquired Condition (HAC) or Infection (HAI)
A preventable medical problem or infection not present on admission that arose during the stay in a facility. CMS' Medicare and Medicaid programs may refuse payment for treatment related to a hospital-acquired infection/condition.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
A patient satisfaction survey required by CMS for all hospitals in the U.S. The survey is for adult inpatients, excluding psychiatric patients, and provides the patient perspective of hospital care given.

Hospital Inpatient Quality Reporting Program
In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their health care.

Hospital Market Basket
A measure of all the goods and services a specific organization must purchase to provide care.

Hospital Quality Alliance
National public-private collaboration that monitors and makes information about hospital performance accessible to the public and encourages efforts to improve quality.

Hospitalist
A dedicated inpatient physician who works exclusively in hospitals.

Incident Report
A written report that documents a problem, occurrence or situation for which follow-up action is indicated. Examples include falls, accidental needle sticks and errors. The purpose of the report is to document the exact details of the occurrence while they are fresh in the minds of those who are involved or witness the event.

Incurred But Not Reported (IBNR)
An accounting term referring to health services that have been provided for a specified period, but the claim for payment has not been submitted.

Independent Payment Advisory Board (IPAB)
Created by the ACA in 2010, the IPAB seeks to achieve specified savings in Medicare without affecting coverage or quality. The IPAB is to issue recommendations to lower Medicare costs if spending exceeds targets established in the ACA.

Independent (or Individual) Practice Association (IPA)
An independently organized network of physicians, and other health care providers, who form with the purpose of contracting with one or more HMOs. IPAs provide care to HMO patients based on a negotiated per capita rate, flat retainer fee or fee-for-service but may also provide care to non-HMO patients.

Indigent Care
Care given by health care providers to patients who are unable to pay for care and who are not eligible for health care coverage such as Medicaid, Medicare or private insurance.

Indirect Medical Education
Reimbursement from Medicare to teaching hospitals that have residents in an approved graduate medical education program.

Inpatient
Patient admitted to a hospital for a stay of longer than 24 hours for observation or to receive medically necessary care.

Institute for Healthcare Improvement (IHI)
An independent nonprofit organization that focuses on improving health care. IHI's Triple Aim, 100,000 Lives and 5 Million Lives campaigns are initiatives to engage U.S. hospitals in a commitment to implement proven changes that improve patient care and quality.

Institute of Medicine (IOM)
An independent nonprofit organization that is part of the National Academies of Sciences, Engineering and Medicine and advises on issues related to science, medicine and health.

Institutional Review Board (IRB)
A committee that provides peer review to protect the rights of human subjects through approval, monitoring and the review of medical research and clinical trials.

Insurance Exchange
State and federal health insurance marketplaces that are set up to facilitate the purchase of health insurance for individuals not covered by employer-based or government health insurance. A federal exchange is available for those living in states that have chosen not to create their own, including Texas.

Integrated Delivery System (IDS)
Network of health care providers typically between physicians and hospitals that collaborate to provide a coordinated continuum of services.

Intergovernmental Transfer (IGT)
The transfer of public funds between governmental entities either between one level of government to another or within the same level of government. In health care this is a mechanism in which states may use revenue from local governments to help fund the state's share of allowable Medicaid expenditures, such as disproportionate share hospital payments.

Intermediate Care Facility
A facility that provides nursing, supervisory and supportive services to elderly, disabled or chronically ill patients who do not require the degree of care or treatment that a skilled nursing facility provides.

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10)
An international system used by physicians and other health care providers for classifying and coding all diagnoses, symptoms and services using a six-digit code to classify diseases by diagnosis (Diagnosis Related Groups).

International Organization for Standardization (ISO)
Organization established to develop a set of international standards for quality management in manufacturing and service businesses, including health care.

Interpretive Guidelines
Established to provide guidance and interpretation of the Medicare Conditions for Participation.

Investor-Owned Hospital
Generally operated as either a business corporation or a subsidiary of a multihospital system and subject to the ultimate control of shareholders who receive dividends based on a percentage of shares owned.

ISO 9000
Set of quality management standards developed by the ISO that establishes a quality assurance system to ensure that suppliers create products and services that meet certain standards.

Joint Commission Resources (JCR)
An affiliate of The Joint Commission that offers health care providers consulting services, educational services and publications to assist in improving quality and safety.

Joint Venture
Legal arrangement, for a finite time, between two or more entities (such as a hospital and a physician, two hospitals, or a hospital and an HMO) to develop a new entity or provide service(s) and/or product(s) in which risks, benefits and equity are shared.

Length of Stay (LOS)
Term used to describe a single period of hospitalization as measured in days billed; a standard measurement of hospital usage.

Licensed Facilities
Health care facilities that offer health care services, including hospitals, hospices, nursing homes and home health agencies, and require licensure to comply with federal or state laws or rules.

Licensed Vocational Nurse (LVN)
A licensed entry-level nurse who works under the supervision of a physician or registered nurse to provide basic-level care. LVNs are more commonly referred to as Licensed Practical Nurses (LPNs). California and Texas are the only states that use the term LVN rather than LPN.

Liquidity
Degree to which an asset or security can quickly be bought or sold in the market with a minimum change in price.

Living Will
Document generated by a person for the purpose of providing guidance about the medical care desired if the person becomes incompetent or is unable to articulate those decisions (see Advance Directive).

Local Coverage Determinations (LCD)
Policies developed by Medicare and administrative contractors deciding which procedures and treatments are reasonable and necessary for different types of conditions, and are eligible for insurance coverage.

Long-Term Care
Ongoing health and social services provided for individuals who need assistance to perform basic activities of daily living because of physical and/or mental disability. Services may be provided in an institution, the home or the community by professionals or agencies as well as friends and family.

Long-Term Care Facility (LTCF)
Residential health care facility that administers health, rehabilitative and/or personal services for a prolonged period of time. Long-term care facilities include nursing homes and assisted living facilities.

