

# HEALTH SYSTEMS TRANSFORMATION

## GLOSSARY OF TERMS

- **ACA - The Patient Protection and Affordable Care Act (ACA):** The Patient Protection and Affordable Care Act (ACA) is the formal name of the comprehensive national health reform legislation.
- **Access to Primary Care Services:** The timely use of essential healthcare services that are integrated and quality. The services are lasting partnerships between patients and their providers to achieve the best health outcomes.<sup>2</sup>
- **Accountable Care Organization (ACO):** An organization using a payment and delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.<sup>1</sup>
- **Accountable Collaboratives of Health (ACH):** An Accountable Collaborative of Health (ACH) is a regionally governed, public private partnership organization or structure tailored by the region to align actions and initiatives of a diverse coalition of players in order to achieve healthy communities and populations. ACH participants are envisioned to include public health, behavioral and physical health, housing and social service providers, risk-bearing entities, county and local jurisdictions, education, philanthropy partners, consumers, and tribes and other critical actors within a region. ACH representatives will participate in development of statewide Medicaid procurement objectives as the state moves to integrate physical and behavioral health, and will be a meaningful partner in providing ongoing oversight of the effectiveness of the state's accountable risk bearing entities. The precise organizational and governance structures will not be dictated at the state level, because they should be determined in collaboration with parties in the region.<sup>1</sup>
- **Accountable Risk Bearing Entity (ARBE):** Managed care plans, risk bearing public/private entities, county governmental organizations, or other community-based organization with a risk bearing partner or the direct capacity to assume full financial risk (for physical and/or behavioral health). This term is used specifically in reference to future Medicaid procurement.<sup>1</sup>
- **Actuarial Value:** The ACA establishes four levels of coverage based on the concept of 'actuarial value,' which represents the share of health care expenses the plan covers for a typical group of enrollees. As plans increase in actuarial value – bronze, silver, gold, and platinum – they would cover a greater share of enrollees' medical expenses overall, though the details could vary across plans.

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<sup>1</sup> Washington State Health Care Innovation Plan (SHCIP)

<sup>2</sup> Primary Care: America's Health in a New Era (IOM)

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- **All-Player Claims Database (APCD):** An APCD provides transparent data to support improving health, health care quality and containing costs by securely compiling claims data from private and public insurance carriers to provide a comprehensive picture of health care costs and utilization in a state.<sup>1</sup>
- **Behavioral Health:** This term is used to refer to both mental health and substance abuse.<sup>1</sup>
- **Bi-Directional Integration:** Physical-behavioral health services integration and delivery. ‘Bi-directional’ refers to inclusion of behavioral health services in primary care settings, and physical health services in behavioral health settings.<sup>1</sup>
- **Care Coordination:** The as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care.
- **Child Welfare Coalition:** Need definition
- **Choosing Wisely Campaign:** An initiative of the ABIM Foundation, Choosing Wisely encourages physicians, consumers and other healthcare stakeholders to think and talk about medical tests and procedures that may be unnecessary and in some instances, harmful.<sup>1</sup>
- **Community:** A group of people who have common characteristics; communities can be defined by geographic proximity, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds.<sup>3</sup>
- **Community Health Worker (CHW):** Frontline workers who help individuals and communities improve their health. The CHW model is founded on natural helping systems within communities and is based on peer-to-peer relationships rather than provider-client relationships. A key feature of CHWs is that they are individuals who have a relationship with and understanding of the community in which they serve, often belonging to the same culture, speaking the same language, and having similar life experiences. They ‘gain their core experience from local forms of knowledge.’ As a result, they are in a unique position to engage individuals and populations that medical professionals have difficulty reaching.<sup>1</sup>
- **Community Services, Social Services and Education:** All play key roles in helping to keep people healthy and prevent disease outside the health care system, and include the YMCA, Boys and Girls Clubs, Senior Centers, faith based organizations, and many others.<sup>1</sup>
- **Community Transformation Grant:** Need definition
- **Comprehensive framework:** Need definition

