**Glossary of Integrated Care Terms (draft for T and D)**

This document was compiled using multiple sources. In some cases definitions remain largely the same as the sources used. In many cases definitions were refined to better suit the intended audience. Special recognition to major sources used which were National Integration Academy Council, Lexicon for Behavioral Health and Primary Care Integration; Managed Care Glossary from Tufts Health Care Institute; Healthcare.gov and Health Reform Terms and Definitions from United Health Care. This document is not intended as medical or legal advice. It is intended as a general guide to the meaning of terms commonly used in health care reform and integrated care discussions. It is neither technical nor comprehensive but is meant to facilitate communication.

**Accountable Care Organization-ACO:** These organizations coordinate

patient care and provide the full range of health care services for patients. The

health reform law provides incentives for providers who join together to form

such organizations and who agree to be accountable for the quality, cost, and

overall care of beneficiaries who are assigned to the ACO.

**Accreditation:** This is the “seal of approval” given to the plan by an independent organization to show that the plan meets national quality standards. Common accreditation includes JCAHO (Joint Commission on Accreditation of HealthCare Organizations)

**Acute Care:** A pattern of health care in which an individual is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, acute care is often necessary for only a short time.

**Activities of Daily Living (ADLs):** Routine activities necessary for living in one’s own home. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence. An individual's ability to perform ADLs is important for determining what type of long-term care (e.g. nursing-home care or home care) the individual needs.

**Affordable Care Act:** See Patient Protection and Affordable Care Act

**Ambulatory:** Literally means able to walk but commonly used to describe health care services that can be delivered on an outpatient basis including surgical procedures where the patient can be released home within the same calendar day as the procedure.

**Appeal:** A request for a health insurer or plan to review a decision or a grievance again.

**Attribution:** Refers to a statistical or administrative methodology that assigns a patient to a provider or organization for a number of purposes which can include funding the provider or organization, calculating health care costs/savings or quality of care scores for a population of patients.

**Authorization:** An authorization usually refers to an approval of health care services by an insurance company, often prior to services being rendered (as in preauthorization). Many times payer sources require that services be preauthorized before the services are performed. If the services are not preauthorized the payer source may refuse to pay the provider for the service.

**Authorized Representative:** Someone chosen to act on another person’s behalf. Often a family member or other trusted person. Some authorized representatives may have certain legal authority and rights regarding the other person.

**Behavioral Health Care:** Umbrella term for care that addresses any behavioral problem bearing upon a person’s health, generally mental health and substance use but can be applied to assistance with behavior change to improve health, i.e. quitting smoking, weight loss, etc.

**Behavioral Health Organization (BHO):** A behavioral health organization is essentially a managed care company that manages behavioral health services (psychiatric and substance use services). Colorado Medicaid provides mental health services to recipients through a sub-contracted, capitated managed care program. There are five subcontractors who administer these services, who are known as Behavioral Health Organizations (BHO). Each BHO is responsible for managing the delivery of behavioral health services to Medicaid-eligible individuals in its' assigned geographic services area. There are five such regions in Colorado.

**Benefits:** The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

**Blood Pressure (BP):** The pressure exerted by the blood against the walls of the blood vessels, especially the arteries. It varies with the strength of the heartbeat, the elasticity of the arterial walls, the volume and viscosity of the blood, and a person's health, age, and physical condition. Measured as a number such as 120/80. The top number is the systolic; the pressure exerted when the heart is pumping. The bottom number is the diastolic; the pressure exerted between heartbeats. High blood pressure is called hypertension. Ranges vary but in general for an adult: Normal- 90-120/60-79; prehypertension 120-139/80-89; hypertension(stage 1) 140-159/90-99; hypertension(stage 2) 160-179/100-110; hypertensive crisis (needs immediate attention) 180+/110+. It is also possible for blood pressure to be too low (hypotension) generally less than 90/60.

**BMI-Body Mass Index:** A measure of whether a patient is overweight which takes into account height. 18.5 or less- underweight; 18.6 to 24.9-normal; 25 to 29.9-overweight; 30 and over-obese. The formula is weight in pounds divided by height in inches squared times 703.

**Brand Name (Drugs):** A drug sold by a drug company under a specific name or trademark and that is protected by a patent (as opposed to generic). Brand name drugs may be available by prescription or over the counter.

**Bundled Payment:** Also known as "Episode-based payment" means a single payment to providers or healthcare facilities (or jointly to both) for all services to treat a givencondition, or, to provide a given treatment**.** Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.

**Capitation:** A method of payment in which the provider organization is paid a fixed amount for each person covered no matter what the actual number or nature of services delivered or whether a particular member received services at all. Often this is a “per member per month”. For example, if an organization is responsible for 1,000 people in their area the payer may give the organization $10 per member per month ($10,000 a month) and the organization manages that money to provide all the covered services needed by that group of 1,000 people.