Long-Term Care Hospital (LTCH or LTACH)
Provides extended medical and rehabilitative services to patients with serious and often complex medical conditions that require a longer length of stay than customarily provided by an acute-care hospital. LTCHs provide care for such conditions as respiratory failure, non-healing wounds and medically complex diseases. An LTCH must be certified as an acute-care hospital that meets criteria to participate in the Medicare program and has an average inpatient length of stay greater than 25 days.

Magnet Hospital Recognition Program
Designation through the American Nurses Credentialing Center recognizing institutions with excellence in nursing, including quality patient care, high job satisfaction and best practices.

Maintenance Management Information System (MMIS)
Integrated computer system that automates claims processing and information retrieval for Medicaid.

Managed Care
Health care delivery system or health plans that aim to deliver quality health care at lower cost to patients.

Managed Care Organization (MCO)
A provider or organization that uses the principles of managed care as a business model by combining the managed care health plans with the delivery of care from specific providers. Examples are PPOs, HMOs and point-of-service plans.

Management Service Organization (MSO)
Provides non-clinical services to a health care organization. This may include businesses that provide assistance in administrative tasks, billing, information technology, equipment and more.

Market Basket Index
A calculation intended to reflect the average change in the price of goods and services hospitals purchase within a given period of time to furnish patient care. There are separate indices for various types of Medicare providers, including PPS hospitals, PPS-excluded hospitals, skilled nursing facilities, home health agencies and renal dialysis facilities. This index allows for CMS to update its payment systems appropriately.

Master of Science in Nursing (M.S.N.)
An advanced nursing degree that registered nurses pursue in order to become a specialized nurse (i.e., nurse practitioner or nurse educator).

Meaningful Use
The effective use of certified EHR technology to improve the health care landscape and set organizational objectives in the use of EHRs in order to receive Medicare and Medicaid incentive payments.

Medicaid
A joint state-federal insurance program under Title XIX of the Social Security Act for low-income individuals. The program provides health care to qualifying individuals based on their citizenship status, income and assets. The federal government has established minimum eligibility levels and required covered populations, but states determine covered benefits and reimbursement rates and whether to expand coverage to optional populations.

Medicaid 1115 Transformation Waiver
A waiver approved by CMS for Texas that allows it to expand Medicaid managed care while preserving hospital funding, provides health care improvements, and directs more funding to hospitals that serve large numbers of uninsured patients.

Medicaid Waiver
Authorization granted by the U.S. Secretary of Health and Human Services that allows a state to develop new programs or continue providing services in Medicaid and CHIP. States receive federal Medicaid matching funds that can be used to implement home- and community-based services programs or managed care delivery models and to expand coverage to populations not otherwise eligible for Medicaid. Waivers are typically referred to as 1915(b), 1915(c) or 1115 waivers.

Medical Error
A preventable adverse event that may or may not be evident or harmful to the patient. These can occur in diagnosis, treatment, preventative monitoring or lab reports or through the use of medical equipment.

Medical Home
A comprehensive and patient-centered model of care wherein a primary care provider leads a team that takes collective responsibility for care of a patient. This team is responsible for providing and coordinating the patient's health care or arranging for appropriate care with other qualified physicians or providers if needed. Also referred to as a patient-centered medical home (PCMH).

Medical Loss Ratio
The percentage of premium dollars an insurance company spends on clinical services and quality improvement rather than on administrative costs or profits. The ACA requires insurers in the large group market to have a ratio of 85 percent and insurers in the small group and individual markets to have a ratio of 80 percent of premium funds spent on medical care. Managed care plans in Medicaid and CHIP must have a ratio of 85 percent.

Medical Malpractice
Occurs when a health care professional causes harm to the patient during the course of treatment.

Medical Power of Attorney
A legal document that allows individuals to designate another person to make health care decisions on their behalf if they are unable to make decisions themselves.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medically Underserved Area
A federal designation of a geographic location that has insufficient health resources to meet the medical needs of the population. More specifically, this is based on four variables: insufficient number of primary care providers, high infant mortality, high poverty or a large elderly population.

Medicare
Federal program under Title XVIII of the Social Security Act that provides hospital and medical coverage to people 65 and over and to certain disabled individuals regardless of age. It has four parts: Part A covers inpatient costs (hospital insurance); Part B covers outpatient costs (medical insurance); Part C is the Medicare Advantage Program that provides managed care benefits for Part A and Part B; and Part D covers prescription drugs.

Medicare Administrative Contractor (MAC)
A private health care insurer that has regional jurisdiction, awarded by CMS, to manage enrollment, provide claims for payment, provide customer service, and establish regional policy guidelines. MACs serve as the fiscal intermediary and point of contact for Medicare. Novitas Solutions is the current MAC for Texas.

Medicare Advantage
Medicare managed care program created by the Balanced Budget Act of 1997 as Medicare+Choice and given a new name under the Medicare Prescription Drug Improvement and Modernization Act of 2003. Beneficiaries have the choice during an open enrollment season each year to enroll in a Medicaid managed care plan or to remain in traditional Medicare. These plans may include coordinated care plans (HMOs, PPOs or plans offered by provider-sponsored organizations); private fee-for-service plans; or high-deductible plans with medical savings accounts.

Medicare Cost Report
Annual report required of institutions participating in the Medicare program that records each institution's total costs and charges associated with providing services to all patients, as well as the percentage of these costs allocated to Medicare patients and the Medicare payments received.

Medicare Geographic Classification Review Board (MGCRB)
Renders decisions on hospital requests for geographic reclassification for Medicare PPS purposes.

Medicare Payment Advisory Commission (MedPAC)
An independent congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program in addition to analyzing access to care and quality of care.

Medicare Severity Diagnosis Related Groups
A classification system that enables CMS to provide greater reimbursement to hospitals serving more severely ill Medicare patients. Hospitals treating less severely ill patients receive reduced reimbursement.

Medicare-Supplement Policy
Health insurance policy that provides benefits for services Medicare does not cover. Also known as a Medigap policy.

Medigap Policy
Health insurance sold by private companies that can help pay for costs Medicare does not cover.

