

MATERNAL AND CHILD HEALTH LEADERSHIP SKILLS TRAINING INSTITUTE

GLOSSARY OF TERMS AND ACRONYMS

This glossary has been compiled by the MCH Leadership Skills Training Institute to support and extend the curriculum that comprises the Institute training sessions. Institute trainees are encouraged to refer to the display copies of the document during the institute session in which they participate. Diskettes with the document in either MSWord or Word Perfect formats are available at all institute sessions. Additionally, the glossary is available to download at the project web site, <http://soph.lhl.uab.edu/mch/leadership> on the Learning Resources page.

The glossary is divided into two sections; terms and acronyms. Each section has its own table of contents and its own references. The glossary of terms is followed by the glossary of acronyms.

Comments regarding suggested additions or corrections may be directed to the project office. Any definitions of terms submitted for inclusion must be accompanied by source reference.

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**MATERNAL AND CHILD HEALTH
LEADERSHIP SKILLS TRAINING INSTITUTE
GLOSSARY OF TERMS**

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ADMINISTRATION/FINANCE/PLANNING

acceptability

The level of satisfaction expressed by consumers with the availability, accessibility, cost, quality, continuity, and degree of courtesy and consideration afforded them by the health care system.

access

Often defined as the potential and actual entry of a population into the health care system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Actual entry into the system is described by utilization rates and subjective evaluations of care. Ability to obtain wanted or needed services may also be influenced by the distance one has to travel, waiting time, total income, and whether one has a regular source of care.

accreditation

A process whereby a program of study or an institution is recognized by an external body as meeting certain predetermined standards. For facilities, accreditation standards are usually defined in terms of physical plant, governing body, administration, and medical and other staff. Accreditation is often carried out by organizations created for the purpose of assuring the public of the quality of the accredited institution or program. The State or Federal Governments can recognize accreditation in lieu of, or as the basis for licensure or other mandatory approvals. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent or may be given for a specified period of time.

actual charge

One of the factors determining a physician's payment for a service under Medicare; equivalent to the billed or submitted charge.

admission certification

A form of utilization review in which an assessment is made of the medical necessity of a patient's admission to a hospital or other inpatient institution. Admission certification seeks to assure that patients requiring a hospital level of care, and only such patients, are admitted to the hospital. Lengths of stay appropriate for the patient's admitting diagnosis are usually assigned and certified, and payment by any program requiring certification for the assigned stay is assured. Certification can be done before admission (preadmission) or shortly after (concurrent).

adjusted average per capita cost (AAPCC)

The basis for HMO or CMP reimbursement under Medicare-risk contracts. The average monthly amount received per enrollee is currently calculated as 95 percent of the average costs to deliver medical care in the fee-for-service sector.

adverse selection

A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average life expectancy or health apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.

Affiliation

An agreement (usually formal) between two or more otherwise independent entities or individuals which defines how they will relate to each other. Affiliation agreements between hospitals may specify procedures for referring or transferring patients from one facility to another, joint faculty

and/or medical staff appointments, teaching relationships, sharing of records or services, or provision of consultation between programs.

allowable costs

Items or elements of an institution's costs which are reimbursable under a payment formula. Both Medicare and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury accommodations, costs which are not reasonable expenditures, which are unnecessary, for the efficient delivery of health services to persons covered under the program in question, or depreciation on a capital expenditure which was disapproved by a health planning agency.

ambulatory setting

A type of institutional organized health setting in which health services were provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).

amortization

The act or process of retiring a debt, usually by equal payments at regular intervals over a specific period of time.

ancillary services

Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, that are provided in conjunction with medical or hospital care.

antitrust

A legal term encompassing a variety of efforts on the part of government to assure that sellers do not conspire to restrain trade or fix prices for their goods or services in the market.

appropriateness

Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.

bad debts

Income lost to a provider because of failure of patients to pay amounts owed. Bad debts may sometimes be recovered by increasing charges to paying patients. Some cost-based reimbursement programs reimburse certain bad debts. The impact of the loss of revenue from bad debts may be partially offset for proprietary institutions by the fact that income tax is not payable on income not received.

Blue Cross plan

A nonprofit, tax exempt insurance plan providing coverage for hospital care and related services. The individual plans should be distinguished from their national association, the Blue Cross Association. Historically, the plans were largely the creation of the hospital industry and designed to provide hospitals with a stable source of revenue, although formal association between Blue Cross and the American Hospital Association ended in 1972. A Blue Cross plan must be a nonprofit community service organization with a governing body whose membership includes a majority of public representatives.

Blue Shield plan

A nonprofit, tax exempt insurance plan which provides coverage for physicians' services. Blue Shield coverage is sometimes sold in conjunction with Blue Cross coverage, although this is not always the case.

board certified

Status granted a medical specialist who completes a required course of training and experience (residency) and passes an examination in his or her specialty. Individuals who have met all requirements except examination are referred to as "board eligible".

capital

Fixed or durable non-labor inputs or factors used in the production of goods and services, the value of such factors, or the money specifically allocated for their acquisition or development. Capital costs include, for example, the buildings, beds, and equipment used in the provision of hospital services. Capital assets are usually thought of as permanent and durable as distinguished from consumables such as supplies.

capital costs

Expenditures for land, facilities, and major equipment. They are distinguished from operating costs, which include such items as labor, supplies, and administrative expenses.

capital depreciation

The decline in value of capital (assets of a permanent or fixed nature, e.g., goods and plant) with use over time. The rate and amount of depreciation is calculated by a variety of different methods (e.g., straight line, sum of the digits, declining balance) which often give quite different results. Third-party reimbursement for health services usually includes an amount intended to be equivalent to the Capital depreciation in any given period experienced by the provider of a service.

capital expenditure

An expenditure for the acquisition, replacement, modernization, or expansion of facilities or equipment which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

capital expenditure review

A review of proposed capital expenditures of hospitals and/or other health facilities to determine the need for, and appropriateness of, the proposed expenditure. The review is done by a designated regulatory agency and has a sanction attached which prevents or discourages unneeded expenditures.

capitation

1. A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant" from the Federal Government for each student enrolled.
2. A method of payment for health services in which a physician or hospital is paid a fixed, per capita amount over a specific period of time for each person served, regardless of the actual number or nature of services provided to each person.
3. Compensation to providers for delivering specified health services for a preset fixed fee.

carve out

Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.

case management

1. The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.
2. Management directed toward serious conditions likely to require numerous providers and involve costly care. Case managers handle each case individually, identifying the most cost-effective treatments for extremely resource-intensive conditions, such as accidents, AIDS, cancer, major trauma, prematurity, and strokes.
3. Process of identifying, assessing, organizing, coordinating, and monitoring the necessary and appropriate services to meet and individual's health, vocational and social service needs.

case-mix

A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

catastrophic health insurance

Health insurance which provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

catchment area

A geographic area defined and served by a health program or institution such as a hospital or community mental health center which is delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. By definition, all residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria.

Certificate of Need (CON)

A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

certification

The process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution, or educational program as meeting predetermined standards. One so recognized is said to be "certified." It is essentially synonymous with accreditation, except that certification is usually applied to individuals, and accreditation to institutions. Certification programs are generally nongovernmental and do not exclude the uncertified from practice as do licensure programs.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

A Department of Defense program supporting private sector care for military dependents.

charity care

Generally refers to physician and hospital services provided to persons who are unable to pay for the cost of services, especially those who are low-income, uninsured, and underinsured. A high proportion of the costs of charity care is derived from services for children and pregnant women (e.g., neonatal intensive care).

chronic care

Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes and mental hospitals may be considered chronic care facilities.

clinic

A facility, or part of one, devoted to diagnosis and treatment of outpatients. "Clinic" is irregularly defined. It may either include or exclude physicians' offices; may be limited to describing facilities which serve poor or public patients; and may be limited to facilities in which graduate or undergraduate medical education is done.

coinsurance

A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.

community-based care

The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

community rating

1. A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.

2. Premium calculation based on the entire expected population use rather than on use by specific groups.

community rating by class (class rating)

For federally qualified HMOs, the Community Rating by Class (CRC)-adjustment of community-rated premiums on the basis of such factors as age, sex, family size, marital status, and industry classification. These health plan premiums reflect the experience of all enrollees of a given class within a specific geographic area, rather than the experience of any one employer group.

competition

A characteristic of market economics in which buyers choose from among alternative goods and services made available in the market by two or more sellers. In a classic competitive market, there are many buyers and many sellers.

competitive medical plan (CMP)

A state-licensed entity, other than a federally qualified HMO, that signs a Medicare Risk Contract and agrees to financial risk for providing care to Medicare eligibles on a prospective, prepaid basis.

comprehensive health planning (CHP)

Health planning that encompasses all personal factors and community programs which impact on people's health.

consumer

One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is not associated in any direct or indirect way with the provision of health services.

continuing medical education (CME)

Formal education obtained by a health professional after completing his or her degree and full-time postgraduate training. For physicians, some States require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.

continuous quality improvement (CQI)

Process identifying problems in delivery of services, testing solution, and constantly monitoring the solutions for improvement. Intended to encourage appropriate and necessary care, as well as accountability for cost and quality.

contractual allowance

The difference between what hospitals bill and what they receive in payment from third party payers, most commonly government programs; also known as contractual adjustment.

contribution margin

Revenue from sales less all variable expenses.

coordination of benefits (COB)

Procedures used by insurers to avoid duplicate payment for losses insured under more than one insurance policy. A coordination of benefits, or "nonduplication," clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered. Standard rules determine which of two or more plans, each having COB provisions, pays its benefits in full and which becomes the supplementary payer on a claim.

copayment

A type of cost-sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, their insurer paying the rest. The copayment is incurred at the time the service is used. The amount paid does not vary with the cost of the service.

cost

Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an individual or third party, may or may not be equal to service costs.

cost-benefit analysis

An analytic method in which a program's cost is compared to the program's benefits for a period of time, expressed in dollars, as an aid in determining the best investment of resources. For

example, the cost of establishing an immunization service might be compared with the total cost of medical care and lost productivity which will be eliminated as a result of more persons being immunized. Cost-benefit analysis can also be applied to specific medical tests and treatments.

cost center

An accounting device whereby all related costs attributable to some "financial center" within an institution, such as a department or program are segregated for accounting or reimbursement purposes.

cost containment

1. A set of steps to control or reduce inefficiencies in the consumption, allocation, or production of health care services which contribute to higher than necessary costs. Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the cost of producing health services could be reduced by using a different combination of resources.

2. Strategies such as market incentives, global budgeting, tax caps, managed care, prevention, and health promotion efforts used to manage health promotion efforts used to manage health care costs while maximizing their increasing rate.

cost of goods sold

Inventoriable costs that are expensed because the units are sold; equals beginning inventory plus cost of goods purchased or manufactured minus ending inventory.

cost-effectiveness analysis

A method of comparing alternative ways for achieving a specific set of results. Alternatives are compared on the basis of the ratio of the cost of each alternative to its estimated future effect on objectives which need not be measured in financial terms.

cost-shifting

The condition which occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically results from providing health care to the medically indigent or the Medicare patients.

cost utility

An economic analysis assessed as a quality-adjusted outcome per net cost expended.

covered services

Health care services covered by an insurance plan.