**Care Coordination:** The deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services. All providers working with a particular patient share important clinical information and have clear, shared expectations about their roles.  Equally important, they work together to keep patients and their families informed and to ensure that effective referrals and transitions take place.

**Catastrophic Coverage:** A coverage option with a limited benefit plan design accompanied by a high deductible. The plan design is intended to

protect primarily against the cost for unforeseen and expensive illnesses or injuries. These plans are attractive to young adults in relatively good health.

**Chronic Care:**  Long-term services and supports for individuals with long standing, persistent diseases or health conditions.

**Chronic Care (Disease) Management:** The coordination of health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. The goals of these programs are to improve the quality of care and manage costs.

**Chronic Health Condition:** A chronic condition is a  [health](http://en.wikipedia.org/wiki/Health) problem or [disease](http://en.wikipedia.org/wiki/Disease) that is persistent or otherwise long-lasting in [its effects](http://en.wikipedia.org/wiki/Natural_history_of_disease). The term *chronic* is usually applied when the [course](http://en.wikipedia.org/wiki/Course_(medicine)) of the disease lasts for more than three months. Common chronic health conditions include [arthritis](http://en.wikipedia.org/wiki/Arthritis), [asthma](http://en.wikipedia.org/wiki/Asthma), schizophrenia, and [diabetes](http://en.wikipedia.org/wiki/Diabetes). The opposite of chronic is acute.

**Claim:** A request for payment that a patient or health care provider submits to a health insurer for items or services thought to be covered under the plan.

**COBRA:** Refers to Consolidated Omnibus Budget Reconciliation Act. In its most common usage means a terminated employee’s right to continue their health insurance benefits for a limited time (usually 18 months) by paying a premium. Applies to group health plans that cover 20 or more employees.

**Collaborative Care:** General term for an approach to delivering services where providers combine perspectives and skills from different disciplines to cooperatively provide coordinated care considering multiple needs.

**Co-Insurance:** This term may have multiple meanings but in the most general use it means the sharing of risk or liability by two or more payer sources (insurance companies). It may also be used to mean that the insured assumes some of the costs of care.

**Co-Located Care:** Generally refers to a place of service delivery where behavioral health providers and physical health care providers share the same space. This is thought to increase coordination of behavioral and physical health care services.

**Copayment (Co-Pay):** A fixed dollar amount paid by an individual receiving a health care service covered by the member’s plan. The plan then typically pays the rest of the cost.

**Commercial Insurance:** Insurance purchased by employers for their employees or purchased directly by the consumer from the insurance company. This is in contrast to public insurance programs such as Medicaid or Medicare.

**CPT Code**- Current Procedural Terminology- the coding system by which providers bill for services. For example-99214 may be a CPT code for an office visit. These codes are often used to determine payment for a service rendered.

**Deductible:** The dollar amount that a plan member must pay for health care services each year before the insurer begins to reimburse for health care services.

**Diabetes Mellitus (DM):** DM is a chronic disorder of carbohydrate metabolism, characterized by hyperglycemia and glycosuria, resulting from inadequate production or utilization of insulin. DM is classified according to two syndromes: Type I, or insulin-dependent diabetes mellitus (IDDM), or Type II, non- insulin-dependent diabetes mellitus (NIDDM). The normal range for hyperglycemia (high) or hypoglycemia (low) blood sugar is 70 – 120 mg/100 ml of blood.

**Donut Hole:** A gap in prescription drug coverage under Medicare Part D, where beneficiaries pay 100 percent of their prescription drug costs after their

total drug costs exceed an initial coverage limit until they qualify for a second tier of coverage.

**Dual Eligibles:** Individuals who are eligible for both Medicaid and Medicare. Also called Full Benefit Medicare/Medicaid Enrollees (FBMME)

**Durable Medical Equipment (DME):** Medical equipment that provides therapeutic benefits to a patient in their own home because of certain medical conditions and/or illnesses. Must be reusable, ordered by a physician, and not useful in the absence of an illness or health condition. Examples include wheelchairs, oxygen, hospital beds, walkers, kidney machines and ventilators. Many insurance plans cover DME.

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**Electronic Health Record (EHR)/Electronic Medical Records (EMR):** Computerized patient health records, including medical, demographic and administrative information. These records can be created and storedwithin one organization or shared across multiple health care organizations and sites.

**EPSDT:** Early and Periodic Screening, Diagnosis and Treatment. A child health benefit of Medicaid. EPSDT is designed to address physical, mental, and developmental health needs. Screening services “to detect physical and mental conditions” must be covered at periodic intervals as well as diagnostic and treatment coverage.

**Episode of Care:** Refers to all the health services related to the treatment of a particular condition on the occasion that condition requires care.