Messenger Model PPO
A contract negotiation model conducted by an entity that provides participating providers access to non-risk PPO contracts. The provider, within a limited timeframe, may accept or reject the contract terms.

Methicillin-Resistant *Staphylococcus Aureus* (MRSA)
A staph bacteria resistant to many antibiotics. In a medical facility, this can cause life-threatening infections. It is usually caused by contact with an infected wound or contaminated hands/devices.

Metropolitan Statistical Area
Geographic area that includes at least one city with 50,000 or more inhabitants or a Census Bureau-defined urbanized area of at least 50,000 inhabitants and a total population of at least 100,000. This often consists of several counties.

Morbidity
Incidence and severity of illness or disease in a defined population.

Mortality
Incidence of death in a defined population.

Multi-Specialty Group
Physician group practice that employs providers from different fields of medicine, allowing for more types of care at one organization.

National Committee for Quality Assurance (NCQA)
Nonprofit organization dedicated to improving health care quality by creating rigorous quality standards and performance measures for health care organizations to use for identifying where improvements need to be made before reaching accreditation. NCQA also helps in tracking the quality of care delivered nationwide by health plans.

National Drug Code (NDC)
A 10-digit numerical code made up of three segments that is assigned to each drug product as its universal identifier. The NDC database is maintained by the Food and Drug Administration.

National Incident Management Systems (NIMS)
A nationwide systematic framework designed to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards, regardless of cause, size, location or complexity.

National Institutes of Health (NIH)
Agency of the U.S. Department of Health and Human Services responsible for the nation's medical research. It is made up of 27 components that each focus on a specific area of research, the majority of which are funded directly by the U.S. Congress.

National Labor Relations Board (NLRB)
Independent federal agency that is charged with conducting elections for labor union representation and with investigating and remedying unfair labor practices.

National Practitioner Data Bank (NPDB)
An electronic information repository created by the U.S. Congress that contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers and suppliers. This information is not made available to the public.

National Program of Cancer Registries
Administered by the CDC, this program collects data on the occurrence of cancer, the type of treatment conducted and the outcome.

National Provider Identifier (NPI)
Required by HIPAA, this is a unique 10-digit identification number assigned to each covered health care provider to use for billing purposes.

National Quality Forum
A membership-based organization that works to improve health care by establishing national priorities and goals, creating quality standards, and continuously driving improvement among health care leaders.

Neonate
Refers to a newborn during the first four weeks of life.

Nosocomial Infection
Infections acquired from a health care setting, also called hospital-acquired infections. The patient must not have shown any symptoms of this infection upon being admitted to the hospital in order for it to be classified as such.

Not-for-Profit Hospital
A hospital that operates as a nonprofit corporation with all profits invested into the organization. It is exempt from federal and state taxes and is required to report community benefits offered by the facility.

Nurse Practitioner
A registered nurse who has advanced education and clinical training in a health care specialty. NPs are qualified to prescribe medicine, order tests, conduct physical examinations and procedures, and provide treatment.

Nursing Home
Health care facility with residential beds and an organized professional staff that provides continuous nursing and other health-related, psychosocial and personal services to patients who are not in an acute phase of illness but who require continued inpatient care.

Nursing Levels of Education
Designations of nursing education and proficiency. They are: licensed vocational nurse (LVN); associate degree in nursing (A.D.N.); registered nurse (RN); Bachelor of Science in Nursing (B.S.N.); Master of Science in Nursing (M.S.N.); Doctor of Philosophy in Nursing (Ph.D.); and Doctor of Nursing Practice (D.N.P.).

Occupational Safety and Health Administration (OSHA)
Agency of the U. S. Department of Labor charged with making sure that workplaces are safe and healthy. Primary responsibilities include establishing rules, monitoring compliance through inspection, and enforcing rules through penalties and fines for non-compliant organizations.

Occurrence Coverage
A common insurance policy type, offered by medical malpractice insurance companies, that responds to events that occur during the policy period regardless of when the claim is made.

Office for the Advancement of Telehealth (OAT)
Federal office that is part of the Office of Rural Health Policy within the Health Resources and Services Administration created to promote the wider adoption of advanced technologies in providing health care services and education. Because the use of telecommunications and information technologies is especially important in rural areas that do not have access to specialty care, this office also provides funds that help support the use of these services.

Office for Civil Rights (OCR)
Division of the U.S. Department of Health and Human Services responsible for protecting fundamental nondiscrimination and health information privacy rights through the federal civil rights laws and HIPAA.

Office of Inspector General (OIG)
Division of the U.S. Department of Health and Human Services responsible for fighting waste, fraud and abuse in Medicare, Medicaid and more than 100 other HHS programs.

Office of Management and Budget (OMB)
Located in the Executive Office of the President of the United States, the OMB is the largest office that implements and enforces presidential policy throughout the government. OMB is charged with compiling the president's budget, managing government agencies, coordinating federal regulations, reviewing agency communications with Congress, and creating executive orders/presidential memoranda.

Office Visit
An outpatient visit to a physician for routine care or care related to illness or injury.

Ombudsperson or Ombudsman
Person designated to receive and investigate complaints from beneficiaries about quality of care, inability to access care, discrimination and other issues.

Online Survey, Certification and Reporting (OSCAR)
A data network maintained by CMS in cooperation with the state long-term care surveying agencies of all the data elements collected by surveyors during the inspection survey conducted at nursing facilities for the purpose of certification for participation in the Medicare and Medicaid programs.

Open Enrollment Period
Time each year during which people can enroll in a health insurance plan through the federal insurance exchange or Medicare. Employers also may have open enrollment periods during which employees and their dependents may enroll in a plan or change plans.

Open Medical Staff
Opening of hospital medical staff membership to all physicians in the community who meet membership and clinical privilege requirements.

Operating Budget
Financial plan for the expected revenues and expenditures of day-to-day operations of the hospital. It is a combination of known expenses and expected costs as well as forecasted income over the course of a year.

Operating Margin
A measure of profitability calculated by dividing the income from operations by the total operating revenue and multiplying it by 100.