Credentialing

The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used.

current cost

Cost stated in terms of current values (of productive capacity) rather than in terms of acquisition cost.

customary charge

One of the factors determining a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period.

customary, prevailing, and reasonable (CPR)

Current method of paying physicians Medicare. Payment for a service is limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. Similar to the Usual, Customary, and Reasonable system used by private insurers.

debt service

Required payments for interest on and retirement of a debt; the amount needed, supplied, or accrued for meeting such payments during any given accounting period; a budget or operating statement heading for such items.

deductible

1. The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed-dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g., \$100 per calendar year, benefit period, or spell of illness.

2. A specific amount the insured person must pay before payments for covered health care services begin under a medical insurance plan.

default

Failure to pay debt service when due.

defined benefit

Funding mechanisms for pension plans that can also be applied to health benefits. Typical pension approaches include: (1) pegging benefits to a percentage of an employee's average compensation over his entire service or over a particular number of years; (2) calculation of a flat monthly payment; (3) setting benefits based upon a definite amount for each year of service, either as a percentage of compensation for each year of service or as a flat dollar amount for each year of service.

defined contribution

Funding mechanism for pension plans that can also be applied to health benefits based on a specific dollar contribution, without defining the services to be provided.

deinstitutionalization

Policy which calls for the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.

demand

In health economics, the amount of a good or service consumers are willing and able to buy at varying prices, given constant income and other factors. Demand should be distinguished from utilization (the amount of services actually used) and need (which has a normative connotation

and relates to the amount of goods or services which should be consumed based on professional value judgments).

direct cost

A cost which is identifiable directly with a particular activity, service, or product of the program experiencing the costs. These costs do not include the allocation of costs to a cost center which are not specifically attributable to that cost center.

discounting

A method for adjusting the value of future costs and benefits. Discounting - expressed as a present dollar value - is based on the time-value of money; i.e., a dollar is worth more than it will be a year from now (even if inflation is not considered).

exclusive provider arrangement (EPA)

An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).

exclusive provider organization (EPO)

An EPO is a more rigid type of PPO that requires the insured to use only designated providers or sacrifice reimbursement altogether.

expenditure target (ET)

A mechanism to adjust fee updates (or the fees themselves) based on how actual expenditures in an area compare to a target for those expenditures.

experience rating

1. A method of adjusting health plan premiums based on the historical utilization data and distinguishing characteristics of a specific subscriber group.
2. Premium calculations based on the cost of a group's health care claims. Those with the sickest workers pay the highest premiums.

family practice

A form of specialty practice in which physicians provide continuing comprehensive primary care within the context of the family unit.

favorable selection

A tendency for utilization of health services in a population group to be lower than expected or estimated.

fee-for-service

1. Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of U.S. country's physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.
2. Traditional method of paying for medical services whereby a physician or other practitioner bills for each encounter or service rendered. This system contrasts with salary, per capita, or prepayment systems, in which the payment is not changed with the number of services actually used.

fee schedule

An exhaustive list of physician services in which each entry is associated with a specific monetary amount that represents the approved payment level for a given insurance plan.

fiduciary

Relating to, or founded upon, a trust or confidence. A fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person's or organization's interests in matters which affect the other person or organization. A physician has such a relation with his patient, and a hospital trustee has one with a hospital.

financial feasibility

The projected ability of a provider to pay the capital and operating costs associated with the delivery of a proposed health care service.

fixed costs

The portion of total costs of a program incurred even when output is nil, e.g., costs associated with overhead, facilities, and overhead salaries.

gatekeeper

Primary care practitioner or other individual who serves as a patient's initial contact for medical care and referrals. Often responsible for directing patients through a managed care system. Also refers to utilization review personnel who authorize certain services, such as hospitalization, for insured patients.

general practice

A form of practice in which physicians without specialty training provide a wide range of primary health care services to patients.

global budgeting

A method of hospital cost containment in which participating hospitals must share a prospectively set budget. Method for allocating funds among hospitals may vary but the key is that the participating hospitals agree to an aggregate cap on revenues that they will receive each year. Global budgeting may also be mandated under a universal health insurance system.

global fee

A total charge for a specific set of services, such as obstetrical services that encompass prenatal, delivery and post-natal care.

goal

A statement of expectations of desired, attainable levels of health status and/or health system performance.

gross margin

Net sales minus goods sold; the difference between sales revenues and manufacturing costs as an intermediate step in the computation of operating profits or net income.

group model

A type of HMO with medical centers where many different health services are provided in a central location. Doctors and staff of a group model HMO usually treat only HMO members.

group practice

A formal association of three or more physician or other health professionals providing health services. Income from the practice is pooled and redistributed to the members of the group

according to some prearranged plan (often, but not necessarily, through partnership). Groups vary a great deal in size, composition, and financial arrangements.

health facilities

Collectively, all physical plants used in the provision of health services; usually limited to facilities which were built for the purpose of providing health care, such as hospitals and nursing homes. They do not include an office building which includes a physician's office. Health facility classifications include: hospitals (both general and specially), long-term care facilities, kidney dialysis treatment centers, and ambulatory surgical facilities.

health insurance

Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

health maintenance organization (HMO)

1. An entity with four essential attributes: (1) An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons; and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

2. An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital medical plans.

health manpower shortage area (HMSA)

An area or group which the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HMSAs can include: (1) an urban or rural geographic area, (2) a population group for which access barriers can be demonstrated to prevent members of the group from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.

health personnel

Collectively, all persons working in the provision of health services, whether as individual practitioners or employees of health institutions and programs, whether or not professionally trained, and whether or not subject to public regulation. Facilities and health personnel are the principal health resources used in producing health services.

health planning

Planning concerned with improving health, whether undertaken comprehensively for a whole community or for a particular population, type of health service, institution, or health program. The components of health planning include: data assembly and analysis, goal determination, action recommendation, and implementation strategy.

health promotion

Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.

health service area

Geographic area designated on the basis of such factors as geography, political boundaries, population, and health resources, for the effective planning and development of health services.

home health care

Health services rendered in the home to the aged, disabled, sick, or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA) home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive. The most common types of home health care are the following-nursing services; speech, physical, occupational and rehabilitation therapy; homemaker services; and social services.

hospital

An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat), and by type of ownership or control (Federal, State, or local government; for-profit and nonprofit). The hospital system is dominated by the short-term, general, nonprofit community hospital, often called a voluntary hospital.

indemnity

1. Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services.
2. Benefits paid in a predetermined amount in the event of a covered loss.

indemnity benefits

Benefits in the form of cash payments rather than services. In most cases, after the provider of service has billed the patient, the insured person is reimbursed by the company.

independent practice association (IPA)

An organized form of prepaid medical practice in which participating physicians remain in their independent office settings, seeing both enrollees of the IPA and private-pay patients. Participating physicians may be reimbursed by the IPA on a fee-for-service basis or a capitation basis.

indigent care

Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for Federal or State programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.

indirect cost

A cost which cannot be identified directly with a particular activity, service, or product of the entity incurring the cost. Indirect costs are usually apportioned among an entity's services in proportion to each service's share of direct costs.

individual practice association (IPA)

A type of HMO in which a partnership, corporation, or association has entered into an arrangement for provision of their service. Physicians provide care in their own offices and serve

HMO members as part of their regular practice. IPAs are one source of professional services for HMOs and are modeled after medical foundations.

institutional health services

Health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient institutions. The term may also refer to services delivered on an outpatient basis by departments or other organizational units of, or sponsored by, such institutions.

interest

The cost incurred for borrowing funds. Interest is usually expressed as a percentage of the total loan.

intermediate care facility (ICF)

An institution which is licensed under State law to provide on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally or retarded people with related conditions are also included in the definition. The distinction between "health-related care and services" and "room and board" has often proven difficult to make but is important ICFs are subject to quite different regulations and coverage requirements than institutions which do not provide health-related care and services.

inventory

A detailed description of quantities and locations of different kinds of facilities, major equipment, and personnel which are available in a geographic area and the amount, type, and distribution of services these resources can support.

license/licensure

A permission granted to an individual or organization by a competent authority, usually public, to engage lawfully in a practice, occupation, or activity. Licensure is the process by which the license is granted. It is usually granted on the basis of examination and/or proof of education rather than on measures of performance. A license is usually permanent but may be conditioned on annual payment of a fee, proof of continuing education, or proof of competence.

malpractice

Professional misconduct or failure to apply ordinary skill in the performance of a professional act. A practitioner is liable for damages or injuries caused by malpractice. For some professions like medicine, malpractice insurance can cover the costs of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit. To prove malpractice requires that a patient demonstrate some injury and that the injury be caused by negligence.

managed care

1. Any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that requires utilization review to control unnecessary use of health services.

2. Managed care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of health care providers, formal programs for ongoing quality assurance and utilization review, and significant financial incentives for members to use providers and procedures associated with the plan.

managed competition

A theory of health care delivery in which a large group of consumers choose among health plans that offer similar benefits; competition is based, therefore, on cost and quality.

margin

Revenue less specified expenses.

maximum allowable actual charge (MAAC)

A limitation on billed charges for Medicare services provided by nonparticipating physicians. For physicians with charges exceeding 115 percent of the prevailing charge for nonparticipating physicians, MAACs limit increases in actual charges to 1 percent a year. For physicians whose charges are less than 115 percent of the prevailing, MAACs limit actual charge increases so they may not exceed 115 percent.

Medicaid notch

The reduction in real income that occurs when increased earnings removes a person from not only public cash-assistance programs, and from Medicaid.

medical audit

Detailed retrospective review and evaluation of selected medical records by qualified professional staff. Medical audits are used in some hospitals, group practices, and occasionally in private, independent practices for evaluating professional performance by comparing it with accepted criteria, standards, and current professional judgement. A medical audit is usually concerned with the care of a given illness and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it.

medically indigent

People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.

medically under served population

A population group experiencing a shortage of personal health services. A medically under served population may or may not reside in a particular medically under served area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for Federal assistance (e.g., the National Health Service Corps).