**Essential Health Benefits:** A broad set of 10 benefit categories including hospitalization, outpatient services, emergency care, prescription drugs, maternity

care, preventive services and other benefits.

**Explanation of Benefits (EOB):** A statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for or denied payment on their behalf by the insurance company.

**Family Medical Leave Act (FMLA):** The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

**Federally Qualified Health Center (FQHC):** Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

**FQHC Look Alike:** An organization that meets PHS Section 330 eligibility requirements but does not receive grant funding and also may receive special Medicare and Medicaid reimbursement.

**Fee for Service:** A method of reimbursement based on payment for services rendered. Payment may be made by an insurance company, the individual or a government program such as Medicaid. With respect to physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered. In relation to individual, it refers to payment in specific amounts for specific services received, in contrast to a set per member per month or other advance payment of an insurance premium or membership fee for coverage.

**Flexible Spending Account (FSA):** A tax advantage account that can be used to pay for certain medical expenses, deductibles and copays that are not covered by a person’s health care insurance. Usually offered through an employer.

**Formulary:** A list of prescription medications. In its most common use refers to medicines that are covered for payment by a particular insurance policy.

**Gatekeepers:** An informal though widely used term that refers to an organization or individual (often a primary care physician) who controls referrals for specialty care, hospitalization or more expensive forms of care. Often a cost and utilization control component of managed care plans.

**Generalist:** Family physician or primary care physician trained to take care of a majority of common health care conditions (as opposed to specialist).

**Generic (Drugs):** A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

**Global Payments:** Global payments are fixed-dollar payments for the care that patients may receive in a given time period, such as a month or year. Global payments place providers at financial risk for both the occurrence of medical conditions and the management of those conditions.

**Group Health Plan:** Health insurance that is offered by a plan sponsor, typically an employer, on behalf of its employees.

**Health Maintenance Organization (HMO):** An organization that insures that comprehensive health care services are provided to its members on a prepaid basis. Members are typically required to choose a primary care provider and access to specialty care and higher levels of service are monitored and often need to be preapproved.

**Health Benefit Exchange or Health Insurance Exchange:** A program that facilitates the purchase of health insurance through qualified health plans that is designed to assist people in enrolling in health insurance plans including Medicaid and private insurance plans. States may either partner with the federal government when establishing an exchange or allow the federal government to establish one on

their behalf. These exchanges operate through websites. In Colorado the website is called connectforhealthco.com.

**Health Information Exchange:** Health information exchange (HIE) is the electronic movement of health-related information among organizations according to nationally recognized standards.  The goal of health information exchange is to facilitate access to and retrieval of clinical data to provide safer, timelier, efficient, effective, equitable, patient-centered care.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** This

law sets standards for the security and privacy of protected health information. In addition, the law makes it easier for individuals to change jobs without the risk of extended waiting periods due to pre-existing conditions.

**Health Plan Employer Data and Information Set (HEDIS):** A set of performance measures designed to standardize the way health plans report data to employers or payer sources. HEDIS currently measures five major areas of health plan performance: quality, access and individual satisfaction, membership and utilization, finance, and descriptive information on health plan management.

**Health Savings Account (HSA):** A tax advantaged savings account that can be used to pay for qualified medical expenses. Individuals can obtain HSAs from most financial institutions, or through their employer. Both employers and employees can

contribute to the plan.

**Home Health Care:** Sometimes referred to as in home care or in home supports and services (IHSS). Care and services provided in a person’s own home and intended to assist the person to remain in their own home as opposed to having to reside in a care facility or nursing home. Services may be provided by professionals such as nurses or non-professionals such as aides. Examples include assistance with wound care, preparing meals, administering medications, house cleaning, toileting and other functions.

**Hospice:** Hospice is a type and philosophy of care that helps reduce clinical, emotional and spiritual suffering for the patient near the end of life. Hospice embraces a holistic approach of interdisciplinary care that upholds and respects the patient’s wants, needs and traditions and helps the patient and family focus on what is important to them. Hospice services can be provided in a variety of settings.

**ICD (9 or 10):** International Classification of Diseases currently on the 9th edition with the 10th edition to go into use on October 1, 2014. Standard classification system for health care conditions maintained by the World Health Organization and used throughout the world. For Example: The ICD 10 code for Post Traumatic Stress Disorder is F43.10.

**Indemnity Health Insurance:** Insurance that pays for health care services to providers or members after the services are performed, typically without any need for preapproval or monitoring for medical necessity. This was previously the most common type of medical insurance but has become increasingly rare due to inadequate cost controls inherent in the system. Works on a fee for service basis.

**Informed Consent:** Informed consent is a legal procedure to ensure that a patient, client, or research participant is aware of all the potential risks and costs involved in a treatment or procedure. The elements of informed consent include informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment. In order for informed consent to be considered valid, the client must be competent and the consent should be given voluntarily.