Organ Procurement Organization (OPO)
A nonprofit organization authorized by federal law to perform the life-saving mission of recovering organs from deceased donors for transplantation. Texas is served by three OPOs.

Organized Health Care Arrangement (OHCA)
A recognized relationship under the HIPAA privacy rules that allow two or more covered entities working with the same patients to share protected health information in order to manage and benefit their joint operations. These organizations must be clinically or operationally aligned.

ORYX
Initiative of The Joint Commission that integrates the reporting of data into the accreditation process. Organizations have flexibility in choosing the minimum six different measure sets they must report. The data collected in this program are shared publicly to allow for user comparisons.

Outcome and Assessment Information Set (OASIS)
Data elements developed for the purpose of performance improvement in home health care to measure individual patient outcomes and to identify opportunities to improve performance and patient satisfaction. Home health agencies must comply with OASIS collection and transmission requirements to become Medicare certified as mandated by the Medicare CoPs.

Outcomes
The intended result of health care. Outcomes are usually measured in terms of quality, cost, mortality, health status, and quality of life or patient function.

Outcomes Measurement
The specific criteria and process of systematically tracking a patient's clinical treatment and responses to that treatment to determine or describe the outcome.

Outcomes Research
Investigation designed to determine the relative effectiveness of specific treatments for specific health conditions.

Outlier
A case in which costs exceed the allowable amount for the specific diagnosis or treatment. The outlier amount is typically specified in advance in the contract between the provider and the payer.

Out-of-Network
A health care provider who has not contracted with an insurance company for reimbursement at a negotiated rate. A patient choosing to go to an out-of-network provider likely will have to pay more, often absorbing the entire cost.

Out-of-Pocket
The health care expenses patients pay that are not reimbursed by insurance. This includes copayments and deductibles.

Outpatient Prospective Payment System (OPPS)
Method of financing health care that defines payments in advance for the provision of outpatient services and is based on the ambulatory payment classification.

Over-the-Counter (OTC) Drugs
Drugs sold without a prescription from a health care provider.

Paid Claims Loss Ratio
The total amount of losses an insurance company pays out in claims divided by the premiums earned.

Palliative Care
Specialized medical care for people with a serious illness focused on relieving suffering and improving the quality of life. Palliative care consists of pain management along with emotional and spiritual support from a team of caregivers.

Participating Provider
A physician, hospital or other provider who agrees to accept the amount assigned by Medicare or other insurance carrier as the total cost for covered services.

Patient Advocate
An individual who supports a patient as they navigate the health care system. This individual investigates and mediates patients' problems and complaints regarding a health care provider's services.

Patient Days
The number of calendar days of care provided to a hospital inpatient under the terms of the patient's health plan, excluding the day of discharge. Patient days are used in accounting in which each day represents a unit of time and are used in calculating the cost of care.

Patient Dumping
A statutorily imposed liability that occurs when a hospital capable of providing the necessary medical care transfers a patient to another facility or simply turns the patient away because of the patient's inability to pay for services.

Patient Mix
The distribution of demographic variables in a patient population often represented by the percentage of a given race, age, sex or ethnic origin.

Patient Safety and Quality Improvement Act (PSQIA)
Federal law that establishes a voluntary reporting system to assess and resolve medical errors and health care quality issues. The PSQIA also created patient safety organizations to collect, aggregate and analyze confidential information reported by health care providers regarding patient safety events.

Patient Safety Organization (PSO)
A collaboration of health care organizations that share in the goal of improving the safety and quality of health care delivery by learning from one another through the voluntary confidential sharing of privileged information in a legally secure environment. Organizations eligible to become federally certified PSOs under the Patient Safety and Quality Improvement Act include public or private entities, for-profit or nonprofit entities, provider entities such as hospital chains, and other entities that establish special components to serve as PSOs. The Texas Hospital Association runs a PSO for Texas hospitals.

Patient Self-Determination Act
Federal law that requires health care facilities to inform patients of their rights in deciding their medical care, determine if a patient has a living will and/or medical power of attorney, and consider patients' wishes - including those stated in an advance directive - in the development of treatment plans.

Patient's Rights
Guidelines that inform patients of their rights and responsibilities concerning their own health care.

Pay for Performance
Initiatives aimed at improving the quality, efficiency and overall value of health care. These arrangements provide financial incentives to hospitals, physicians and other health care providers to carry out such improvements and achieve optimal outcomes for patients.

Payer (Payor)
Agency, insurer or health plan that pays for health care services and is responsible for the costs of those services.

Peer Review
Evaluation conducted by practicing physicians or other clinical professionals of the quality, appropriateness, effectiveness and efficiency of medical services ordered or performed by other practicing physicians or clinical professionals.

Peer Review Organization (PRO)
An independent organization contracted with CMS to review the medical necessity and quality of care provided to Medicare beneficiaries. PROs also conduct limited review of medical records and claims to evaluate the appropriateness of care provided.

Penalty
Required by the ACA, a fee that must be paid if an individual or family chooses not to purchase health insurance. The penalty is calculated by either a percentage of household income or a rate per person - whichever one is higher. This is also referred to as the individual mandate penalty or the individual shared responsibility payment.

Per Diem Cost
Hospital or other inpatient institutional costs per day or for a day of care. Hospitals occasionally charge for their services on a rate derived by dividing their total costs by the number of inpatient days of care given.

Per Diem Payments
Payment from an insurance provider for a patient's care based on the number of days the patient is directly receiving treatment from the health care provider.

Performance Measure
A set of technical specifications to evaluate important quality indicators. This can be a comparative indicator such as a benchmark.

Performance Standards
Standards set by management or a payer that the provider will need to meet in order to maintain its credentialing, renew its contract, receive incentives or avoid penalty.

Personal Health Records (PHR)
Personal health records contain the same types of information as electronic health records such as diagnoses, medications, immunizations, family medical histories and provider contact information. However, PHRs are designed to be set up, accessed and managed by patients. Patients can use PHRs to maintain and manage their health information in a private, secure and confidential environment.

Pharmacy Benefit Management
Administration of prescription drug programs. This involves a third-party organization that negotiates price discounts and rebates on drugs to reduce expenditures as well as provide information to participants about ways they can control prescription costs.

