Glossary

2015 Mandate for Interoperable EHR

The 2007 Minnesota Legislature mandated in Minnesota Statute $62J.495 (Electronic Health Record Technology), that “By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems.”

Source: Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate or www.health.state.mn.us/e-health/hitimp/2015mandateguidance.pdf

Accountable Care

The terms “accountable care” or “Accountable Care Organization,” or “ACO” are being used to reflect the concept of a group of diverse health care providers that have collective responsibility for patient care and that coordinate services. This term is meant to include the broad range of health and health care providers that are not formally part of an existing ACO as defined by the Centers for Medicare and Medicaid Services (CMS) or other payers, but that are also moving towards greater accountability for the quality and cost of care they provide to their patients.

Accountable Care Organization (ACO)

An Accountable Care Organization is a group of health care providers with collective responsibility for patient care that helps providers coordinate services—delivering high-quality care while holding down costs.


Behavioral Health

The term “behavioral health” is a general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders. Behavioral health includes the identification, treatment of, and recovery from mental health and substance use disorders. It also increasingly refers to lifestyle changes and actions which improve physical and emotional health, as well as the reduction or elimination of behaviors which create health risks.

Source: DHS Community Supports Division

Behavioral Health Homes

Section 2703 of the Affordable Care Act defines health homes services as comprehensive and timely high-quality services provided by a designated provider or a team of providers and specifically include: care management; care coordination; health promotion; transitional care; patient and family support; referral to community and social support services; and improved exchange of health information.
DHS is developing a framework for “health homes” to serve the needs of complex populations covered by Medicaid. DHS, with input from stakeholders, is working to design behavioral health services for adults and children with serious mental illness. DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS may build on this framework to serve other complex populations in the future.

Providers that wish to become a behavioral health home must meet federal and Minnesota state requirements and certification standards, currently under development.


**Bundled episodes**

A payment approach in which a single payment is made to cover the cost of services delivered by multiple providers over a defined period of time to treat a given episode of care (e.g., a knee replacement surgery, or a year’s worth of diabetes care).

**Care Coordination**

Care coordination is a function that supports information-sharing across providers, patients, types and levels of service, sites and time frames. The goal of coordination is to ensure that patients’ needs and preferences are achieved and that care is efficient and of high quality. Care coordination is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time.


**Care Coordinator**

A care coordinator is a person who has primary responsibility to organize and coordinate care and services for clients/patients served in a variety of settings, e.g., health care homes, behavioral health clinics, acute care settings and so on.

**Care Manager**

A care manager is a person who has primary responsibility to organize and coordinate care based on a set of evidence-based, integrated clinical care activities that are tailored to the individual patient, and that ensure each patient has his or her own coordinated plan of care and services.

**Care Plan**

A care plan is the structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Community-based Prevention/Community-based Interventions/Community-based Programs are terms used interchangeably to refer to programs or policies within a community that seek to improve the health of a population by addressing non-medical factors, or social determinants of health. Such programs often include the application of non-clinical preventive methods in non-traditional health care settings by non-clinical providers.
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Community Care Team

A Community Care Team is a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations to provide citizens with the support they need for well-coordinated preventive health services and coordinated linkages to available social and economic support services.

Source: Fawcett et al., 1995 or http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Community Engagement

Community Engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.

Source: Fawcett et al., 1995 or http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Computerized Provider Order Entry (CPOE)

Computerized Provider Order Entry (CPOE) is a computer application that allows a physician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.

Continuum of care

Continuum of care is the full array of services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health and well-being of a population.

Source: Adapted from Alaska Health Care Commission or http://dhss.alaska.gov/ahcc/Documents/definitions.pdf

Data Analytics

Data analytics is the systematic use of data and related business insights to drive fact-based decision making for planning, management, measurement and learning. Analytics may be descriptive, predictive or prescriptive.

Determinants of health

Health is determined through the interaction of individual behaviors and social, economic, genetic and environmental factors. Health is also determined by the systems, policies, and processes encountered in everyday life. Examples of determinants of health include job opportunities, wages, transportation options, the quality of housing and neighborhoods, the food supply, access to health care, the quality of public schools and opportunities for higher education, racism and discrimination, civic engagement, and the availability of networks of social support.

Source: MDH Health Equity Terminology webpage or http://www.health.state.mn.us/divs/chs/healthequity/definitions.htm

E-Health

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT) including health information exchange to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions.

Source: Minnesota Department of Health or http://www.health.state.mn.us/e-health/

Electronic Health Records (EHR)

EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. EHR is considered more comprehensive than the concept of an Electronic Medical Record (EMR).

Source: Office of the National Coordinator for HIT or http://www.healthit.gov/providers-professionals/faqs/what-electronic-health-record-ehr

Emerging health professionals

Emerging health professionals include Community Health Workers, Community Paramedics, Dental Therapists and Advanced Dental Therapists, with possible future inclusion of other practitioners such as Doulas and Certified Peer Support Specialists.