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<sup>1</sup> Washington State Health Care Innovation Plan (SHCIP)

<sup>3</sup> Public Health: What It Is and How It Works (BJ Turnock)

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- **Continuity of Care:** Continuity of care the consistent and coherent approach to management of a health condition that is responsive to patient's changing needs. Continuity of care represents an individual patient's experience of coordination over time with either a single clinician or with multiple clinicians; the extent to which the appropriate care is perceived to occur at the right time and in the right order.
- **Co-Payment:** This is a fixed amount you pay for a covered health care service, usually when you get the service. For example, if you are receiving care from a licensed mental health counselor your plan may require you to pay a co-payment of \$15 when you arrive for your appointment. Copayments vary by plan and can vary by the type of covered service.
- **Data Sources:** Specific resources where organizations can access useful data for measuring or assessing social, environmental, behavioral and/or clinical elements that impact population health. Preference will be given to data sources that are widely available; however, others may be included as good examples that could spur expanded data collection.
- **Deductible:** The amount you pay for covered services before your health insurance begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've spent (met) \$1,000 on covered health care services and met your deductible for the year. The deductible does not apply to all services.
- **Donut Hole:** Most Medicare Prescription Drug Plans have a coverage gap (also called the 'donut hole'). This means there's a temporary limit on what the drug plan will cover for drugs (commonly around \$2,800 in an elderly adult's drug spending). ObamaCare has implemented a plan to close this gap slowly over by working with pharmaceutical companies, who have agreed to subsidize part of the cost of the expanded drug coverage.
- **Dr. Robert Bree Collaborative (Bree):** A statewide public-private consortium established in 2011 by the Washington State Legislature 'to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.' Annually, the Bree identifies up to three areas where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes. Recommendations from the Bree are sent to the Health Care Authority to guide state purchasing for programs such as Medicaid and Public Employees Benefits Board (PEBB).<sup>1</sup>
- **Essential Community Providers (ECP):** The Affordable Care Act requires the health insurance marketplace to include in their network a sufficient number and geographic distribution of providers that provide care to groups that are predominately high risk, special needs, low-income, and medically underserved individuals. These providers are referred to as essential community providers.

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- **Essential Health Benefits (EHB):** The Affordable Care Act ensures health plans offered in the individual and small group markets offer a comprehensive package of items and services, known as the ten essential health benefits. The ten essential health benefits include:
  - Ambulatory patient services;
  - Emergency services;
  - Maternity and newborn care;
  - Rehabilitative and habilitative (helping maintain daily functioning) services;
  - Laboratory services;
  - Hospitalization;
  - Prescription drugs;
  - Preventative and wellness and chronic disease management;
  - Mental health and substance abuse services, behavioral health treatment; and
  - Pediatric services, including oral and vision.
- **eValue8:** A system of measuring and evaluating health plan performance created by business coalitions and employers like Marriott and General Motors. eValue8™ asks health plans probing questions about their capabilities in several key driver areas. Locally, Puget Sound Health Alliance has worked with major purchasers to deploy eValue8 to measure the performance of health plans.<sup>1</sup>
- **Explanation of Benefits (EOB):** All individuals who enroll in any type of health plan (private, employer based, Medicare, and Medicaid) should receive an EOB. EOBs are documents issued by the insurance company after you receive care that was paid for by your carrier. EOBs are important because they provide you with your medical billing history and information regarding payments on insurance claims. Often included in an EOB is name of patient and insurance identification information, type and date of service, billed charges, the amount not covered by the insurance company, and total patient cost.
- **Federal Poverty Level (FPL):** A measure of income level issued annually by the Department of Health and Human Services.
- **Federally Qualified Health Centers and Community Health Centers:** Community Health Centers (CHC) are one type of FQHC. CHCs were established in the early 1960s as part of LBJ's War on Poverty. In particular, FQHCs are required to have the majority of their governing boards comprised of patients (at least 51 percent). The allocation of federal funds also requires that recipient Community Health Centers care for patients that are deemed to be medically under-served according to the Public Health Service. The Medically under-served population includes individuals who are uninsured but not eligible for Medicare and/or Medicaid; rural populations with limited access to medical facilities; migrant and seasonal workers; people living in public housing and residents in other types of economically disadvantaged urban communities with significant rates of homelessness; and HIV/AIDS and substance abusers.