Physician Assistant (PA)
A trained, licensed individual who can perform similar duties of a physician but who must practice under the supervision of one or more supervising physicians and, if prescribing drugs, must have a prescriptive delegation agreement with the supervising physician(s).

Physician-Hospital Organization (PHO)
A legal entity formed by physicians and one or more hospitals with the intention of negotiating contracts with payers and sharing in the financial rewards of controlling costs while delivering high-quality care.

Physician Organization (PO)
A practice of two or more physicians representing one or more specialties to provide health care services and negotiate on behalf of its members to accept managed care or discounted fee-for-service contracts. Also referred to as a physician practice or group practice.

Physician Payment Review Commission (PPRC)
Independent legislative advisory group created in 1986 to provide advice to the U.S. Congress on reforms in the methods used to pay physicians in the Medicare program.

Plan Administration
The management unit with responsibility to run and control a managed care plan. Responsibilities can include billing, personnel management, marketing, legal, purchasing, facility maintenance and account services.

Point of Service (POS) Plans
A managed care insurance plan that allows patients to pay less for care if they use health care providers that fall within the plan's network. Additionally, this plan requires referral from a primary care doctor in order for a patient to see a specialist. Similar to an HMO plan, a patient will designate a primary care physician that falls within the network, but similar to a PPO plan, patients are allowed to seek care outside of the network - they will likely just have to absorb most of the cost.

Potentially Preventable Admissions (PPA)
A hospital stay that could have been avoided had there been access to ambulatory care or the correct health care coordination.

Potentially Preventable Complications (PPC)
A harmful event or negative outcome with respect to a person, including an infection or surgical complication, that occurs after the person's admission to an inpatient acute-care hospital and may have resulted from the care, lack of care, or treatment provided during the hospital stay rather than from a natural progression of an underlying disease.

Potentially Preventable Readmissions (PPR)
A return hospital admission shortly after discharge (usually within 30 days) as a result of problems from the previous hospitalization or a lack of appropriate follow-up.

Practice Guidelines
Systematically developed statements on medical practices that assist a practitioner in making decisions about appropriate health care for specific medical conditions and intended to optimize patient care. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care.

Predictive Analytics
Using different statistical techniques to look at historical data and assess the likelihood of future events based on that data.

Pre-Existing Condition
A physical or mental condition that an insured patient is diagnosed with prior to the effective date of coverage. Under the ACA, insurers can no longer deny coverage to individuals based on pre-existing conditions.

Preferred Provider Organization (PPO)
A health care plan arrangement that allows plan participants the freedom to choose physicians, other health care providers and hospitals within a certain network of participating providers. By receiving care from network providers consumers receive a discounted rate and do not pay out-of-network costs. PPOs do not require plan members to select a primary physician but do allow plan members to see a specialist without a referral.

Premium
The amount paid for health insurance coverage. With employer-sponsored coverage, typically the employer and employee share the cost of the premium.

Premium Subsidies
A financial assistance mechanism, for those who qualify, to help offset the cost of insurance through the federal insurance exchange.

Prepaid Group Practice Plan
A health maintenance organization under which specified health services are paid in advance and rendered by participating physicians. Enrollees make fixed periodic payments in advance or an insurance carrier contracts to pay in advance for the full range of health services.

Prepayment
Method of reimbursing or providing payment of health care services in advance of their use.

Present on Admission
A patient's current diagnosis upon arriving at a hospital. The pre-existing state of the patient must be reported to CMS. Hospitals can be penalized for conditions that appear upon discharge that were not there upon admission (i.e., infections).

Primary Care
Basic care including health promotion, prevention, initial diagnosis and treatment, maintenance of chronic conditions, and referral to specialists.

Primary Care Physician or Provider (PCP)
A physician who treats a variety of health problems across patient age groups on a continual basis and frequently serves as the patient's first point of contact with the health care system. Primary care providers may be internal medicine physicians, obstetricians/gynecologists, pediatricians, physician assistants or nurses.

Principal Diagnosis
The condition, after testing, that causes a patient to be admitted to a hospital.

Prior Authorization
Requires a physician to obtain approval from a health insurance plan to provide a service, conduct a procedure or prescribe a specific medication to a patient. If authorization is not obtained from an insurer the service, procedure or medication may not be covered and could result in increased costs for the patient.

Privileges
Permission granted by a governing board allowing a physician or other health care provider to render care in a hospital within a specific scope of services. Privileges are specific to the facility and are based on credentials, past performance and other determinants.

Professional Standards Review (PSRO)
Physician-sponsored organization charged with reviewing the services provided to patients who are covered by Medicare, Medicaid, and maternal and child health programs. The purpose of the review is to determine if the services rendered are medically necessary, provided in accordance with professional standards, economically sound and provided in the appropriate setting.

Prospective Payment System (PPS)
Method of reimbursement in which Medicare payment is made based on a predetermined, set rate based on the classification system of that service, regardless of the length of stay or time it takes to provide care.

Prospective Review
Process in which hospitalization or services are reviewed and authorized prior to administration to determine appropriateness and medical necessity of the proposed level of care.

Protected Health Information
Individually identifiable health information that is transmitted or maintained in any form or medium (electronic, oral or paper) by a covered entity or its business associates, excluding certain educational and employment records. This includes identifiable demographic and other information relating to the past, present or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer or health care clearinghouse.

Provider Reimbursement Review Board
Independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a reimbursement decision by its Medicare contractor or by CMS.

Provider-Sponsored Network (PSN)
An affiliation of providers (hospital, physician group or health system) that removes third-party or intermediary payers and offers a full range of health care services.

Provider-Sponsored Organization (PSO)
A type of managed care plan that is operated by a group of doctors, hospitals and other health care providers that form a network of providers within which an individual must stay to receive coverage for care.

Public Health Department
A department of city or county government responsible for protecting and improving the lives of communities through promotion of healthy lifestyles, injury prevention, and detection and control of infectious diseases.