Fee-for-service

A payment approach in which health care providers receive a separate fee for each service they deliver.

Global capitation

A single payment made to a provider organization to cover the cost of a pre-defined set of services delivered to a patient (e.g., an amount paid per member per month to cover the cost of all of a patient’s health care needs). The provider organization is responsible for reimbursing other providers for care they deliver to the patient.

Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Health Care Home

A "health care home," also called a "medical home," is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

Source: Minnesota Department of Health, Health Care Homes (aka Medical Homes) or www.health.state.mn.us/healthreform/homes/

Health Equity

Exists when every person has the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Source: in Minnesota: Report to the Legislature or http://www.health.state.mn.us/divs/chs/healthequity/

Minnesota Department of Health

Health Information Exchange (HIE)

Health information exchange or HIE means the electronic transmission of health related information between organizations according to nationally recognized standards.

Source: Minnesota Statutes §62J.498 sub. 1(f) or https://www.revisor.mn.gov/statutes/?id=62J.498

Health Information Technology (HIT)

HIT is the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Source: Office of the National Coordinator for HIT Glossary or http://www.healthit.gov/policy-researchers-implementers/glossary

Interoperability

The ability of two or more information systems or components to exchange information and to use the information that has been exchanged accurately, securely, and verifiably, when and where needed.

Source: Office of the National Coordinator for HIT or http://www.healthit.gov/providers-professionals/faqs/what-does-interoperability-mean-and-why-it-important

Integrated care

Integrated care covers a complex and comprehensive field and there are many different approaches to and definitions of the concept. One overarching definition (Grone, O. and Garcia-Barbero, M. 2002)is integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.

Integrated delivery system

A network of health care providers and organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the
clinical outcomes and health status of the population served. The organization may include virtual integration for contractual purposes.

**Interprofessional Team**

Interprofessional Team, as defined in the Institute of Medicine’s (IOM) Report, *Health Professions Education: A Bridge to Quality*, (2003), an interdisciplinary (Interprofessional) team is “composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods.” (p. 54) Members of an Interprofessional team communicate and work together, as colleagues, to provide quality, individualized care for patients.


**Learning Community**

A Learning Community is defined as primary care teams from clinics who share common goals or interests, who are actively engaged in learning and implementing transformation from each other in a structured manner.

*Source: MDH Learning Communities* or [http://www.health.state.mn.us/healthreform/homes/collaborative/lclearningcomm.html](http://www.health.state.mn.us/healthreform/homes/collaborative/lclearningcomm.html)

**Local Public Health**

In Minnesota, local public health services are provided through Community Health Boards, which have statutory responsibilities for public health (MN Stat. Chapter 145A), and by Tribal Governments, which are sovereign nations. Local public health responsibilities include prevention and control of communicable disease; protection from environmental health hazards; promoting healthy communities and healthy behaviors (including maternal and child health); preparing for and responding to public health emergencies; and assessing, and sometimes addressing gaps in health services. Local public health professionals carry out these activities in collaboration with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate high quality, non-duplicative programs.

*Source: Adapted from Minnesota Department of Health, Local Public Health Act* or [http://www.health.state.mn.us/divs/ opi/gov/lphact/](http://www.health.state.mn.us/divs/ opi/gov/lphact/)

**Long-Term and Post-Acute Care (LTPAC)**

Long-Term and Post-Acute Care is characterized by a variety of settings, from complex care in long-term acute-care hospitals to supportive services in the community or home-based care. Typical services include rehabilitation, medical management, skilled nursing services, and assistance with activities of daily living due physical and/or cognitive impairments. Common types of LTPAC providers include but are not limited to: nursing facilities or skilled nursing facilities; home health agencies; hospice providers; inpatient rehabilitation facilities (IRFS); long-term acute care hospitals; assisted living facilities; continuing care retirement communities; home and community-based services; and adult day service providers.


**LTPAC Settings**

(e.g., Skilled Nursing Facility (SNF), Home Health, Inpatient Rehab, Long Term Acute Care Hospital, Hospice.) This category of providers serves some of the nation’s most vulnerable individuals and uses a significant portion of the Medicare and Medicaid budgets. Patients served by these providers experience frequent transitions in care and episodes of care coordination with eligible hospitals and professionals. Some of these providers may need
interoperable EHR technology to support new care delivery and payment models in the Affordable Care Act and in private sector initiatives.


**Minnesota e-Health Initiative**

The Minnesota e-Health Initiative is a public-private collaborative whose vision is to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs and improve public health.

