

## **Speaking Health Care's Language**

One challenge housing and health providers can run into is not understanding each other's lingo and terminology. This glossary highlights some of the common terms you might hear from health providers to help with bridging some of the communication gaps between the two worlds.

**Accountable Care Organization (ACO):** An ACO is a network of providers who accept shared responsibility for the quality and cost of health care of a defined patient population. ACOs can include physicians, hospitals and other health care providers. Providers participating in an ACO are eligible to receive a share of any savings achieved through their improved care delivery, provided they meet established quality and spending targets. (See the [Appendix of the Housing and Health Care: Partners in Healthy Aging guide](#) for more information.)

**Activities of daily living (ADLs):** A set of basic, routine self-care tasks, including: eating, bathing, dressing, toileting, transferring (walking) and continence.

**Acuity:** The level of severity of an illness.

**Acute care:** Short-term medical treatment, usually in a hospital, for patients having an acute illness or injury or recovering from surgery.

**Ambulatory care:** A generic term for any health services for which an overnight stay in a hospital is not required (e.g. doctor office visits, x-rays, day surgery and medical diagnostics). Also referred to as "outpatient" care.

**Ambulatory care sensitive conditions (ACSC):** Illnesses or health conditions where appropriate ambulatory care prevents or reduces the need for hospital admission. Examples include hypertension, diabetes, asthma, and congestive heart failure. With proper care management, most people should not need to be hospitalized for ambulatory sensitive conditions.

**Bundled payment:** A single payment that covers the cost of services provided by a provider or multiple providers for a given episode of care (e.g. a surgery or a chronic disease) over a defined period of time.

**Capitation:** A system that pays a physician or group of physicians a set amount for each person assigned to them for a defined set of services over a defined time period, regardless of the amount of services. The usual unit for a capitated payment is "per member per month (PMPM)."

**Care transition:** Movement from one health care setting to another health care setting (e.g., from a hospital to a skilled nursing facility) or to home. **Transitional care** refers to services that ensure coordination and continuity of care during these movements and help to avoid preventable adverse outcomes.

**Chronic condition:** A long-lasting condition or diseases that can be controlled but not cured. Examples include heart disease, stroke, cancer, diabetes, chronic obstructive pulmonary disease, arthritis, and dementia. Also included are behavioral conditions, such as substance use and addiction disorders, mental illnesses, dementia and other cognitive impairment disorders, and developmental disabilities.

**Comorbid:** The simultaneous presence of two or more conditions or diseases in the same patient. Comorbidity is associated with worse health outcomes, more complex clinical management, and increased health care costs.

**Discharge planner:** A social worker or nurse who helps a patient in their transition from a hospital or nursing home to another care setting or to their home.

**Duals demonstration:** see Financial Alignment Initiative.

**Dual eligible:** A person who is eligible for both Medicare and Medicaid.

**Financial Alignment Initiative:** An effort created by the Affordable Care Act that tests models with States that better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees. Also referred to as “duals demonstration.”

**Health literacy:** The degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness.

**Hospital community benefit:** Nonprofit hospitals are required by federal and state laws to demonstrate that they provide a benefit to the community in exchange for their tax-exempt status. These hospitals can demonstrate their community benefit by providing community health improvement services, subsidized health services, and cash or in-kind contributions. The Affordable Care Act also requires nonprofit hospitals to:

- Conduct a community health-needs assessment at least every three years and develop a strategy to meet those needs.
- Adopt and publicize a written financial assistance policy.
- Limit charges, billing and debt collection practices aimed at individuals who qualify for financial assistance.

**Instrumental activities of daily living (IADLs):** Activities that help a person live independently in the community, including: using the telephone, managing medications, preparing meals, housekeeping, managing finances, shopping, using transportation

**Medicare advantage plan:** Medicare beneficiaries have the option of receiving their Medicare benefits through the federally-administered original Medicare program (also known as “fee-for-service”) or through a Medicare Advantage Plan. A Medicare Advantage Plan is a health plan offered by a private company, typically a Health Maintenance Organizations or Preferred Provider Organizations, that contracts with Medicare to provide all Part A (hospital) and Part B

(outpatient) benefits to its members. Most Medicare Advantage Plans also provide Part D prescription drug coverage. See also Special Needs Plans.

**Medicare Shared Savings Program:** Medicare's Accountable Care Organization plan.

**Medigap policy:** Medicare Supplement Insurance is often referred to as a Medigap policy. These policies are sold by a private company and help pay health care costs not covered by original Medicare, such as copayments, deductibles and coinsurance.

**Patient activation:** Understanding one's own role in the care process and having the knowledge, skills, and confidence to take on that role.

**Patient engagement:** There is no singular definition of patient engagement. However, it refers to an individual's participation in designing, managing and achieving their own health outcomes. Patient engagement is increasingly recognized as having a major role in improving the quality and success of health care interventions and service delivery.

**Per member per month (PMPM):** A typical unit for a capitated payment. See "capitation."

**Post-acute care:** Skilled nursing care and therapy typically furnished after an inpatient hospital stay. It is provided in a variety of settings, including skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, outpatient rehabilitation facilities, and in patients' homes by home health agencies.

**Prevention:** Prevention can include a wide range of activities or interventions. They are usually grouped into three categories:

- **Primary prevention:** The goal is generally to prevent someone from developing a disease or experiencing an injury in the first place. Examples include immunizations, health education about good nutrition, and exercise.
- **Secondary prevention:** The goal is generally to halt or slow the progression of a disease or injury in its preclinical or early stages. Examples include screening for heart disease, glaucoma or breast cancer.
- **Tertiary prevention:** The goal is helping manage long-term health problems once they are accepted to prevent further physical deterioration and maximize quality of life. Examples include treatment of diabetes or management of chronic heart disease to prevent further complications.

**Primary care medical home (PCMH):** A primary care medical home, or medical home, refers to a model of care delivery. A medical home model provides comprehensive, team-based care that is generally coordinated by the primary care physician. The team of care providers may be together in one office or may be virtually connected in the community. The team can consist of physicians, nurses, social workers, health educators, pharmacists, nutritionists and others that address and coordinate the patient's range of physical and mental health care needs. To learn more see [www.pcpcc.org/about/medical-home](http://www.pcpcc.org/about/medical-home).

**Risk-based payment:** Risk-based payments are predicated on an estimate of what the expected costs to treat a particular condition or patient population should be. This includes capitation, bundled payments, and shared savings arrangements.

**Social Determinants of Health:** The circumstances in which people are born, grow up, live, work and age. These circumstances are influenced by the economic and social conditions under which people live. Examples of social determinants of health include early childhood development, education, type of work, food security, access to health services, housing status, neighborhood, income, and social support. The social determinants of health are also sometimes referred to as “upstream” factors.

**Special Needs Plans (SNPs):** SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). SNPs limit membership to Medicare beneficiaries with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve. SNPs are designated for people who are: (1) are dually eligible for Medicare and Medicaid, (2) live in long-term care institutions (or would otherwise require an institutional level of care), or (3) have certain chronic or disabling conditions.