Medicare risk contract

An agreement by an HMO or competitive medical plan to accept a fixed dollar reimbursement per Medicare enrollee, derived from costs in the fee-for-service sector, for delivery of a full range of prepaid health services.

merit good

A good or service which is socially sanctioned and deemed worthy of use or consumption by the general population. Often, a merit good is publicly provided or subsidized in order to ensure widespread availability. Primary education is an example of a merit good which is made compulsory by the government.

modernization

Remodeling, renovation, or sometimes, replacement of health facilities and equipment to bring them up to current construction standards, into compliance with fire and safety codes, or to meet contemporary health delivery needs and capabilities.

neighborhood health center

An ambulatory health care program usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs and is often known as a community health center. Neighborhood health centers attempt to coordinate Federal, State, and local resources in single organization capable of delivering both health care and related social services to a defined population.

nursing home

Includes a wide range of institutions which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems which range from minimal to very serious. The term includes free-standing institutions, or identifiable components of other health facilities which provide nursing care and related services, personal care, and residential care. Nursing homes include skilled nursing facilities and extended care facilities but not boarding homes.

occupancy rate

A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital beds occupied and may be institution-wide or specific for one department or service.

open enrollment

A method for assuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

operating cost

In the health field, the financial requirements necessary to operate an activity which provides health services. These costs normally include the costs of personnel, materials, overhead, depreciation, and interest.

operating margin

Revenues from sales minus current cost of goods sold. A measure of operating efficiency that is independent of the cost flow assumption for inventory. Sometimes called "current (gross) margin."

outpatient review

A review that assures the appropriateness of treatment and monitors ongoing care.

overhead

The general costs of operating an entity which are allocated to all the revenue producing operations of the entity but which are not directly attributable to a single activity. For a hospital, these costs normally include maintenance of plant, occupancy costs, housekeeping, administration, and others.

patient origin study

A study, generally undertaken by an individual health program or health planning agency, to determine the geographic distribution of the residences of the patients served by one or more health programs. Such studies help define catchment and medical trade areas and are useful in locating and planning the development of new services.

payer

An organization responsible for payment of health care costs.

planning

The conscious design of a desired future state (described in a plan by its goals and objectives); including: description of, and selection among, alternative means of achieving the goals and objectives; the conduct of the activities necessary to the design (such as data gathering and analysis); and the activities necessary to assure that the plan is achieved.

point of service (POS)

1. A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of medical services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from HMO providers are less than when care is rendered by PPO or non-contracting providers.

2. Often known as open-ended HMOs or PPOs, these plans encourage the use of network providers, but permit insured individuals to choose providers outside the plan at the time service is rendered.

policy

A course of action adopted and pursued by a government, party, statesman, or other individual or organization; any course of action adopted as proper, advantageous, or expedient. The term is sometimes used less actively to describe any stated position on matters at issue, i.e., an organization's policy statement on national health insurance. Policies bear the same relationship to rules (regulations) as rules do to law, except that unlike regulations, they do not have the force of law.

portability

Ability of a worker to remain covered in the same health plan regardless of employment status.

poverty area

An urban or rural geographic area with a high proportion of low income families. Normally, average income is used to define a poverty area, but other indicators, such as housing conditions, illegitimate birth rates, and incidence of juvenile delinquency, are sometimes added to define geographic areas with poverty conditions.

preadmission certification

1. A process under which admission to a health institution is reviewed in advance to determine need and appropriateness and to authorize a length of stay consistent with norms for the evaluation.

2. Review of the need for proposed inpatient service(s) prior before admission to an institution to determine the appropriateness of the setting, procedure, or length of stay. Preadmission certification seeks to ensure that providers do not hospitalize people unnecessarily or for longer than is medically necessary.

preferred provider arrangement (PPA)

Selective contracting with a limited number of health care providers, often at reduced or prenegotiated rate of payment.

Preferred Provider Organization (PPO)

An arrangement whereby a third-party payer contracts with a group of "preferred" medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

prepayment

Usually refers to any payment to a provider for anticipated services (such as an expectant mother paying in advance for maternity care). Sometimes prepayment is distinguished from insurance as referring to payment to organizations which, unlike an insurance company, take responsibility for arranging for, and providing, needed services as well as paying for them (such as health maintenance organizations, prepaid group practices, and medical foundations).

prevailing charge

One of the factors determining a physician's payment for a service under Medicare, set at a percentile of customary charges of all physicians in the locality.

prior authorization

Requirement of a third party, under some systems of utilization review, that a provider justify the need for delivering a particular service to a patient before providing the service in order to receive reimbursement.

proprietary

Profit making: owned and operated for the purpose of making a profit, whether or not one is actually made.

prospective payment

Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for a defined period (usually a year). Institutions are paid these amounts regardless of the costs they actually incur. These systems of payment are designed to introduce a degree of constraint on charge or costs increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs. Prospective payment contrasts with the method of payment originally used under Medicare and Medicaid (as well as other insurance programs) where institutions were reimbursed for actual expenses incurred.

provider

Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.

public good

A good or service whose benefits may be provided to a group at no more cost than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded. For example, a public health measure that eradicates smallpox protects all, not just those paying for the vaccination.

quality of care

Can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of services delivery (the use of

appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

rate review

Review by a Government or private agency of a hospital's budget and financial data, performed for the purpose of determining the reasonableness of the hospital rates and evaluating proposed rate increases.

redlining

Practice of insurers denying coverage to high-risk groups, sometimes whole professions or industries. (Fear of AIDS, for example, has prompted some insurers to avoid insuring artists, hairdressers, dancers, interior decorators, etc.)

reimbursement

The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

reinsurance

The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

retrospective reimbursement

Payment made after-the-fact for services rendered on the basis of costs incurred by the facility. See also prospective payment.

revenue

The gross amount of earnings received by an entity for the operation of a specific activity. It does not include any deductions for such items as expenses, bad debts, or contractual allowances.

risk rating

Plans that differentiate premiums according to assessed risk status, with premium setting based on health risk status and health-related behavior that are indicators for high health care expenditures

self-funding of health benefits

An employer or group of employers sets aside funds to cover the cost of health benefits for their employees. Benefits may be administered by the employer(s) or handled through an administrative service only agreement with an insurance carrier or third party administrator. Under self-funding, it is generally possible to purchase stop-loss insurance that covers expenditures above a certain aggregate claim level and/or covers catastrophic illness or injury when individual claims reach a certain dollar threshold.

service period

Period of employment that may be required before an employee is eligible to participate in an employer-sponsored health plan, most commonly one to three months.

shadow pricing

Within a given employer group, pricing of premiums by HMO(S) based upon the cost of indemnity insurance coverage, rather than strict adherence to community rating or experience rating criteria.

shared services

The coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or nonmedical services on the part of two or more otherwise independent hospitals or other health programs. The sharing of medical services might include an agreement that one hospital provide all pediatric care needed in a community and no obstetrical services while another provide obstetrics and no pediatrics. Examples of shared nonmedical services would include joint laundry or dietary services for two or more nursing homes.

single-payer system

Health care system funded exclusively by government, usually through taxes, that provides payment directly to providers.

skilled nursing facility (SNF)

A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.

sole community hospital (SCH)

A hospital which (1) is more than 50 miles from any similar hospital, (2) is 25 to 50 miles from a similar hospital and isolated from it at least one month a year as by snow, or is the exclusive provider of services to at least 75 percent of its service area populations, (3) is 15 to 25 miles from any similar hospital and is isolated from it at least one month a year, or (4) has been designated as an SCH under previous rules. The Medicare DRG program makes special optional payment provisions for SCHs, most of which are rural, including providing that their rates are set permanently so that 75 percent of their payment is hospital-specific and only 25 percent is based on regional DRG rates.

solo practice

Lawful practice of a health occupation as a self-employed individual. Solo practice is by definition private practice but is not necessarily general practice or fee-for-service practice (solo practitioners may be paid by capitation, although fee-for-service is more common). Solo practice is common among physicians, dentists, podiatrists, optometrists, and pharmacists.

specialist

A physician, dentist, or other health professional who is specially trained in a certain branch of medicine or dentistry related to specific services or procedures (e.g., surgery, radiology, pathology); certain age categories of patients (e.g., pediatrics, geriatrics); certain body systems (e.g., dermatology, orthopedics, cardiology); or certain types of diseases (e.g., allergy, psychiatry, periodontics). Specialists usually have advanced education and training related to their specialties.

spend down

The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in States that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.

staff model

A type of HMO, similar to the group model, in which physicians are salaried employees who provide their services exclusively to HMO enrollees.

supply

In health economics, the quantity of services provided or personnel in a given area.

third-party administrator

A person or organization that provides certain administrative services to group benefit plans, including premium accounting, claims review and payment, claims utilization review, maintenance of employee eligibility records, and negotiations with insurers that provide stop-loss protection for large claims.

third-party payer

Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

24-hour coverage-insurance coverage that removes the boundary, or part of the boundary, between occupational and nonoccupational claims. The most comprehensive definition describes a complete system of medical and disability benefits available to individuals regardless of employment or financial status or whether the cause is work-related. The simplest definition describes a system that ensures that an employee's claim is covered under the correct insurance policy, that is, workers'compensation, group health, or disability and that there is no double recovery. There are many variants between these two extremes.

uncompensated care

Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.

underinsured

People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.

uninsured

People who lack public or private health insurance.

usual, customary and reasonable (UCR) fees

The use of fat screens to determine the lowest value of physician reimbursement based on: (1) the physician's usual charge for a given procedure, (2) the amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case.

utilization

Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.

utilization review

Independent evaluation of a patient's clinical progress to make sure the care being provided is appropriate and necessary. Widely used cost-containment device and a key element in managed care.

variable costs

The portion of the total cost that increases with greater output, e.g., the costs associate with increasing the number of persons seen in an education program.

willingness to pay

an approach for determining the value of a health outcome based on society's valuation of (willingness to pay for) that outcome.

working capital

The sum of an institution's short-term or current assets including cash, marketable (short-term) securities, accounts receivable, and inventories. Net working capital is defined as the excess of total current assets over total current liabilities.

AGENCIES/ORGANIZATIONS

Agency for Health Care Policy and Research (AHCPR)

One of the newest agencies of the U.S. Public Health Service, the AHCPR was created in 1989. The Agency's primary goal is to enhance the quality, appropriateness, and effectiveness of health care services by conducting and sponsoring credible and timely research. It is the Federal government's focal point for health services research, the efforts of which are built upon the work of AHCPR's predecessor, the National Center for Health Services Research and Health Care Technology Assessment.

Area Health Education Center (AHEC)

An organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use, and efficiency of health care personnel in specific medically underserved areas. An AHEC's objectives are to educate and train the health personnel specifically needed by the underserved areas and to decentralize health work force education, thereby increasing supply and linking the health and educational institutions in scarcity areas.

Blue Cross plan

A nonprofit, tax exempt insurance plan providing coverage for hospital care and related services. The individual plans should be distinguished from their national association, the Blue Cross Association. Historically, the plans were largely the creation of the hospital industry and designed to provide hospitals with a stable source of revenue, although formal association between Blue Cross and the American Hospital Association ended in 1972. A Blue Cross plan must be a nonprofit community service organization with a governing body whose membership includes a majority of public representatives.

Blue Shield plan

A nonprofit, tax exempt insurance plan which provides coverage for physicians' services. Blue Shield coverage is sometimes sold in conjunction with Blue Cross coverage, although this is not always the case.

Centers for Disease Control and Prevention (CDC)

The Centers for Disease Control and Prevention, based in Atlanta, Georgia, is the Federal agency charged with protecting the nations' public health by providing direction in the prevention and control of communicable and other diseases and responding to public health emergencies. CDC is the U.S. Public Health Service agency that led efforts to prevent such diseases as malaria, polio, smallpox, toxic shock syndrome, Legionnaire's disease and, more recently, acquired immunodeficiency syndrome (AIDS) and tuberculosis. CDC's responsibilities as the nation's prevention agency have expanded over the years and will continue to evolve as the agency addresses contemporary threats to health, such as injury, environmental and occupational hazards, behavioral risks, and chronic diseases.

clinic

A facility, or part of one, devoted to diagnosis and treatment of outpatients. "Clinic" is irregularly defined. It may either include or exclude physicians' offices; may be limited to describing facilities which serve poor or public patients; and may be limited to facilities in which graduate or undergraduate medical education is done.

community health center

An ambulatory health care program (defined under section 330 of the Public Health Service Act) usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs; sometimes known as "neighborhood health center." Community health centers attempt to coordinate Federal, State, and local resources in a single organization capable

of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Community Mental Health Center (CMHC)

An entity which provides comprehensive mental health services (principally ambulatory), primarily to individuals residing or employed in a defined catchment area.