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- **Fee For Service (FFS):** Health care providers are paid for each service like an office visit, test, or procedure; currently the predominant reimbursement methodology in the United States and in Washington State.<sup>1</sup>
- **Formulary:** Is a list of prescription drugs that are covered by your health insurance plan or a prescription drug plan or another insurance plan offering prescription drug benefits.
- **Geo Mapping or GIS Mapping:** In the health care context, a computerized and typically real-time geographic information system that is used to show on a map where and what health events or conditions occur in a geographic area. It provides tools and applications to place and display items on a map with alternative ways to filter or amplify objects or conditions and view changes over time. This technology provides local contextually relevant information and can help support planning, interventions, identify potential health threats and trends and a valuable tool for collaborative health ventures.<sup>1</sup>
- **Health:** A state of well-being rather than the absence of disease. This is consistent with the World Health Organization's definition, which has not been amended since 1948: 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'
- **Healthy Communities: Need definition**
- **Health Benefits Exchange (HBE):** A marketplace through which consumers can research health insurance options and purchase coverage. Washington's HBE is called the Washington Healthplanfinder.<sup>1</sup>
- **Health Care Authority (HCA):** The state agency which administers Medicaid and governs the qualified health plans.
- **Health Care Delivery System:** Consists of all of the parts of the way health care is delivered in Washington, whether in a hospital, a doctors office a clinic or pharmacy and involves all areas of medicine including primary care, obstetrics, mental health, and rehabilitation services and across the state including hospitals, medical centers including services for primary and specialty care, behavioral health, substance abuse, oral health, and other individual services. Health care is delivered by practitioners in medicine, optometry, dentistry, nursing, pharmacy, allied health, and other care providers. It refers to the work done in providing primary care, secondary care, and tertiary care. A summary of Washington's Health Care System is available from the 2012 Rural Health Strategic Plan. [www.wsha.org/files/2012%20Rural%20Health%20Care%20Report\\_FINAL2\\_1.pdf](http://www.wsha.org/files/2012%20Rural%20Health%20Care%20Report_FINAL2_1.pdf)<sup>1</sup>

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- **Health Information Exchange (HIE):** A secure, interoperable, standards based health information infrastructure to enable timely exchange of clinical data between providers at the point of care.<sup>1</sup>
- **Health Plan Finder (HPF):** The Washington Healthplanfinder is the name of the website where the qualified health plans are listed for comparison and applying for coverage.
- **Health Savings Account (HAS) or Flexible Spending Account (FSA):** Health Savings Accounts (HSAs) were created in 2003 so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses. As of 2011, the ACA prohibits those who use HSAs or FSAs to use these tax-free-funds to pay for over-the-counter drugs without a doctor's prescription. Secondly, a \$2,500 cap was imposed in 2013, limiting the amount of untaxed dollars you can have in this account. Overtime, the cap will be adjusted to account for inflation.
- **Health Systems Transformation (HST):** Health Systems Transformation is the term used by the Department of Health to describe agency, healthcare and public health system efforts related to implementing the ACA, including moving health systems from treating disease to preventing disease; building healthier communities; assuring the quality of our health systems; and providing the data and information necessary for research, planning and making effective public health decisions.
- **Hot spotting:** Typical GIS-based studies include an analysis such as 'hot spot' analysis. Hot spots are detected clusters of chronic illness, infectious disease, simulation of disease spread, risk factors, or supply and demand analysis that identifies patterns within geographical areas. Hot spotting will be used in Washington to identify small area variations at the census tract level.<sup>1</sup>
- **In-Person Assisters/Navigators/CACs:** These are all the same thing: Individual or organizations that are trained and able to provide help to consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.
- **Measures:** Specific metrics (including indicators, rates, numerical counts, etc.) that clinical health care systems, public health agencies and/or other stakeholders can use to assess key aspects of and/or contributors to the health of a population. Relevant measures identified in working with the federal government and communities will be included in the Action Guide.
- **Medicaid or Applehealth:** Medicaid, called Applehealth, is a means-tested health and medical services social welfare program for certain individuals and families with low incomes and few resources. Primary oversight of the program is handled at the federal level, but each state: establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services, and administers its own Medicaid program.