Quality (Health Care)
The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Assurance
The process of providing a desired level of quality care on a consistent basis. Quality assurance includes the continual monitoring and evaluation of current processes to determine consistency or areas of improvement.

Quality Improvement Organization (QIO)
Mostly private, nonprofit organizations staffed by doctors and other health care professionals trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

Quality Innovation Network (QIN or QIN-QIO)
A product of QIOs, often referred to as a QIN-QIO. These are networks of health care providers who collaborate to improve health care services through education, outreach, sharing practices that have worked in other areas, using data to measure improvement, working with patients and families, and convening community stakeholders for communication and collaboration.

Rapid Response Team
A group of health care providers who respond to hospitalized patients with early signs of clinical deterioration on non-intensive care units to prevent events such as cardiac arrest or respiratory failure.

Recovery Audit Contractor (RAC)
Works on behalf of CMS' Recovery Audit Program to review, identify and correct incorrect Medicare payments, both overpayment and underpayment, so that CMS can implement corrective actions that will prevent future issues.

Referral
A written order from a primary care physician to a specialist allowing a patient to seek certain medical services. If a referral is not provided, the health plan may not pay for the services.

Regional Health Information Organization (RHIO)
A type of health information exchange organization that convenes stakeholders within a defined area and governs health information exchange among them for the purpose of improving health and care in that community.

Registered Nurse (RN)
Graduate from a college or university nursing education program who has met state board requirements and is licensed by the state.

Rehabilitation
Coordinated use of treatments and therapies, including physical, occupational, speech or psychiatric services, in inpatient and/or outpatient settings to train or retrain individuals disabled by disease or injury.

Relative Value Unit (RVU)
Measure of value used in the Medicare reimbursement formula for physician services. RVUs are often used in physician practice management to compare performance of doctors within a group.

Reporting Hospital Quality for Annual Payment Update (RHQDAPU)
An initiative that requires hospitals to submit data for specific quality measures for health conditions common among people with Medicare and that typically result in hospitalization. Acute-care hospitals face a reduction of 2 percent in their annual PPS update for a given year unless they submit certain hospital quality data to CMS.

Resident
A medical school graduate participating in a GME program and receiving professional training under the supervision of a physician. First-year residents typically are referred to as interns.

Resource-Based Relative Value Scale (RBRVS)
A common scale used by CMS and other payers for pricing physicians' services. The payments for services are determined by the resource costs needed to provide them.

Respite Care
Care that provides caregivers who care for an individual requiring 24-hour care a temporary reprieve from caregiving.

Restraint
A physical hold that restricts a patient's movement when the patient's behavior presents a danger to himself, staff or others.

Retrospective Reimbursement
Payments made after a service has been provided, such as fee-for-service reimbursement.

Risk Adjustment in Quality Programs
A method to increase payments to health insurers or providers who treat higher-risk populations and reduce incentives for the avoidance of higher-risk patients.

Risk Management
Identification and evaluation of risks followed by the application of resources to reduce injury to patients, staff members and visitors within a health care facility.

Root Cause Analysis
Systematic process used to identify causal factors that underlie variations in performance or adverse events.

Rural Health Clinic (RHC)
A federally qualified health clinic certified to receive special Medicare and Medicaid reimbursement. The clinic must be located in a medically underserved area or a health professional shortage area and staffed with a physician assistant and/or nurse practitioner to deliver services. A physician (M.D. or D.O.) is required to supervise the mid-level practitioner in a manner consistent with state and federal law.

Rural Health Network
A network of rural health care providers that shares resources to achieve common goals and expands access to health care services.

Rural Referral Center (RRC)
A CMS classification for a rural facility that receives referrals from surrounding hospitals and provides high-volume acute care for a large number of complex cases. Several criteria must be met to be classified as an RRC.

Safe Harbor
Set of federal regulations providing protection for certain health care business arrangements (primarily physician-hospital arrangements) from the criminal and civil sanction provisions of the federal anti-kickback statute.

Safe Haven Law-Infant
The decriminalization for a mother, or parents, to relinquish unharmed infants at designated sites. Child Protective Services assumes custody of the child and places him or her with an appropriate caregiver.

Safe Medical Devices Act (SMDA)
Federal law that requires that personnel report any incident in which a medical device may have caused or contributed to an adverse event, death, serious illness or serious injury to a patient.

Safety Net Providers
Public hospitals, community health centers, local health departments, clinics and other facilities that deliver large amounts of care to the uninsured or other vulnerable populations.

Sarbanes-Oxley Act (SOX)
Federal law that protects shareholders and the general public from accounting errors and fraudulent practices in the enterprise and improves the accuracy of corporate disclosures. The U.S. Securities and Exchange Commission administers the law, which sets deadlines for compliance and publishes rules on requirements.

Self-Insurance
Employer or group of employers who set aside funds to cover the cost of health benefits for their employees, thus assuming the financial risk. Benefits may be administered by the employer(s) or handled through an administrative services-only agreement with an insurance carrier or third-party administrator.

Sentinel Event
An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Serious Adverse Event
The occurrence of patient harm in health care facilities that is often preventable and may be the unintended consequences resulting from individual minor mishaps that sometimes combine to cause permanent damage or even death.

Service Area
Geographic area in which a health insurance plan accepts members or has contracted with providers within a certain county or region.

Site-of-Service Differential
The rate that a physician service is paid under the physician fee schedule, determined by the setting where the service was provided.

Site-Neutral Payments
Payment or reimbursement of the same amount for the same service, regardless of treatment setting or practice setting.

Skilled Nursing Facility (SNF)
A facility that provides residential nursing care and rehabilitative services on a continuous basis under the care of a registered nurse or doctor.

Small Business Health Options Program (SHOP)
A marketplace created for small businesses with fewer than 50 FTEs to provide health and dental coverage to employees at an affordable price to the employer through tax credits.

Sole Community Provider
A health care facility designated by Medicare as meeting criteria including being located at least 35 miles from similar hospitals with fewer than 50 beds. Also, because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Solo Practice
Medical practice where the sole responsibility for practice decisions, regulatory compliance and management falls to the independent physician.