**Source:** [MN Department of Health](http://www.health.state.mn.us/e-health/abouthome.html), accessed 09.11.2013

**Minnesota Model for EHR Adoption**

In 2008, the Minnesota e-Health Initiative developed the Minnesota Model for Adopting Interoperable EHRs that is applied to all aspects of the Initiative’s work and policy development. The model has seven steps which are grouped into three major categories:

- **Adopt**, which includes the sequential steps of Assess, Plan and Select.
- **Utilize**, which involves implementing an EHR product and learning how to use it effectively.
- **Exchange**, including readiness to exchange information electronically with other partners, and implementing regular, ongoing exchange between interoperable EHR systems.

**Source:** [Minnesota Department of Health](http://www.health.state.mn.us/e-health/legrpt2013.pdf)

**Partial capitation**

When a payer pays for some types of services on a capitated basis (e.g., by contracting with a group of providers to deliver all of their enrollees’ outpatient care) and pays for other services on a fee-for-service basis (e.g., reimbursing any hospital in their network for inpatient care delivered to their enrollees).

**Patient and Family Centered Care**

Patient and family centered care means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices. It also incorporates the participant’s knowledge, values, beliefs, and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.

**Population**

For purposes of Accountable Communities for Health (ACH), “population” is defined broadly and can include the population in a geographic area, people in a location or setting such as a high rise apartment, a patient or other population group, a group with an identified community health need such as tobacco use, or a group of people who utilize many health resources.

**Population Health**

An aim to optimize the health and well-being of an entire community and reduce inequalities in health and well-being between population groups. A “community” may be either geographic regions and/or groups of people who share attributes (e.g., elderly, minorities, employees, disabled persons, students). Population health requires collaboration across all sectors of a community to address factors such as public infrastructure, the environment,
education systems, social supports, and the health care system, in order to address all social determinants of health. Population health within an accountable care organization requires collaboration between all health care providers in the community, social support services within the community, and local public health.


**Practice Facilitation**

“Practice facilitation is a supportive service provided to primary care by a trained individual or team of individuals. These individuals use a range of organizational development, project management, QI, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals. This support may be provided on site, virtually (through phone conferences and Webinars), or through a combination of onsite and virtual visits. In the research literature, Practice Facilitation sometimes is called quality improvement coaching or practice enhancement assistance.” Within the State Innovations Model (SIM), we will be open to applying practice facilitation to behavioral health, social services, long term care, and acute care services.


**Practice Transformation**

Practice Transformation is a process that results in observable and measureable changes to practice behavior. These behaviors include core competencies:

- Engaged leadership and quality improvement
- Empanelment and improved patient health outcomes
- Business and financial acumen
- Continuous, team-based relationships that incorporate culture, values, and beliefs
- Organized, evidence-based care
- Patient-centered interactions
- Enhanced access
- Progression toward population based care management
- State-of-the-art, results-linked, care
- Intentional approach of practices to maximize the systematic engagement of patients and families
- Systematic efforts to reduce un-necessary diagnostic testing and procedures with little or no benefit.


**Provider**

For purposes of SIM, the term “provider” is meant to include the broad range of health care professionals within medicine, nursing, behavioral health, or allied health professions. Health care providers may also be a public/community health professional. Institutions include hospitals, clinics, primary care centers, long-term care organizations, mental health centers, and other service delivery points.
Public Health

Public health is the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries. Public health also entails policy development and health surveillance. Public health professionals rely on policy and research strategies to understand issues such as infant mortality and chronic disease in particular populations. In Minnesota, local public health departments partner with multiple systems including schools, law enforcement, social services, municipalities, non-profits and private health care providers to coordinate programs.


Quality improvement (QI)

Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The Institute of Medicine’s (IOM) which is a recognized leader and advisor on improving the Nation's health care, defines quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and populations (1)

Source: Health Resources and Services Administration or http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/

Shared savings

A payment approach whereby a provider or provider organization shares in the savings that accrue to a payer when actual spending for a defined population is less than a targeted amount. (Typically, performance targets on quality measures must be met to qualify for shared savings). If actual costs are higher than projections, there are no financial repercussions for providers.

Social Determinants of Health

Complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.


Social Services

The system of programs, benefits and services made available by public, non-profit or private agencies that help people meet those social, economic, educational, and health needs that are fundamental to the well-being of individuals and families. Examples of social services, for the purposes of SIM, include but are not limited to organizations that provide housing, transportation, or nutritional services to individuals or families.

Teamwork

Teamwork is defined as the interaction and relationships between two or more health professionals who work interdependently to provide safe, quality patient care. Teamwork includes the interrelated set of specific
knowledge (cognitive competencies), skills (affective competencies), and attitudes (behavioral competencies) required for an inter-professional team to function as a unit (Salas, Diaz Granados, Weaver, and King, 2008).

**Transitions of Care**

The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.


**Triple Aim**

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, which we call the “Triple Aim”: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

*Source: Institute for Healthcare Improvement Triple Aim or [www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx](http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx)*