Health-Related Acronyms and Important Terms

This list pulls primarily from two glossaries:

1) The American Medical Informatics Association (AMIA): https://www.amia.org/glossary
2) The Healthcare Association of New York State (HANYS): https://www.hanys.org/search/?action=terms

ACO: Accountable Care Organization - An ACO is a network of healthcare providers that together manages and coordinates care for patients along the continuum of care. The network is held accountable for the quality and cost of care, and may share in the cost savings achieved. (HANYS)

Accountable Health Communities - The Accountable Health Communities Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization. (https://innovation.cms.gov/initiatives/ahcm/)

AHRQ: Agency for Healthcare Research and Quality - A federal agency within the US Department of Health and Human Services (HHS) with a mission to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Formerly known as the Agency for Health Care Policy and Research, AHRQ supports research and technology assessment, including implementations of health information technology. (AMIA)

APCD: All-Payer Claims Databases - APCDs are large-scale databases that systematically collect health care claims data from a variety of payer sources which include claims from most health care providers. https://www.apcdcouncil.org/frequently-asked-questions

Business Associates - A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity (https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html)

CDC: Centers for Disease Control and Prevention - A part of the US Department of Health and Human Services (HHS) with a mission is to collaborate in creating the expertise, information, and tools that people and communities need to protect their health. (AMIA)

CE: Covered Entity - Under HIPAA, a health plan, a health care clearinghouse, or a healthcare provider who transmits any health information in electronic form in connection with a HIPAA-covered transaction. (AMIA) See also: https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html

CMS: Centers for Medicare and Medicaid Services - A federal agency within the US Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. (AMIA)

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Community Health Assessment - Community health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processed may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation. http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.02.pdf

CHNA: Community Health Needs Assessment - A community health needs assessment (CHNA) is required under the Internal Revenue Code (IRS) by the Patient Protection and Affordable Care Act (ACA). The IRS requires hospital organizations to document compliance with CHNA requirements for each of their facilities in a written report that includes: (a) A description of the community served; (b) A description of the process and methods used to conduct the assessment; (c) A description of methods used to include input from people representing the broad interests of the community served; (d) A prioritized description of all community health needs identified in the CHNA, as well as a description of the process and criteria used in prioritizing such needs; and (e) A description of existing health care facilities and other resources in the community available to meet the needs identified in the CHNA. (www.irs.gov/pub/irs-drop/n-10-39.pdf). http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.02.pdf

CHIP: Community Health Improvement Plan - A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community (http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.02.pdf)

DRGs: Diagnosis Related Groups - A method for classifying patients in categories according to patient diagnosis and treatment resource requirements. It is the basis for CMS' hospital Prospective Payment System for Medicare and for state Medicaid inpatient reimbursement. (HANYS)

ED/ER: Emergency Department/Emergency Room - A department that provides immediate emergency care on a 24-hour basis for acutely ill or injured persons. (HANYS)

EHR: Electronic Health Record or **EMR (Electronic Medical Record)** - A repository of electronically maintained information about an individual's health status and health care, stored such that it can serve the multiple legitimate users of the record. (AMIA)

FQHC: Federally Qualified Health Center - A type of provider defined by the Medicare and Medicaid statutes, including all organizations receiving grants under Section 330 of the Public

Health Service Act, certain tribal organizations, and FQHC "look-alikes." FQHCs must provide primary care services for all age groups and must provide preventive health services onsite or by arrangement with another provider. (HANYS)

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services - A term used to refer to the comprehensive set of benefits covered for children in Medicaid. https://www.healthcare.gov/glossary/early-and-periodic-screening-diagnostic-and-treatment-services-EPSDT/

HIE: Health Information Exchange- the electronic movement of health related information among organizations according to national guidelines (2). (AMIA)

HIPAA: Health Insurance Portability and Accountability Act [of 1996] - A government act to reduce fraud and abuse in health care. HIPAA governs privacy, security, and electronic transaction standards for health care information. This federal law also protects individuals' rights to health coverage during events such as changing or losing jobs, pregnancy, moving, or divorce. (HANYS)

HITECH: Health Information Technology for Economic and Clinical Health Act - A government act to enable coordination and alignment within and among states, establish connectivity to the public health community in case of emergencies, and assure the workforce is properly trained and equipped to be meaningful users of EHRs. HL7: Health Level 7 - An ad hoc standards group formed to develop standards for exchange of health care data between independent computer applications. (AMIA)

HMO: Health Maintenance Organization - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. https://www.healthcare.gov/glossary/health-maintenance-organization-HMO/

ICD-10-CM: Tenth International Classification of Diseases-Clinical Modification - ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013. (AMIA)

Managed Care - A health insurance provider or plan that attempts to control costs by closely monitoring patient treatment, limiting referrals to outside providers, and requiring pre-authorization for hospital care and surgical procedures. (HANYS)

MCO: Managed Care Organization - Any organization or healthcare plan that takes a managed care approach to the delivery of services. (HANYS)

NDC: National Drug Code - An essential part of an out-of-hospital drug reimbursement program under Medicare, the NDC directory serves as a universal product identifier for human drugs. (HANYS)

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ONC: Office of the National Coordinator [also referred to as ONCHIT] - Part of HHS that oversees and encourages the development of a national, interoperable (compatible) health information technology system to improve the quality and efficiency of health care. (AMIA)

Payer - A public or private organization that pays for or underwrites healthcare coverage expenses. (HANYS)

PHI: Personal Health Information or Protected Health Information - Information about patients that is protected from inappropriate disclosure under the privacy and security mandates of the Health Insurance Portability and Accountability Act of 1996 and subsequent related legislation. (AMIA)

Population Health - Population health is the health status within a population and the factors, policies, and interventions that influence this status. Population health management is an approach to managing healthcare through education, behavioral interventions, care coordination, and the evidence-based use of healthcare resources. It places greater emphasis on preventive care and maintaining good health, rather than treating illness, and can be targeted at specific diseases or at improving the overall health of a community. (HANYS) Note: This definition likely varies depending on a stakeholder's position in the health field (e.g. health care versus public health).

Triple Aim - The three-part goal of improving population health, enhancing the quality of patient care, and reducing the cost of healthcare. (HANYS)