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- **Medicaid Plans:** Need definition and what the plans are and their definitions (what that means and the plan for dual eligibles)
- **Medical Home:** A team-based primary care model that provides comprehensive and continuous care to consumers over time; its goal is to improve health, health care and costs.<sup>1</sup>
- **Mental Health Parity:** The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that the financial requirements and treatment limitations applicable to mental health or substance use disorder services are no more restrictive than the predominant requirements or limitations applied to medical/surgical benefits. To help Americans be productive and healthy the ACA has supported the MHPAEA and expanded access to mental health coverage by including these services within the essential health benefits.
- **Open Enrollment:** Open enrollment is the period of time the marketplace was accessible to the public as a means to enroll in an insurance plan as required by the ACA. It started on October 1, 2013 and will end on March 31, 2014. However, if you do not enroll in an insurance plan before March 31<sup>st</sup>, 2014 you will only have one chance each year, between October 15 and December 7, to enroll or change your coverage in the marketplace. However, you are allowed to use the marketplace after open enrollment if you can prove you faced a qualifying event. These events include situations like you lost your employer sponsored coverage; permanently moved to a new state; had a significant shift in your personal or family's income; or perhaps you had a life changing event such as a marriage, divorce, birth, or adoption.
- **Pay For Performance:** In a pay-for-performance system, providers are compensated by payers for meeting certain pre-established measures for quality and efficiency. Pay-for-performance can be seen as a means of attaching financial incentives to clinical care objectives. Using quantitative metrics, a percentage of physician compensation can be tied to achieving specific clinical benchmarks in the care they provide.
- **Point of Service (POS):** Is a health plan that provides you with more flexibility in your choice of providers. This type of managed care plan provides you with a choice of at the time you seek service, rather than at the time you choose to enroll in a health plan. POS plans are centered on the theory that choice is a key to promoting quality of care. If you enroll in a POS plan you are likely to have higher deductibles, coinsurance and copayments, however, you are guaranteed freedom in choosing your provider.

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- **Population:** It may be determined based on all individuals within a geopolitical area, but other characterizations exist:
  - Focus on health should be from a broader perspective of well-being rather than the mere absence of disease
  - Requires involvement of the public health system, the clinical care system, and other diverse stakeholders<sup>4</sup>
- **Population Health:** Health of all people in a distinct group or subpopulation within a given geopolitical area. Examples include all people of a certain race, ethnicity, or age range; all individuals with a certain health condition; or groups such as employees and dependents. While preference will be given to conceptual frameworks that address total population health improvement, elements of the Action Guide (tools, measures, data) will likely address specific subpopulation health needs. Total population health refers to the health of all people within a geopolitical area.
- **Preferred Provider Organization (PPO):** A type of integrated delivery system in which the PPO acts as a broker between the purchaser and the provider of care. In other words, this is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of providers. If you are enrolled in a PPO, you have the option to use or not use the preferred providers available. However, as in most plans you will pay less if you use providers within the PPO's network. Remember every plan is different so it's best to check your policy or call to clarify any questions you have regarding the needs of you and your family; this is especially important if you want to go to a specific doctor or provider.
- **Public Employee Benefit plan (PEB):** Washington's state employee benefits plan featuring fully insured and self-funded health plans provided to eligible state and higher-education employees and retirees as a benefit of employment and administered through the Washington State Health Care Authority's Public Employees Benefits Board (PEBB) program.<sup>1</sup>
- **Public Health System:** Consist of the Washington State Department of Health, 35 independent local health jurisdictions and our tribal health partners. Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases. Public health is concerned with protecting the health of the entire populations. These populations can be as small as a local neighborhood, or as big as an entire country or region of the world. Our public health system provides a diversity of services including health care provider credentialing, control of communicable disease, food and water protection, laboratory services, immunization and other prevention services, birth and death certificates, disease surveillance and emergency preparedness.<sup>1</sup>