Competitive Medical Plan (CMP)

A state-licensed entity, other than a federally qualified HMO, that signs a Medicare Risk Contract and agrees to financial risk for providing care to Medicare eligibles on a prospective, prepaid basis.

Health Care Finance Administration (HCFA)

The Government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs.

health maintenance organization (HMO)

An entity with four essential attributes: (1) An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons; and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

Health Resources and Services Administration (HRSA)

One of the eight agencies of the U.S. Public Health Service, HRSA has responsibility for addressing resource issue relating to access, equity and quality of health care, particularly to the disadvantaged and underserved. HRSA provides leadership to assure the support and delivery of primary health care services, particularly in underserved areas, and the development of qualified primary care health professionals and facilities to meet the health needs of the nation. HRSA focuses on support of states and communities in their efforts to plan, organize, and deliver primary health care, as well as strengthen the overall public health system.

Health Systems Agency (HSA)

A health planning agency created under the National Health Planning and Resources Development Act of 1974. HSAs were usually nonprofit private organizations and served defined health service areas as designated by the States.

independent practice association (IPA)

An organized form of prepaid medical practice in which participating physicians remain in their independent office settings, seeing both enrollees of the IPA and private-pay patients. Participating physicians may be reimbursed by the IPA on a fee-for-service basis or a capitation basis.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

A national private, nonprofit organization whose purpose is to encourage the attainment of uniformly high standards of institutional medical care. Establishes guidelines for the operation of hospitals and other health facilities and conducts survey and accreditation programs.

Physician Payment Review Commission (PPRC)

In 1986, the Congress created the Physician Payment Review Commission to advise it on reforms of the methods used to pay physicians under the Medicare program. The Commission has conducted analyses of physician payment issues and worked closely with the Congress to bring about comprehensive reforms in Medicare physician payment policy. Its recommendations formed the basis of 1989 legislation that created the RBRVS, a resource-based fee schedule limiting the amount physicians may charge patients.

Preferred Provider Organization (PPO)

Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.

Prospective Payment Assessment Commission (ProPAC)

In 1983, the Congress created the Prospective Payment Assessment Commission to advise the secretary of the Department of Health and Human Services on Medicare's diagnosis related group-based prospective payment system. Its members are appointed by the director of the Office of Technology Assessment. The commission's main responsibilities include recommending an appropriate annual percentage change in DRG payments; recommending needed changes in the DRG classification system and individual DRG weights; collecting and evaluating data on medical practices, patterns, and technology; and reporting on its activities.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The mission of SAMHSA is to provide, through the U.S. Public Health Service, a national focus for the Federal effort to promote effective strategies for the prevention and treatment of addictive and mental disorders. SAMHSA is primarily a grant-making organization, promoting knowledge and scientific state-of-the-art practice. SAMHSA strives to reduce barriers to high quality, effective programs and services for individuals who suffer from, or are at risk for, these disorders, as well as for their families and communities.

HEALTH: CONDITIONS, FIELDS, PROVIDERS/TREATMENT

active intervention

An active intervention is a prevention strategy which requires the direct participation of the individual him/herself to be effective (e.g., weight loss programs).

Activities of Daily Living (ADL)

An index or scale which measure a patient's degree of independence in bathing, dressing, using the toilet, eating, and moving around the house.

acute care

1. Medical treatment rendered to individuals whose illnesses or health problems are of a short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.

2. Short-term health care provided to patients who do not require concentrated and continuous observation

acute disease

A disease which is characterized by a single episode of a relatively short duration from which the patient returns to his normal or previous state of level of activity. While acute diseases are frequently distinguished from chronic diseases, there is no standard definition or distinction. It is worth noting that an acute episode of a chronic disease (for example, an episode of diabetic coma in a patient with diabetes) is often treated as an acute disease.

alcoholism

A chronic disease manifested by intake of alcoholic beverages in excess of dietary uses, social uses and norms of the community, and which to some extent interferes with the drinker's health and/or his or her social or economic functioning. The definition of alcoholism in both theory and practice is highly variable. Some definitions require either excessive drinking or interference with the drinker's functions rather than both; other definitions require physical signs of drug dependence in addition to the above. There are various systems in use for separating different types of alcoholism and grading its severity.

allied health personnel

Specially trained and licensed (when necessary) health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses. The term has no constant or agreed-upon detailed meaning; sometimes being used synonymously with paramedical personnel, sometimes meaning all health workers who perform tasks which must otherwise be performed by a physician, and at other times referring to health workers who do not usually engage in independent practical

alternatives to long-term institutional care

The whole range of health, nutritional, housing, and social services designed to keep persons out of institutions, such as skilled nursing facilities, which provide care on a long-term basis. The goal is to provide the range of services necessary to allow the persons to continue to function in the home and community environment. Alternatives to long-term care usually focus on the aged, disabled, and retarded, and include: day care centers, foster homes, or homemaker services.

ambulatory care

All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay. See also ambulatory settings and outpatient.

ambulatory setting

A type of institutional organized health setting in which health services are provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).

ancillary services

Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, that are provided in conjunction with medical or hospital care.

antepartum fetal death

Fetal death occurring before the initiation of labor.

audiologist

A person with a master's degree in audiology who examines, evaluates, and provides treatment for persons with hearing defects.

birth defect

A structural abnormality present at birth.

case management

1. The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.
2. Management directed toward serious conditions likely to require numerous providers and involve costly care. Case managers handle each case individually, identifying the most cost-effective treatments for extremely resource-intensive conditions, such as accidents, AIDS, cancer, major trauma, prematurity, and strokes.

cause-of-death

As defined by the World Health Organization, the underlying cause of death, indicated on the death certificate, and defined as a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury.

Children with Special Health Care Needs (CSHCN)

1. *(For budgetary purposes)* Infants of children from birth through the 21st year with special health care needs show the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems.
2. *(For planning and systems development)* Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

chronic care

Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes and mental hospitals may be considered chronic care facilities.

chronic disease

A disease which has one or more of the following characteristics: is permanent, leaves residual disability; is caused by nonreversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.

continuity of care

Health care provided on a continuous basis, starting with the patient's initial contact with the primary care practitioner and following the patient through all episodes of his or her health care needs.

deinstitutionalization

Policy which calls for the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.

dental health services

All services designed or intended to promote, maintain, or restore dental health including educational, preventive, and therapeutic services.

developmental disability (DD)

1. A severe, chronic disability which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, economic self-sufficiency; and reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care treatments of services which are of lifelong or extended duration and are individually planned and coordinated.

2. One of a group of heterogeneous conditions that 1) are attributable to mental and/or physical impairments, 2) are manifested before the person reaches 22 years of age, 3) are likely to continue indefinitely, 4) result in substantial functional limitations in three or more areas of self-care, and 5) reflect the need for specialized services.

Diagnosis Related Groups (DRGs)

Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system.

dietician

A specialist in food and nutrition science who assists the public in the modification and/or enhancement of its food-related behaviors.

disability

Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person's usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.

disease

May be defined as a failure of the adaptive mechanisms of an organism to counteract adequately, normally, or appropriately to stimuli and ID, which it is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and drug dependence are presently seen by some as diseases, when they were previously considered to be moral or legal problems.

drug abuse

Persistent or sporadic drug use inconsistent with or unrelated to acceptable medical or cultural practice. The definition of drug abuse is highly variable, sometimes also requiring excessive use of a drug, unnecessary use (thus incorporating recreational use), dependence, or illegal use.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.

emergency medical services (EMS)

Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.

epidemic

A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of in epidemic, e.g., an epidemic of violence.

exposure

A general term used to describe contact with a risk factor. An exposure can be a physical agent (e.g., radiation) or a behavior (e.g., excessive drinking).

family practice

A form of specialty practice in which physicians provide continuing comprehensive primary care within the context of the family unit.

fetal death

As defined by the World Health Organization "death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy. The death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles." This definition includes stillbirths, spontaneous abortions, and miscarriages as fetal deaths.

foreign medical graduate (FMG)

A physician who graduated from a medical school outside of the United States, usually Canada. U.S. citizens who go to medical school abroad are classified as foreign medical graduates (sometimes distinguished as USFMGs), just as are foreign-born persons who are not trained in a medical school in this country. U.S. citizen represent only a small portion of the FMG group.

gatekeeper

Primary care practitioner or other individual who serves as a patient's initial contact for medical care and referrals. Often responsible for directing patients through a managed care system. Also refers to utilization review personnel who authorize certain services, such as hospitalization, for insured patients.

gestational weight gain

Maternal weight gain during pregnancy.

handicapped

As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.

health

The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms of morbidity and mortality.

health education

Any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conducive to health.

health facilities

Collectively, all physical plants used in the provision of health services; usually limited to facilities which were built for the purpose of providing health care, such as hospitals and nursing homes. They do not include an office building which includes a physician's office. Health facility classifications include: hospitals (both general and specialty), long-term care facilities, kidney dialysis treatment centers, and ambulatory surgical facilities.

health promotion

Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.

health protection

Disease and injury prevention strategies that depend on changes in an individual's environment.

holism

Refers to the integration of mind, body, and spirit of a person and emphasizes the importance of perceiving the individual (regarding physical symptoms) in a "whole" sense. Holism teaches that the health care system must extend its focus beyond solely the physical aspects of disease and particular organ in question, to concern itself with the whole person and the interrelationships between the emotional, social, spiritual, as well as physical implications of disease and health.

home health care

Health services rendered in the home to the aged, disabled, sick, or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA) home health agency, county public health department, hospital, or other organized

community group and may be specialized or comprehensive. The most common types of home health care are the following—nursing services; speech, physical, occupational and rehabilitation therapy; homemaker services; and social services.

hospice

A program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Originally a medieval name for a way station for crusaders where they could be replenished, refreshed, and cared for, hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.

hospital

An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat), and by type of ownership or control (Federal, State, or local government; for-profit and nonprofit). The hospital system is dominated by the short-term, general, nonprofit community hospital, often called a voluntary hospital.

impaired fecundity

In the National Survey of Family Growth, the status of a woman who is either part of an infertile couple or who reports that it is physically difficult or impossible to conceive or deliver a baby or who has been told by a physician that pregnancy would pose a danger to her or the baby.

infant mortality

The death of a live-born infant before its first birthday.

infertile

The status of a married couple who is not surgically sterilized, has not used contraception, and has not become pregnant for at least 12 months.

inpatient

A person who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his or her room and board) for the purpose of receiving diagnostic treatment or other health services.

instrumental activities of daily living (IADL)

An index or scale which measures a patient's degree of independence in aspects of cognitive and social functioning including shopping, cooking, doing housework, managing money, and using the telephone.