Specialist
Physician whose advanced training focuses on a particular area of medicine rather than family medicine or general medicine. Examples of these types of doctors include gynecologists and oncologists.

Specialty Hospital
A limited-service hospital designed to provide one medical specialty such as orthopedics or cardiology.

Staff Model HMO
A type of health maintenance organization in which enrollees pay premiums directly to the HMO, which hires physicians. The physicians are then paid a salary and predetermined bonuses.

Standard of Care
A legal term that means the degree of care and skill of the average health care provider who practices the provider's specialty, taking into account the medical knowledge that is available to the physician.

Stark Law
Federal law that bans physicians from referring patients to entities with which the physician has a financial relationship. This financial relationship could include ownership, investment or a structured compensation arrangement.

Stop-Loss Insurance
A product that provides protection for self-insured employers by serving as a reimbursement mechanism for catastrophic claims exceeding pre-determined levels.

Supplemental Security Income (SSI)
Federal cash assistance program for eligible individuals who are low-income, blind, disabled or age 65 or older. States may use SSI income limits to establish Medicaid eligibility.

Surveillance Epidemiology and End Results (SEER)
A component of the National Cancer Institute that, through the collection of data, works to provide information on cancer statistics in the U.S.

Swing Bed Providers
Providers permitted by the Social Security Act to enter into a swing bed agreement under which hospitals can use its beds, as needed, to provide either acute or skilled nursing facility care. A swing bed hospital is a hospital or CAH participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements.

Teaching Hospitals
Hospitals that have accredited physician residency training programs and typically are affiliated with a medical school.

Telehealth
The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Telehealth is a broader scope of remote health care services than telemedicine and can refer to non-clinical services, such as provider training, administrative meetings and continuing medical education, in addition to clinical services.

Tertiary Care
Highly specialized medical care, often received after referral from a primary or secondary care provider, usually over an extended period of time, that involves advanced and complex procedures and treatments performed by medical specialists in a state-of-the-art facility.

The Joint Commission
An independent, nonprofit organization that evaluates and accredits health care organizations and programs in the U.S.

Third-Party Administrator (TPA)
An independent person or firm that provides a variety of services including processing claims and assisting with employee benefit plans. Self-insured organizations may use TPAs.

Third-Party Payer
An entity, public or private, that pays or reimburses for health and medical expenses on behalf of beneficiaries or recipients.

Total Quality Management (TQM)
A management approach to long-term success where all members of an organization participate in improving processes, products, services and the culture in which they work.

Trauma Center
A hospital or health care facility appropriately equipped and staffed to receive and treat critically ill or injured patients. There are four trauma designation levels (I, II, III, IV) determined by the level of care a facility is able to provide. Level I and II trauma centers are capable of providing the most advanced trauma care. The trauma center designation is evaluated and assigned at the state level.

Triage
A process for sorting injured people into groups based on their need for or likely benefit from immediate medical treatment.

Unbundling
Occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment.

Uniform Billing (UB-04)
Forms and codes used in medical claims billing in the U.S. for institutional providers like hospitals, nursing homes, hospices, home health agencies and other providers.

Uninsured
Individuals who do not have health care coverage.

Update Factor
A recommended yearly increase in payment by providers based on the estimated changes in total cost of care for the next year.

U.S. Senate Health Education, Labor and Pensions Committee (HELP)
Standing U.S. Senate committee charged with reviewing proposed legislation related to measures that affect education, labor, health and public welfare.

Utilization
Usage rate for a particular health care facility, type of medical care or treatment, physician visit, or health care coverage, often measured within a population or covered group.

Utilization Review
The examination, usually by a physician or nurse, of health care services provided to patients especially for the purpose of controlling costs and monitoring the quality of care.

Value-Based Purchasing
A CMS initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries.

Vital Statistics
Official government records of events such as births, deaths, marriages, divorces and fetal deaths.

Women, Infants and Children (WIC) Program
A federal supplemental nutrition program of the Food and Nutrition Services under the Department of Agriculture that provides federal grants to states for low-income pregnant, breastfeeding and non-breastfeeding postpartum women as well as children up to age 5 who are found to be at nutritional risk.

Zone Program Integrity Contractor
An entity established by CMS to combat fraud, waste and abuse in the Medicare program.