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<sup>4</sup> Jacobson and Teutsch

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- **Qualified Health Plan (QHP):** Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each marketplace in which it is sold.
- **Reference Pricing:** An innovative payment/benefit design element successfully used by several major purchasers including CalPERs and Intel. It is similar to a reverse deductible with the insurer paying the first part of the total allowed charge, and the enrollee pays the remainder. This requires price transparency to the enrollee. Typically used where there is significant variation in cost in the same markets without a difference in quality, and with procedures that can be scheduled.<sup>1</sup>
- **RHIC:** A Regional Health Improvement Collaborative (RHIC) provides a neutral, trusted mechanism through which all of the key healthcare stakeholders in a state or region -- physicians, hospitals, health plans, employers, and patients -- can plan, facilitate, and coordinate the many different activities required for successful transformation of its healthcare system.
- **Regional Support Networks (RSN):** There are 11 Regional Support Networks who administer public mental health services in Washington. RSNs provide mental health services through contracted providers in their regions. RSNs ensure consumers receive quality and timely services in areas such as mental and behavioral health, child care, and foster parenting.
- **Social Determinants of Health:** The circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.<sup>1</sup>
- **Tiered Networks:** A health plan delivery system and benefit design structure through which purchasers can continue to offer a larger health plan network to enrollees, but out-of-pocket costs will vary based on the ability of the chosen facility or service provider to deliver value (better outcomes and lower costs).<sup>1</sup>
- **Tools:** Items such as surveys, communication materials, online calculators or other apps, etc., that can be used in the process to improve population health.
- **Transformation Support Regional Extension Service:** The convener and coordinator of practice transformation services and clearinghouse of tools and resources modeled after the 'primary care extension program' outlined in section 5405 of the Affordable Care Act. The extension service design envisions a central coordinating 'hub,' and community based 'spokes.' Local extension agents will provide supports required for practice transformation through facilitating and providing assistance for implementing quality improvement or system redesign necessary for high-quality, cost-effective, efficient and safe person-centered care.<sup>1</sup>

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- **Triple Aim:** Originally coined by the Institute for Healthcare Improvement, the ‘Triple Aim’ is a framework for optimizing health system performance to improve the health of populations, improve customer experience of care (quality and patient experience) and reduce cost.<sup>1</sup>
- **Value Based Payment:** Value-Based Payment (VBP) is a broad class of strategies used by purchasers, payers and providers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to health outcomes. Examples of such payments include pay-for-performance programs that reward improvements in quality metrics; bundled payments that reduce avoidable complications; global arrangements that tie upside and downside payments to specific quality targets in addition to actual to target cost trend rate. VBP programs share a common objective of slowing the increase in the total cost of care by encouraging a reduction in the reported 30% of wasted health care dollars.<sup>1</sup>
- **Washington Health Alliance:** The Washington Health Alliance serves to build a strong alliance among patients, doctors, hospitals, purchasers, health plans and others to promote health and improve quality and affordability by reducing overuse, underuse and misuse of health care services.
- **Wellness Program:** The Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. Wellness programs include, for example, programs that reimburse for the cost of membership in a fitness center; that provide a reward to employees for attending a monthly, no-cost health education seminar; or that provides a reward to employees who complete a health risk assessment without requiring them to take further action. Implementing and expanding employer wellness programs may offer our nation the opportunity to not only improve the health of Americans, but also help control health care spending.
- **Whole person centered:** An approach to care that places the person at the center of their care, encourages self-management, and takes into account the full set of medical, behavioral, oral health, and long term services and supports that contribute to health.<sup>1</sup>

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<sup>1</sup> Washington State Health Care Innovation Plan (SHCIP)