intentional injury

An injury arising from purposeful action, such as interpersonal or self-directed violence

intermediate care facility (ICF)

An institution which is licensed under State law to provide on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally or retarded people with related conditions are also included in the definition. The distinction

between "health-related care and services" and "room and board" has often proven difficult to make but is important ICFs are subject to quite different regulations and coverage requirements than institutions which do not provide health-related care and services.

intervention or intervention strategies

A generic term used in public health to describe a program or policy designed to have an impact on an illness or disease. Hence a mandatory seat belt law is an intervention designed to reduce automobile-related fatalities.

intrapartum fetal death

Fetal death occurring after the initiation of labor and before delivery.

legal induced abortion

An abortion conducted by a licensed health provider under conditions consistent with the legal requirements of the state.

long-term care

A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (eg., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

magnetic resonance (MRI)

This relatively new form of diagnostic radiology is a method of imaging body tissues that uses the response or resonance of the nuclei of the atoms of one of the bodily elements, typically hydrogen or phosphorus, to externally applied magnetic fields.

mental health

The capacity in an individual to effectively in society. Mental health is a concept influenced by biological, environmental, emotional, and cultural factors and is highly variable in definition, depending on time and place. It is often defined in practice as the absence of any identifiable or significant mental disorder and so improperly used as a for mental illness.

mental health services

Comprehensive mental health services as defined under some State laws and Federal statutes, include: inpatient care, outpatient care, day care, and other partial hospitalization and emergency services; specialized services for the mental health of children; specialized services for the mental health of the elderly; consultation and education services; assistance to courts and other public agencies in screening catchment area residents; follow-up care for catchment area residents discharged from mental health facilities or who would require inpatient care without such halfway house services; and specialized programs for the prevention, treatment and rehabilitation of alcohol and drug abusers.

mental illness

All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought, and definitions. It includes a wide range of types and severities.

mental retardation

Substantial limitations in present cognitive functioning. Mental retardation is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in

two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18. In the past, mental retardation was qualified by severity of cognitive impairment as mild (IQ between 69 and 50-55), moderate (IQ between 55 and 35-40), severe (IQ between 35-40 and 20-25), and profound (IQ below 20-25). In 1992, this categorization was replaced by a more qualitative description of the level of supports necessary for a given person to function. Although *mental retardation* denotes a level of behavioral performance without reference to etiology (cause), in light of current genetic, biochemical, and neuroanatomical knowledge, a functional description of mental retardation mandates a meticulous evaluation for such an etiology.

mistimed pregnancy

According to questions included in the National Survey of Family Growth, a pregnancy that was intended but occurred sooner than the mother would have liked.

morbidity

The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

mortality

Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).

natural history of disease

This term refers to the fact that virtually all illnesses and diseases have certain predictable and regular patterns associated with them, i.e., a natural history. Understanding something of a natural history of a disease is a necessity if an effective intervention program is to be implemented.

neighborhood health center

An ambulatory health care program usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs and is often known as a community health center. Neighborhood health centers attempt to coordinate Federal, State, and local resources in single organization capable of delivering both health care and related social services to a defined population.

neonatal death

Death of a live-born infant from birth to <28 days of life.

nulligravida

A woman who has never been pregnant.

nurse

An individual trained to care for the sick, aged, or injured. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing. There are many different types, specialties, and grades of nurses.

nurse midwife

A registered nurse with special qualifications in obstetric and neonatal (newborn) care, certified by the American College of Nurse Midwives (ACNM) (a voluntary body) to manage maternal and perinatal care in normal pregnancy, labor, and childbirth.

nurse practitioner

A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his or her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for-service reimbursement for their services.

nursing home

Includes a wide range of institutions which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems which range from minimal to very serious. The term includes free-standing institutions, or identifiable components of other health facilities which provide nursing care and related services, personal care, and residential care. Nursing homes include skilled nursing facilities and extended care facilities but not boarding homes.

nutritionist

1. A person who works in the area of nutrition of either animals or humans. A nutritionist in the field of human nutrition has usually had training that included chemistry, biochemistry, human physiology and psychology, as well as food science and nutrition. However, there is no consensus among national groups about minimum qualifications needed to call oneself a nutritionist. Currently, anyone who wishes to do so may call herself a nutritionist.

2. A generic term for a health professional specializing in health and nutrition relationships; the American Hospital Association uses the term as a job classification for registered dietitians.

3. **(public health nutritionist)** A health professional specializing in assessment of community nutrition needs and in planning, organizing, implementing, and evaluating appropriate nutrition related services. Public health nutritionists are often members of a publicly funded health agency such as city, county and state health departments. They serve selected groups having special nutritional needs such as mothers and children, pregnant teenagers, and the poor.

obstetrics

The branch of medicine dealing with pregnancy and the delivery of babies.

occupational health services

Health services concerned with the physical, mental, and social well-being of an individual in relation to his or her working environment and with the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the U.S., the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

occupational therapy

Treatment by means of "occupational" activities, that is, tasks which are constructive and often will permit gainful employment. Occupational therapy is used primarily with disabled individuals, but is also used in retraining individuals after illnesses and accidents.

outpatient

A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility. Usually, it does not mean people receiving services from a physician's office or other program which also does not provide inpatient care.

passive intervention

Health promotion and disease prevention initiatives which do not require the direct involvement of the individual (e.g., fluoridation programs) are termed “passive”. Most often these types of initiatives are Government sponsored.

periconceptional

Occurring around the time of conception.

physical therapy

The use of physical means such as exercise, massage, light, cold, heat, and electricity, and mechanical devices in the prevention, diagnosis, and treatment of diseases, injuries and other physical disorders. Physical therapy does not include the use of X-rays or other types of radiation.

physician assistant (PA)

Also known as a physician extender, a PA is a specially trained and licensed or otherwise credentialed individual who performs tasks, which might otherwise be performed by a physician, under the direction of a supervising physician.

postneonatal death

Death of a live-born infant after 30 days of life and before its first birthday.

preconception care

An organized and comprehensive program of health care that identifies and reduces a woman's risk before conception through risk assessment, health promotion, and interventions. Preconception care programs may be designed to include the male partner by providing counseling and educational information in preparation for fatherhood, such as genetic counseling and testing, financial and family planning, etc. May refer to prospective father or mother.

pregnancy-associated mortality

The death of a woman from any cause while pregnant or within one calendar year of termination of pregnancy, regardless of the duration and site of pregnancy.

pregnancy-related mortality

A pregnancy associated death resulting from 1) complications of the pregnancy itself 2) the chain of events initiated by the pregnancy, that led to death: or 3) aggravation of an unrelated condition by the physiologic or pharmacologic effects of the pregnancy that subsequently caused death.

premature mortality

1. Any preventable death
2. Deaths that occur before a specified age, most often age 65 or the average life expectancy of a certain population.

prenatal care

1. Care of the pregnant woman before delivery of the infant.
2. Monitoring and management of the woman during pregnancy to prevent complications of pregnancy and promote a health outcome for the mother and infant.

preterm delivery

Termination of pregnancy before the 37th completed week of gestation.

prevention (primary, secondary, tertiary)

primary prevention: An intervention implemented before there is evidence of a disease or injury. This strategy can reduce or eliminate causative risk factors (risk reduction).

secondary prevention: An intervention implemented after a disease has begun, but before it is symptomatic (screening and treatment).

tertiary prevention: An intervention implemented after a disease or injury is established. This strategy can prevent sequelae.

preventive care

Comprehensive care emphasizing prevention, early detection, and early treatment of conditions, and generally including routine physical examinations, immunization, and well-person care.

preventive medicine

Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunization), early detection of disease (e.g., Pap smear), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine developed following discovery of bacterial diseases and was concerned in its early history with specific medical control taken against the agents of infectious. Preventive medicine is also concerned with general preventive aimed at improving the healthfulness of the environment. In particular, the promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.

preventive strategies (clinical, behavioral, environmental)

A framework for categorizing prevention programs based on how the prevention technology is delivered, i.e., provider to patient (clinical), individual responsibility (behavioral), or alteration in an individual's surroundings (environmental).

primary care

1. Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

2. Initial contact for personal health care, including care from physicians and other health care practitioners trained in general pediatrics, general internal medicine, obstetrics and gynecology, and family practice. Also provides for continuity of services and referral for subsequent necessary care.

3. The point when the patient first seeks assistance from the medical care system; also the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and treatment.

primary prevention

The prevention of an illness or disease before any symptoms manifest themselves.

public health

1. The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.

2. Application of scientific and technical knowledge to address community health needs, thereby preventing disease and promoting health. Core functions include collecting and analyzing data, developing comprehensive policies for entire populations, and assuring that appropriate services are delivered to all.

registered dietician (RD)

A dietician who has met the registration requirements of the Commission on Dietetic Registration of the American Dietetic Association (ADA). The dietician must have at least a bachelor's degree in food relate science, passed a comprehensive registration examination, completed supervised field experience in dietetic practice, and must maintain a record of mandatory continuing professional education experiences.

rehabilitation

The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical, and educational.

screening

The use of quick procedures to differentiate apparently well persons who have a disease or a high risk of disease from those who probably do not have the disease. It is used to identify high risk individuals for more definitive study or follow-up. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons.

secondary opinions

In cases involving nonemergency or elective surgical procedures, the practice of seeking judgment of another physician in order to eliminate unnecessary surgery and contain the cost of medical care.

secondary care

Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists). In the U.S., however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers. This is quite different from the practice in England, for example, where all patients must first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as needed.

secondary infertility

The status of an infertile couple who has had one or more previous conceptions.

secondary prevention

Early diagnosis, treatment and follow-up. Secondary prevention activities start with the assumption that illness is already present and that primary prevention was not successful and the

goal is to diminish the impact of disease or illness through early detection, diagnosis and treatment. For example, blood pressure screening, treatment, and follow up programs.

seroprevalence

The prevalence of HIV in anonymous surveys of blood serum from selected populations such as child-bearing women, patients of sentinel hospitals, and clients of clinics treating sexually transmitted diseases, tuberculosis, and substance abuse.

severity of illness

A risk prediction system to correlate the "seriousness" of a disease in a particular patient with the statistically "expected" outcome (e.g., mortality, morbidity, efficiency of care). Most effectively, severity is measured at or soon after admission, before therapy is initiated, giving a measure of pretreatment risk.

skilled nursing facility (SNF)

A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.

specialist

A physician, dentist, or other health professional who is specially trained in a certain branch of medicine or dentistry related to specific services or procedures (e.g., surgery, radiology, pathology); certain age categories of patients (e.g., pediatrics, geriatrics); certain body systems (e.g., dermatology, orthopedics, cardiology); or certain types of diseases (e.g., allergy, psychiatry, periodontics). Specialists usually have advanced education and training related to their specialties.

spontaneous abortion

Spontaneous death prior to the complete expulsion or extraction from its mother of a product of conception. In some surveillance systems, this term indicates such deaths at gestational age less than 20 weeks.

stillbirth

Death prior to the complete expulsion or extraction from its mother of a product of conception. In some surveillance systems, this term indicates such deaths at gestational age of 20 weeks or more.

symptomatic

Someone who has symptoms of a disease or illness is symptomatic. Someone who has smoked all their life and has a heavy cough is said to be symptomatic. A heavy lifelong smoker who has not yet developed symptoms is said to be pre-symptomatic.

technology

Techniques, devices, drugs, or procedures used to reduce the risk of an adverse health outcome.

teratogen

An exposure that causes birth defects.

tertiary care

Services provided by highly specialized providers (e.g., neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require highly sophisticated equipment and support facilities. The development of these services has largely been a function of diagnostic and therapeutic advances attained through basic and clinical biomedical research.

tertiary prevention

Prevention activities which focus on the individual after a disease or illness has manifested itself. The goal is to reduce long-term effects and help individuals better cope with symptoms.

unintentional injury

Injury arising from unintentional events.

unintended pregnancy

According to questions included in the National Survey of Family Growth, a pregnancy identified as either unwanted or mistimed.

unwanted pregnancy

According to questions included in the National Survey of Family Growth, a pregnancy occurring when the mother reported that she did not want a child at the time of conception or any time in the future.

wellness

A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.