ABN
Advance Beneficiary Notice

ACA
Affordable Care Act

ACHE
American College of Healthcare Executives

ACO
Accountable Care Organization

ADC
Average Daily Census

ADL
Activities of Daily Living

A.D.N.
Associate Degree in Nursing

ADT
Admission, Discharge, Transfer System

AHA
American Hospital Association

AHEC
Area Health Education Center

AHRQ
Agency for Healthcare Research and Quality

ALOS
Average Length of Stay

APG
Ambulatory Patient Group

APR-DRG
All Patient Refined Diagnosis Related Groups

APRN
Advanced Practice Registered Nurse

ASC
Ambulatory Surgical Center

ASO
Administrative Services Only

B.S.N.
Bachelor of Science in Nursing

C. Diff
The toxin-producing bacteria *clostridium difficile*

CAH
Critical Access Hospital

CAUTI
Catheter-Associated Urinary Tract Infection

CDC
Centers for Disease Control and Prevention

CGFNS
Commission on Graduates of Foreign Nursing Schools

CHAMPUS
Civilian Health and Medical Program of the Uniformed Services

CHIN
Community Health Information Network

CHIP
Children's Health Insurance Program

CLABSI
Central Line-Associated Bloodstream Infection

CLIA
Clinical Laboratory Improvement Amendments

CMS
Centers for Medicare & Medicaid Services

COBRA
Consolidated Omnibus Budget Reconciliation Act

CON
Certificate of Need

COP
Condition of Participation

CPI
Consumer Price Index

CPOE
Computerized Physician Order Entry

CPT
Current Procedural Terminology Codes

CQI
Continuous Quality Improvement

CQM
Clinical Quality Measure

CPOM
Corporate Practice of Medicine

CVS
Credentials Verification Service

DEA
Drug Enforcement Administration

DME
Durable Medical Equipment

D.N.P.
Doctor of Nursing Practice

DNR OOH
Do-Not-Resuscitate Out-of-Hospital

DOJ
Department of Justice

DOL
Department of Labor

DOT
Department of Transportation

DRG
Diagnosis Related Group

DSH
Disproportionate Share Hospital

DSHS
Texas Department of State Health Services

DUA
Data Use Agreement

ED
Emergency Department

EDI
Electronic Data Interchange

EHR
Electronic Health Record

EMR
Electronic Medical Record

EMTALA
Emergency Medical Treatment and Labor Act

EPA
Environmental Protection Agency

EPO
Exclusive Provider Organization

EQRO
External Quality Review Organization

ER
Emergency Room

ERISA
Employee Retirement Income Security Act

FAA
Federal Aviation Administration

FCC
Federal Communications Commission

FDA
Food and Drug Administration

FEC
Freestanding Emergency Center or Freestanding Emergency Room

FEMA
Federal Emergency Management Agency

FFS
Fee-for-Service

FFY
Federal Fiscal Year

FMAP
Federal Medical Assistance Percentage

FPL
Federal Poverty Level

FQHC
Federally Qualified Health Center

FTC
Federal Trade Commission

FTE
Full-Time Equivalent Employee

GAAP
Generally Accepted Accounting Principles

GAO
Government Accountability Office

GME
Graduate Medical Education

HAC
Hospital-Acquired Condition

HAI
Hospital-Acquired Infection

HCAHPS
Hospital Consumer Assessment of Healthcare Providers and Systems

HEDIS
Health Plan Employer Data and Information Set

HELP
U.S. Senate Health Education, Labor and Pensions Committee

HFAP
Healthcare Facilities Accreditation Program

HFMA
Healthcare Financial Management Association

HHSC
Texas Health and Human Services Commission

HIPAA
Health Insurance Portability and Accountability Act of 1996

HIT
Health Information Technology

HMO
Health Maintenance Organization

HRSA
Health Resources and Services Administration

HSA
Health Savings Account

IBNR
Incurred But Not Reported

ICD-10
International Classification of Diseases, 10th Revision, Clinical Modification

IDS
Integrated Delivery System

IGT
Intergovernmental Transfer

IHI
Institute for Healthcare Improvement

IOM
Institute of Medicine

IPA
Independent (or Individual) Practice Association

IPAB
Independent Payment Advisory Board

IRB
Institutional Review Board

IRS
Internal Revenue Service

ISO
International Organization for Standardization

JCR
Joint Commission Resources

LCD
Local Coverage Determinations

LMHA
Local Mental Health Authority

LOS
Length of Stay

LTAC
Long-Term Acute Care

LTCF
Long-Term Care Facility

LTCH
Long-Term Care Hospital

LVN
Licensed Vocational Nurse

MAC
Medicare Administrative Contractor

MCO
Managed Care Organization

MedPAC
Medicare Payment Advisory Commission

MGCRB
Medicare Geographic Classification Review Board

MMIS
Maintenance Management Information System

MRSA
Methicillin-Resistant *Staphylococcus Aureus*

M.S.N.
Master of Science in Nursing

MSO
Management Service Organization

NCQA
National Committee for Quality Assurance

NDC
National Drug Code

NIH
National Institutes of Health

NIMS
National Incident Management Systems

NIOSH
National institute for Occupational Safety and Health

NLRB
National Labor Relations Board

NPDB
National Practitioner Data Bank

NPI
National Provider Identifier

OASIS
Outcome and Assessment Information Set

OAT
Office for the Advancement of Telehealth

OCR
Office for Civil Rights

OHCA
Organized Health Care Arrangement

OIG
Office of Inspector General

OMB
Office of Management and Budget

OPO
Organ Procurement Organization

OPPS
Outpatient Prospective Payment System

OSCAR
Online Survey, Certification and Reporting

OSHA
Occupational Safety and Health Administration

OTC
Over-the-Counter (Drugs)

PA
Physician Assistant

PCP
Primary Care Physician or Provider

PHO
Physician-Hospital Organization

PHR
Personal Health Records

PO
Physician Organization

POS
Point of Service

PPA
Potentially Preventable Admissions

PPC
Potentially Preventable Complication

PPO
Preferred Provider Organization

PPR
Potentially Preventable Readmission

PPRC
Physician Payment Review Commission

PPS
Prospective Payment System

PRO
Peer Review Organization

PSN
Provider-Sponsored Network

PSO
Provider-Sponsored Organization or Patient Safety Organization

PSQIA
Patient Safety and Quality Improvement Act

PSRO
Professional Standards Review

QIN or QIN-QIO
Quality Innovation Network

QIO
Quality Improvement Organization

RAC
Recovery Audit Contractor

RBRVS
Resource-Based Relative Value Scale

RHC
Rural Health Clinic

RHCA
Rural Health Clinics Act

RHIO
Regional Health Information Organization

RHQDAPU
Reporting Hospital Quality for Annual Payment Update

RN
Registered Nurse

RRC
Rural Referral Center

RVU
Relative Value Unit

SEC
Securities and Exchange Commission

SEER
Surveillance Epidemiology and End Results

SHOP
Small Business Health Options Program

SMDA
Safe Medical Devices Act

SNF
Skilled Nursing Facility

SOX
Sarbanes-Oxley Act

SSI
Supplemental Security Income

TJC
The Joint Commission

TPA
Third-Party Administrator

TQM
Total Quality Management

UB-04
Uniform Billing

WIC
Women, Infants, and Children Program

Want to Learn More?

Health Care Terms and Abbreviations is one of the many educational resources available from Texas Healthcare Trustees. Other resources include:

- The *Trustee Guidebook,* a nine-module publication on health governance covering such topics as advocacy, finance and community health;
- Trustee Online, the online video companion to the *Trustee Guidebook;*
- Face-to-face and online learning opportunities;
- Research briefs that take a closer look at various governance-related topics; and
- Newsletters and alerts that keep members informed of the latest health care news and information.

Find more information at www.tht.org.

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