EVALUATION/MEASUREMENT/RESEARCH

adverse event (outcome)

Any disease or injury, e.g., premature death or unnecessary morbidity.

attributable risk

The theoretical reduction in the rate or number of cases of an adverse outcome that can be achieved by elimination of a risk factor.

audio-CASI

Audio computer-assisted self-interviewing.

association

A term signifying a relationship between two or more events or variables. Events are said to be associated when they occur more frequently together than one would expect by chance. Association does not necessarily imply a causal relationship. Statistical significance testing enables a researcher to determine the likelihood of observing the sample relationship by chance if in fact no association exists in the population that was sampled. The terms "association" and "relationship" are often used interchangeably.

birth cohort prevalence rate

In developmental disabilities surveillance, the prevalence of a specific disorder in a geographic area, among children of a specific age who were born in that geographic area, within a specified time interval.

birth weight-specific mortality

The number of infant deaths that occurred among live births in a specific birth weight category in a calendar year, divided by the total number of live births that occurred in that category in that year, multiplied by 1,000.

case ascertainment

Identification of cases of an exposure or health outcome in public health surveillance, usually according to a specific case definition.

catchment area

A geographic area defined and served by a health program or institution such as a hospital or community mental health center which is delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. By definition, all residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria.

causality

Relating causes to the effects they produce. Most of epidemiology concerns causality, and several types of causes can be distinguished. A cause is termed "necessary" when a particular variable must always precede an effect. This effect need not be the sole result of the one variable. A cause is termed "sufficient" when a particular variable inevitably initiates or produces an effect. Any given cause may be necessary, sufficient, neither, or both.

cause-of-death

As defined by the World Health Organization, the underlying cause of death, indicated on the death certificate, and defined as a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury.

cohort infant mortality rate

The number of infant deaths that occurred among live births in a calendar year, divided by the total number of live births that year, multiplied by 1,000.

community rating

1. A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.
2. Premium calculation based on the entire expected population use rather than on use by specific groups.

confidence interval

1. A range within which an estimate is deemed to be close to the actual value being measured. In statistical measurements, estimates cannot be said to be exact matches, but rather are defined in terms of their probability of matching the value of the thing being measured.
2. A range of values for a variable of interest, constructed so that this range has a specified probability of including the true value of the variable (1).

continuous quality improvement (CQI)

Process identifying problems in delivery of services, testing solution, and constantly monitoring the solutions for improvement. Intended to encourage appropriate and necessary care, as well as accountability for cost and quality.

contraceptive failure rate

The average probability of having an unintended pregnancy in a year of using a specific contraceptive method.

cost-benefit analysis

An analytic method in which a program's cost is compared to the program's benefits for a period of time, expressed in dollars, as an aid in determining the best investment of resources. For example, the cost of establishing an immunization service might be compared with the total cost of medical care and lost productivity which will be eliminated as a result of more persons being immunized. Cost-benefit analysis can also be applied to specific medical tests and treatments.

cost-effectiveness analysis

A method of comparing alternative ways for achieving a specific set of results. Alternatives are compared on the basis need not be measured in financial terms.

coverage survey

In population vaccination assessment, a survey using population-based sampling techniques to identify vaccination coverage in a specific target population.

current mortality sample

A 10% systematic sample of death certificates filed in State vital records offices and coded by the National Center for Health Statistics.

decision analysis

An analytic technique in which probability theory of probabilistic information processing is used to obtain a quantitative approach to decision making.

demonstration settings

A population- or clinic-based environment in which prevention strategies are field tested.

distributional effects

The manner in which the costs and benefits of a preventive strategy effects different groups of people in terms of demographics, geographic location, and other descriptive factors.

E-codes

The current standard of coding external causes of injury for nonfatal cases. from the ICD-9-CM Supplemental Classification of External Causes of Injury and Poisoning.

effectiveness

A particular application of efficacy, i.e., it reflects the performance of an intervention under ordinary conditions by the average practitioner for the typical patient.

efficacy

The probability of benefit to individuals in a defined population from a medical technology applied to a given medical problem under ideal conditions of use.

efficiency

"Productive" efficiency describes the performance of a service or delivery of medical care of a given quality with the least expenditure of resource. "Allocative" efficiency concerns not only whether care is provided as cheaply as possible given its costs and quality, but also whether the costs expended for the additional care are worth the benefits to be gained.

epidemiology

The study of the patterns of determinants and antecedents of disease in human populations. Epidemiology utilizes biology, clinical medicine, and statistics in an effort to understand the etiology (causes) of illness and/or disease. The ultimate goal of the epidemiologist is not merely

to identify underlying causes of a disease but to apply findings to disease prevention and health promotion.

etiology

Cause. A term used by epidemiologists.

evaluation

In health services research, a systematic analysis of the degree to which a program or initiative has achieved, or is capable of achieving, its goals and objectives. In medicine, an analysis of a patient's condition.

experience rating

1. A method of adjusting health plan premiums based on the historical utilization data and distinguishing characteristics of a specific subscriber group.

2. Premium calculations based on the cost of a group's health care claims. Those with the sickest workers pay the highest premiums.

exposure

A general term used to describe contact with a risk factor. An exposure can be a physical agent (e.g., radiation) or a behavior (e.g., excessive drinking).

favorable selection

A tendency for utilization of health services in a population group to be lower than expected or estimated.

fetal mortality rate

The number of fetal deaths divided by the sum of the number of live births plus the number of fetal deaths in a specified time period, multiplied by 1,000.

fetal mortality ratio

The ratio of the number of fetal deaths to live births in a specified period. multiplied by 1,000.

final data

Complete data from vital records (such as birth and death certificates and fetal death reports) that have been reviewed by the National Center for Health Statistics for validity and consistency; available about 2 years after the close of a data year.

goal

A statement of expectations of desired, attainable levels of health status and/or health system performance.

gross margin

Net sales minus goods sold; the difference between sales revenues and manufacturing costs as an intermediate step in the computation of operating profits or net income.

health status

The state of health of a specified individual, group, or population. It may be measured by obtaining proxies such as people's subjective assessment of their health; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by using the incidence or prevalence of major diseases (communicable, chronic, or nutritional). Conceptually, health status is the proper outcome measure for the effectiveness of a

specific population's medical care system, although attempts to relate effects of available medical care to variation in health status have proved difficult.

height-for-age

Pediatric measurement of a child's height at a specified age, allows for the comparison of a child's height to the reference population of the same age and sex.

incidence

1. In epidemiology, the number of cases of disease, infection, or some other event having their onset during a prescribed period of time in relation to the unit of population in which they occur. Incidence measures morbidity or other events as they happen over a period of time. Examples include the number of accidents occurring in a manufacturing plant during a year in relation to the number of employees in the plant, or the number of cases of mumps occurring in a school during a month in relation to the number of pupils enrolled in the school. It usually refers only to the number of new cases, particularly of chronic diseases.

2. The number of new events occurring during a specified period (1).

instrumental activities of daily living (IADL)

An index or scale which measures a patient's degree of independence in aspects of cognitive and social functioning including shopping, cooking, doing housework, managing money, and using the telephone.

Kessner index

A classification of prenatal care developed by the Institute of Medicine in 1973 that adjusts the timing and quantity of prenatal care for the length of gestation to determine levels of adequate, inadequate, and intermediate prenatal care. David Kessner was the first author of the Institute of Medicine's report.

low birth weight

Birth weight less than 2,500 g.

lead poisoning case

In CDC surveillance, a lead poisoning case is defined in children by a venous sample containing 10 micrograms or more per deciliter of serum lead or two capillary samples taken within 12 weeks of each other, both containing this level

margin

Revenue less specified expenses.

medical audit

Detailed retrospective review and evaluation of selected medical records by qualified professional staff. Medical audits are used in some hospitals, group practices, and occasionally in private, independent practices for evaluating professional performance by comparing it with accepted criteria, standards, and current professional judgement. A medical audit is usually concerned with the care of a given illness and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it.

meta-analysis

A systematic, quantitative method for combining information from multiple studies in order to derive that most meaningful answer to a specific question. Assessment of different methods or outcome measures can increase power and account for bias and other effects.

morbidity

The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

mortality

Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).

natural history of disease

This term refers to the fact that virtually all illnesses and diseases have certain predictable and regular patterns associated with them, i.e., a natural history. Understanding something of a natural history of a disease is a necessity if an effective intervention program is to be implemented.

need

In health services, need has a normative connotation (i.e., the amount of a good or service which should be consumed). Because of the technical nature of medical care this value judgment is generally made by the health professional, rather than the consumer of the services. In health planning, need is the appropriate amount of health facilities and services required for a given area.

net pregnancy weight gain

Total weight gain of the mother during pregnancy after the birth weight of the infant is subtracted.

occupancy rate

A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital beds occupied and may be institution-wide or specific for one department or service.

operating cost

In the health field, the financial requirements necessary to operate an activity which provides health services. These costs normally include the costs of personnel, materials, overhead, depreciation, and interest.

operating margin

Revenues from sales minus current cost of goods sold. A measure of operating efficiency that is independent of the cost flow assumption for inventory. Sometimes called "current (gross) margin."

outcome measures

Disease and injury morbidity and mortality that are the target of prevention programs.

outcomes research

Research on measures of changes in patient outcomes, that is, patient health and satisfaction, resulting from specific medical and health interventions. Attributing changes in outcomes to medical care requires distinguishing the effects of care from the effects of the many other factors that influence patients' health and satisfaction.

outlier

A hospital admission requiring either substantially more expense or a much longer length of stay than average. Under DRG reimbursement, outliers are given exceptional treatment (subject to peer review organization review).

patient origin study

A study, generally undertaken by an individual health program or health planning agency, to determine the geographic distribution of the residences of the patients served by one or more health programs. Such studies help define catchment and medical trade areas and are useful in locating and planning the development of new services.

peer review

Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, and also to review of research by other researchers.

periconceptual

Occurring around the time of conception.

period infant mortality rates

The number of infant deaths occurring in a calendar year per the number of live births occurring during the same period, multiplied by 1,000.

point prevalence rate

In developmental disabilities surveillance, the prevalence of a specific disorder among all children of a specific age in a geographic area, regardless of where the children were born.

precision

In statistics, the quality of being sharply defined or stated. One measure of precision is the number of distinguishable alternatives from which a measurement was selected, sometimes indicated by the number of significant digits in the measurement. Precision can be contrasted with accuracy, which is the degree of conformity of a measure to a standard or true value. Often, however, this contrast is not relevant, because the true value is not known.

pregnancy mortality rate

The number of pregnancy related deaths per 100,000 pregnancies.

pregnancy mortality ratio

The number of pregnancy related deaths per 100,000 live births.

probability (P value)

The likelihood that an event will occur. When looking at differences between data samples, statistical techniques are used to determine if the differences are likely to reflect real differences in the whole group from which the sample is drawn or if they are simply the result of random variation in the samples. For example, a probability (or P value) of one percent indicates that the differences observed would have occurred by chance in one out of a hundred samples drawn from the same data.

prevalence

1. The number of cases of disease, infected persons, or persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It can be a measurement of morbidity at a moment in time, e.g., the number of cases of hemophilia in the country as of the first of the year.

2. The number of cases of a condition in a specified population at a designated time.

preventable fraction

The proportion of an adverse health outcome that potentially can be eliminated as a result of a prevention strategy.

primary infertility

The status of an infertile couple who has not previously conceived.

process measures

Steps in a (prevention) program logically required in order for the program to be successful, e.g., knowledge, attitudes, and behaviors may be targeted by a prevention program for the prevention of an adverse health outcome.

provisional data

Limited, early data from filed death certificates provisional data on infant mortality are provided by the National Center for Health Statistics 3-4 months after the death certificates are filed in the states and include estimates of the number of infant deaths and selected causes of death.

quality management

The process by which an organization measures the extent to which their providers conform to defined standards and, based on that data, improve care and outcomes.

quality of care

Can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

rate

A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates are usually expressed using a standard denominator such as 1,000 or 100,000 persons.

rate ratio

The ratio of two rates, expressed in epidemiology as the ratio of the rate of a health outcome in an exposed population to the rate in the unexposed population.

rate review

Review by a Government or private agency of a hospital's budget and financial data, performed for the purpose of determining the reasonableness of the hospital rates and evaluating proposed rate increases.

registry

A system of ongoing registration of cases of a specific disease or health-relevant condition in a defined population (1).

regression analysis

Given data on a dependent variable and an independent variable, regression analysis involves finding the 'best' mathematical model (within some restricted form) to describe the dependent variable as a function of the independent variable or to predict the dependent from the independent variable. Multiple regression analysis considers a dependent variable as a function of more than one independent variable

relative risk

1. The rate of disease in one group exposed to a particular factor (e.g., a toxic spill) divided by the rate in another group which is not exposed. A relative risk of one (1) indicates that the two groups have the same rate of disease.

2. The ratio of the risk of disease in the exposed population to the risk in an unexposed population.

relative value scale (RVS)

A list of all physician services containing a cardinal ranking of those services with respect to some conception of value, such that the difference between the numerical rankings for any two services is a measure of the difference in value between those services. Two common measures of value used in relative value scales are resources used and charges.

relative value studies (also California Relative Value Studies)

Coded listing of professional services with unit values to indicate relative complexity as measured by time, skill and overhead costs. Third party payers often assign a dollar value to units to calculate provider reimbursement.

resource-based relative value scale (RBRVS)

An RVS that is based on resource costs.

risk or risk factor

Risk is a term used by epidemiologists to quantify the likelihood that something will occur. A risk factor is something which either increases or decreases an individual's risk of developing a disease. However, it does not mean that, if exposed, an individual will definitely contract a particular disease.

risk rating

Plans that differentiate premiums according to assessed risk status, with premium setting based on health risk status and health-related behavior that are indicators for high health care expenditures

safety

As assessment of the level and acceptability of risk of adverse outcomes that occur as a result of a prevention technique in the context of a specific prevention strategy and disease or injury outcome.

sensitivity analysis

A quantitative method for assessing the impact of individual factors in a model by varying values of those factors and observing the effect on the outcome.

seroprevalence

The prevalence of HIV in anonymous surveys of blood serum from selected populations such as child-bearing women, patients of sentinel hospitals, and clients of clinics treating sexually transmitted diseases, tuberculosis, and substance abuse.

standard error

In statistics, the standard error is defined as the standard deviation of an estimate. That is, multiple measurements of a given value will generally group around the mean (or average) value in a normal distribution. The shape of this distribution is known as the standard error.

standards

Generally, a measure set by a competent authority as the rule for measuring quantity or quality. Conformity with standards is usually a condition of licensure, accreditation, and sometimes, payment for services. Standards may be defined most often in relation to: the actual or predicted effects of care; the performance or credentials of professional personnel; and the physical plant, governance and administration of facilities and programs.

supply

In health economics, the quantity of services provided or personnel in a given area.

survey

An investigation in which information is systematically collected. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, by postal service, or in some other way. Each method has its advantages and disadvantages. The generalizability of results depends upon the extent to which those surveyed are representative of the entire population.

technology assessment

A comprehensive form of policy research that examines the technical, economic, and social consequences of technological applications. It is especially concerned with unintended, indirect, or delayed social impacts. In health policy, the term has come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety.

type I error

Also known as “false positive” or “alpha error”. An incorrect judgment or conclusion that occurs when no association is found between variables where, in fact, no association exists. In an experiment, for example, if the experimental procedure does not really have any effect, chance or random error may cause the researcher to conclude that the experimental procedure did have an effect.

type II error

Also known as “false negative” or “beta error”. An incorrect judgement or conclusion that occurs when no association is found between variables where in fact, an association does exist. In a medical screening, for example, a negative test result may occur by chance in a subject who possesses the attribute for which the test is conducted.

unnecessary morbidity

Any preventable disease, injury or disability.

utilization

Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.

utilization review

1. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a peer review group, or a public agency.
2. A mechanism used by some insurers and employers to evaluate health care on the basis of appropriateness, necessity, and quality. For hospital review, it can include preadmission certification, concurrent review with discharge planning, and retrospective review.
3. Independent evaluation of a patient's clinical progress to make sure the care being provided is appropriate and necessary. Widely used cost-containment device and a key element in managed care.

vital statistics

Statistics relating to births (natality), deaths (mortality), marriages, health, and disease (morbidity). Vital statistics for the United States are published by the National Center for Health Statistics.

weight-for-height

Pediatric measurement of weight for height, adjusts a child's weight relative to his or her height and thus is a measurement of body mass.

LEGISLATION/REGULATIONS/PUBLICATIONS

Current Procedural Terminology, fourth edition (CPT-4)

A manual that assigns five digit codes to medical services and procedures to standardize claims processing and data analysis.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.

Employee Retirement Income Security Act (ERISA)

A Federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from State insurance laws.

Healthy People 2000

An extensive description of health goals for the U.S. population in the year 2000, identified by the Public Health Service.

Hill-Burton

Coined from the names of the principal sponsors of the Public Law 79-725 (the Hospital Survey and Construction Act of 1946); this program provided Federal support for the construction and modernization of hospitals and other health facilities. Hospitals that have received Hill-Burton funds incur an obligation to provide a certain amount of charity care.

life safety code

A fire safety code prepared by the National Fire Protection Association. The provisions of this code relating to hospitals and nursing facilities must (except in instances where a waiver is granted) be met by facilities certified for participation under Medicare and Medicaid. The code is based on optimum (non minimum) standards.

Medicaid (Title XIX)

1. A Federally aided, State-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

2. State programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966. Medicaid served about 30 million people at a cost of \$80 billion in 1992.

Medicare (Title XVIII)

A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Medicare

The hospital insurance system and the supplementary medical insurance for the aged, totally disabled, and those with end-stage renal disease created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act. Medicare served 35 million elderly and disabled persons at a cost of \$130 billion in 1992.

Title XVIII (Medicare)

The title of the Social Security Act which contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Title XIX (Medicaid)

The title of the Social Security Act which contains the principal legislative authority for the Medicaid program and therefore a common name for the program.

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**MATERNAL AND CHILD HEALTH
LEADERSHIP SKILLS TRAINING INSTITUTE
GLOSSARY OF ACRONYMS**

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A

AAFP	American Academy of Family Physicians
AAMC	Association of American Medical Clinics; Association of American Medical Colleges
AAMR	American Association on Mental Retardation
AAOHN	American Association of Occupational Health Nurses
AAP	American Academy of Pediatrics
AAPA	American Academy of Physician Assistants
AAPCC	Adjusted Average Per Capita Cost
AAPS	American Association of Physicians and Surgeons
AAUAP	American Association of University Affiliated Programs
AB	Aid to the Blind
ABBS	American Brittle Bone Society
ACCH	Association for the Care of Children's Health
ACEI	Association for Childhood Education International
ACNM	American College of Nurse Midwives
ACOG	American College of Obstetricians and Gynecologists
ACORN	Associations of Community Organizations for Reform Now
ACYF	Administration for Children, Youth, and Families
AD	Aid to the Disabled
ADA	American Dietetic Association; American Dental Association
ADD	Administration on Developmental Disabilities
ADHA	American Dental Hygienists' Association
ADL	Activities of Daily Living
ADRDA	Alzheimer's Disease and Related Disorders Association, Inc.
AFB	American Foundation for the Blind
AFDC	Aid To Families With Dependent Children
AFDC-U	Aid to Families with Dependent Children-Unemployed Parent
AGPA	American Group Practice Association
AHA	American Heart Association
AHA	American Hospital Association
AHCPR	Agency for Health Care Policy and Research
AHEA	American Home Economist Association
AHEC	Area Health Education Center
ALA	American Lung Association
ALS	Amyotrophic Lateral Sclerosis

AMA	American Medical Association
ANA	American Nurses Association
ANHA	American Nursing Homes Association
AOA	American Optometric Association; American Osteopathic Association
APA	Administrative Procedures Act; American Pharmaceutical Association
APHA	American Public Health Associations; American Protestant Hospital Association
ASFSA	American School Food Service Association
ASHA	American School Health Association
ASTHO	Association of State and Territorial Health Officials
ATMCH	Association of Teachers of Maternal and Child Health

B

BDMP	Birth Defects Monitoring Program
BCA	Blue Cross Association
BCHS	Bureau of Community Health Services
BMCHRD	Bureau of Maternal and Child Health and Resources Development
BMI	Body mass index, expressed as kilograms of body mass per height in meters squared (kg/m ²).
BRFS	Behavioral Risk Factor Survey

C

C&Y	Children and Youth Projects
CAP	Community Action Program
CAPI	Computer-assisted personal interviewing.
CASSP	Child and Adolescent Service System Program
CAT	Computerized axial tomography
CATI	Computer-assisted telephone interviewing.
CBO	Congressional Budget Office

CCHP	Consumer Choice Health Plan
CCS	Crippled Children's Services
CCU	Coronary Care Unit
CDC	Centers for Disease Control
CDCP	Centers for Disease Control and Prevention
CDF	Children's Defense Fund
CdLS	Conelia de Lange Syndrome Foundation, Inc.
CEC	The Council for Exceptional Children
CETA	Comprehensive Employment and Training Act
CF	Cystic Fibrosis
CFHS	Child and Family Health Services
CFNP	Community Food and Nutrition Program
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHC	Community Health Center
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMHT	Care Management Health Team
CMP	Competitive Medical Plan
CMS	Children's Medical Services
CMT	Chaarot-Marie-Tooth International
CNI	Community Nutrition Institute
CNM	Certified Nurse Midwife
CNS	Central nervous system
COB	Coordination of Benefits
COG	Council of Governments
COLA	Cost of Living Adjustment
CON	Certificate of Need
COTH	Council of Teaching Hospitals
CPA	Certified Public Accounts
CPHA	Commission on Professional and Hospital Activities
CPI	Consumer Price Index
CPR	Customary, Prevailing, and Reasonable
CPT-4	Current Procedural Terminology, Fourth Edition
CRVS	California Relative Value Studies
CSA	Celiac-Spruce Association
CSFP	Commodity Supplement Food Program
CSHCN	Children with Special Health Care Needs

CSPI Center for Science in the Public Interest
CSTE Council of State and Territorial Epidemiologists.
CT Computer Tomographic (scanners)

D

DCED Department of Community and Economic Development
DD Developmental Disability
DDS Doctor of Dental Surgery
DEA Drug Enforcement Administration
DEBRA Dystrophic Epidermolysis Bullosa Research Association of America, Inc.
DHHS U.S. Department of Health and Human Services
DMCH Division of Maternal and Child Health
DMD Doctor of Dental Medicine
DME Durable Medical Equipment
DO Doctor of Osteopathy
DRG Diagnosis-Related Group
DSCC Division of Services for Crippled Children
DTP Diphtheria-tetanus-pertussis vaccine.
DUI Driving Under the Influence (of alcohol)
DVM Doctor of Veterinary medicine

E

ECF Extended Care Facility
EFNEP Expanded Food and Nutrition Education Program - Cooperative Extension Services
EMS Emergency Medical Services
EMSC Emergency Medical Services for Children
EPA Exclusive Provider Arrangement
EPSDT Early and Periodic Screening, Diagnosis, and Treatment Program
ER Emergency Room
ERISA Employee Retirement Income Security Act
ESL English as a Second Language

ESRD	End Stage Renal Disease
ET	Expenditure Target
EWP	Emergency Work Program

F

FAE	Fetal alcohol effects.
FAH	Federation of American Hospitals
FAS	Fetal alcohol syndrome.
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFY	Federal Fiscal Year (September 1 through August 31)
FICA	Federal Insurance Contributions Act
FICC	Federal Interagency Coordinating Council
FIWSH	Federal Interagency Workgroup on School Health
FMG	Foreign Medical Graduate
FNIC	Food and Nutrition Information Center
FNP	Family Nurse Practitioner
FPNP	Family Practice Nurse Practitioner
FRAC	Food Research and Action Center
FTC	Federal Trade Commission
FY	Fiscal Year

G

GA	General Assistance
GHAA	Group Health Association of America
GISP	Gonococcal Isolate Surveillance Project.
GP	General Practitioner
GUCDC	Georgetown University Child Development Center

H

HCFA	Health Care Financing Administration
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HEDIS	Health Plan Employer Data and Information Set
HHCMS	Home Health Care Management System
(D)HHS	Department of Health and Human Services
HIAA	Health Insurance Association of America
HIV	Human immunodeficiency virus.
HMHB	Healthy Mothers Healthy Babies Coalition
HMO	Health Maintenance Organization
HMSA	Health Manpower Shortage Area
HRA	Hunger Relief Act
HRSA	Health Resources & Services Administration
HSA	Health Systems Agency; Health Service Area

I

IADL	Instrumental Activities of Daily Living
ICDA	International Classification of Diseases, Adapted
ICD-9	International Statistical Classification of Diseases, injuries, and Causes of Death, 9th revision (published by the World Health Organization). This classification system is used primarily for mortality coding.
ICD-9-CM	International Classification of Diseases, 9th revision, Clinical Modification (published by the Health Care Financing Administration, U.S. Public Health Service). This classification system is used primarily for morbidity coding.
ICF	Intermediate Care Facility
ICF(M)	International Cystic Fibrosis (Mucovidosi)s Association
ICHP	Improved Child Health Projects
ICU	Intensive Care Unit
ICU/MR	Intermediate Care Facility for the Mentally Retarded
IFT	Institute of Food Technology
IMR	Infant Mortality Rates
IOM	Institute of Medicine of the National Academy of Sciences
IPA	Independent Practice Association
IUD	Intrauterine device.
IUGR	Intrauterine growth retardation: in epidemiologic surveillance. IUGR is most commonly defined as intrauterine, fetal growth

below the 10th percentile for gestational age, or gestational age of 37 weeks and birth weight of <2,500 g.

J

JCAHO	Joint Commission on Accreditation of Healthcare
JTPA	Jobs Training Partnership Act

L

LHD	Local Health Department
LMP	Last menstrual period
LOS	Length of Stay
LPN	License Practical Nurse
LSC	Life Safety Code
LVN	License Vocational Nurse

M

M&I	Mothers and Infants Projects
MA	Medical Assistance
MAAC	Maximum Allowable Actual Charge
MACDP	Metropolitan Atlanta Congenital Defects Program.
MADDSP	Metropolitan Atlanta Developmental Disabilities Surveillance Program.
MAF	Medical Assistance Facility
MAO	Medical Assistance Only
MAP	Medical Audit Program
MCAT	Medical College Admission Test
MCH	Maternal and Child Health
MCHB	Maternal and Child Health Bureau
MCHING	Maternal and Child Health Interorganizational Group
MCHTAG	MCH/Medicaid Technical Advisory Group
MCO	Managed Care Organization

MEDLARS	Medical Literature and Analysis Retrieval System
MHP	Migrant Health Program
MIS	Management Information System
MLBW	Moderately low birth weight: birth weight 1,500 grams and <2,500g.
MMC	Medicaid Managed Care
MMIS	Medicaid Management Information System
MMWR	Morbidity and Mortality Weekly Report.
MOD	March of Dimes Birth Defects Foundation
MOU	Memorandum of Understanding
MR	Mentally Retarded
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Areas

N

NA	(Information) Not Available
NA	Needs Assessment
NACo	National Association of Counties
NAED	National Foundation for Ectodermal Dysplasias
NAEYC	National Association for the Education of Young Children
NAPAS	National Association of Protection and Advocacy Systems
NAPNAP	National Association of Pediatric Nurse Associates and Practitioners
NAS	National Academy of Science.
NASDSE	National Association of State Directors of Special Education
NASN	National Association of School Nurses
NASW	National Association of Social Workers
NBMRS	National Bacterial Meningitis Reporting System.
NCCIP	National Center for Clinical Infant Programs
NCEMCH	National Center for Education in Maternal and Child Health
NCHS	National Center for Health Statistics
NCHSR/HCTA	National Center for Health Services/Research Health Care Technology Assessment
NEA	National Education Association

NEISS	National Electronic Injury Surveillance System.
NET	Nutrition Education and Training Program
NETSS	National Electronic Telecommunications System for Surveillance.
NGA	National Governor's Association
NHANES (I, II, III)	National Health and Nutrition Examination Surveys.
NHDS	National Hospital Discharge Survey.
NHIS	National Health Interview Survey.
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NICU	Neonatal Intensive Care Unit
NIH	National Institute of Health
NIMH	National Institute of Mental Health
NIOSH	National Institute of Occupational Safety and Health
NLM	National Library of Medicine
NLSY	National Longitudinal Survey of Youth
NMA	National Medical Association
NMIHS	National Maternal and Infant Health Survey.
NNDSS	National Notifiable Diseases Surveillance System.
NNS	National Natality Survey.
NOAH	National Organization for Albinism and Hypopigmentation
NP	Nurse Practitioner
NPA	National Perinatal Association
NPRM	Notice of Proposed Rule Making
NSFG	National Survey of Family Growth.
NTD	Neural tube defect.
NTIS	National Technical Information Service

O

OAA	Old Age Assistance
OASDHI	Old Age Survivors, Disability, and Health Insurance Program
OB/GYN	Obstetrics and Gynecology
OCs	Oral contraceptives.
ODPHP	Office of Disease Prevention and Health Promotion
OMB	Office of Management and Budget

OPD Outpatient Department
OTA Office of Technology Assessment

P

PA Public Assistance
PATCH Planned Approach to Community Health
Part H Early Intervention Program for Infants and Toddlers under the Individuals with Disabilities Education Act (IDEA)
PedNSS Pediatric Nutrition Surveillance System
PHS Public Health Service
PIC Private Industry Council
PID Pelvic inflammatory disease.
PKU Phenylketonuria
PL Public Law
PNC Prenatal Care
PNP Pediatric Nurse Practitioner
PNSS Pregnancy Nutrition Surveillance System.
PPC Pediatric Pulmonary Centers
PRAMS Pregnancy Risk Assessment Monitoring System.
PSA Public Service Announcement
PSC Public Service Commission
PTA Parents and Teachers Association

Q

QA Quality Assessment, Quality Assurance

R

RAP Refugee Assistance Program
RDS Respiratory Distress Syndrome
RFP Request for Proposal
RHI Rural Health Initiative

RIE Report of Description of Intended Expenditures
RR Relative risk or relative ratio.

S

SAM Society for Adolescent Medicine
SAMHSA Substance Abuse and Mental Health Services Administration
SBHC School-Based Health Center
SCAN Shared Communication and Assistance Network
SDA Service Delivery Area
SED Severely Emotionally Disturbed
SES Socioeconomic status.
SFD Society for the Rehabilitation of the Facially Disfigured, Inc.
SHA State Health Agency
SHARE Source of Help in Airing and Resolving Experiences
SIDS Sudden infant death syndrome.
SKIP Sick Kids Need Involved People
SPHE Society for Public Health Education, Inc.
SPRANS Special Projects of Regional and National Significance
SS Social Security
SSA Social Security Administration
SSI Supplemental Security Income
STD Sexually transmitted diseases.
STELLAR System for Tracking Elevated Lead Levels and Remediation (a software program).

T

TA Technical Assistance
TEFAP Temporary Emergency Food Assistance Programs
TSS Toxic shock syndrome.

U

UAF	University Affiliated Facility
UCPA	United Cerebral Palsy Associations, Inc.
USDA	United States Department of Agriculture
USDC, BC	United States Department of Commerce, Bureau of the Census
USRDA	United States Recommended Dietary Allowances

V

VBAC	Vaginal birth after cesarean section
VLBW	Very low birth weight, birth weight 1,500 g.
VNA	Visiting Nurse Association

W

WHO	World Health Organization.
WIC	Special Supplemental Food Program for Women, Infants, and Children.

Y

YRBS	Youth Risk Behavior Survey
YRBSS	Youth Risk Behavior Surveillance System.

REFERENCES

The following sources were used to compile the acronyms in this list.

1. Glossary compiled and periodically updated and edited by the Alpha Center. Major sources of original definitions include:
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2. Last JM. A dictionary of epidemiology. 2nd edition. New York: Oxford University Press, 1988.
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