**Instrumental Activities of Daily Living (IADLs):** Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning, but they may be necessary for an individual to live independently in their community. These include cooking, driving, managing finances, and keeping track of medications.

**Integrated Primary Care or Primary Care Behavioral Health:** Combines medical and behavioral health services (substance use and mental health) in a coordinated, seamless service delivery model: “no wrong door” approach to treatment.

**Lifetime Benefit Maximum:** A limit on the amount an insurer will pay toward the cost of health care services over the lifetime of the policy. Health care reform (the Affordable Care Act) prohibits lifetime dollar limits on “essential health benefits”.

**Long-Term Care (Long Term Services and Supports- LTSS):** Services needed for an individual to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Many of these services are not covered by Medicare or private insurance.

**Mandatory Benefits:** A state or federal requirement that health plans provide coverage for certain benefits, treatment or services.

**Managed Care:** In general, this refers to efforts to coordinate and channel the use of services to achieve desired access, service, and outcomes while controlling costs. It combines the responsibility for paying for a defined set of health service with an active program to control the costs associated with providing those services, while at the same time attempting to control the quality of and access to those services. Members of a managed care health insurance plan usually have to use certain providers who are contracted by the plan. A Managed Care Organization (MCO) undertakes to offer a broad range of services and supports. The MCO receives a fixed sum of money to pay for the benefits in the plans for the defined population of enrollees. Managed care attempts to change the way health care is financed by changing the incentives in the health care system.

**Meaningful Use:** Meaningful use is using certified electronic health record (EHR) technology to improve the quality, safety, and efficiency of health care services. It is hoped that meaningful use will reduce health care disparities, engage patients and family, improve care coordination, and population and public health and maintain privacy and security of patient health information. There are financial incentives for providers to engage in meaningful use.

**Medicaid:** A federal and state-funded program that provides payment for health-related services to certain qualifying Americans, mostly based on low income. The health reform law expanded Medicaid eligibility to new populations and raised the income limit to be eligible for Medicaid.

**Medical Loss Ratio (MLR):** The amount of revenues from health insurance premiums that is spent to pay for the services covered by the plan. Usually referred to by a ratio, such as 0.96 – which means that 96% of premiums were spent on purchasing services

**Medical Necessity:** Accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Payer sources (Medicaid, Medicare private insurance, etc.) require that a service be medically necessary in order to pay for it. Medical necessity includes that the service addresses a recognized health condition, is prescribed by an appropriate professional, is generally accepted as effective and may include other components depending upon the funding source.

**Medicare:** A federal program that provides health care coverage to people age 65 and older, and to those who are under 65 and are permanently physically

disabled or who have a congenital physical disability; or to those who meet other special criteria such as end-stage renal disease. Eligible individuals can receive coverage for hospital services (Medicare Part A), physician-based medical services (Medicare Part B) and prescription drugs (Medicare Part D).

**Medicare Advantage:** Also referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to receive their Medicare benefits through a private insurance plan.

**Mental Health Care:** Services directed towards alleviating or preventing symptoms of mental disorders and psychiatric conditions such as depression and psychosis done by a variety of providers such as psychiatrists, psychologists, social workers, marriage and family therapists and counselors. May include counseling, medications, assessments and various forms of psychotherapy.

**Network (in network):** Most insurance organizations maintain a system of providers who are credentialed by the organization and authorized to provide covered services to the organization’s members. These providers are “in network”. Some plans require members only use in network providers. Other plans require members to pay more if they use “out of network” providers.

**Out-of-Pocket Costs:** Health care costs that are not covered by insurance, such as deductibles, copayments, and coinsurance. Out-of-pocket costs do

not include premium costs.

**Palliative Care:** A multidisciplinary approach to healthcare of patients with serious and life threatening illnesses which focusses on the relief of pain and suffering. Differs from hospice in that the patients do not necessarily have to be nearing the end of life. Focusses on quality of life and dealing with the issues associated with serious health conditions.

**Patient Protection and Affordable Care Act (PPACA):** Also referred to as the “Affordable CareAct,” begins the implementation of a staged set of

rules with an initial effective date of March 23, 2010. The law is intended to increase access to health care for more Americans, and includes many changes

that impact the commercial health insurance market, Medicare and Medicaid.

**Participant-Direction:** Participant-directed services are home and community-based services that help people of all ages, across all types of disabilities, maintain their independence and determine for themselves what mix of personal assistance supports and services work best for them. Participant-directed services are sometimes referred to as consumer-directed or self-directed.

**Patient Centered Care**: The experience of the recipient of service that the services delivered are understandable, related to the patient’s self-defined needs, delivered with respect, dignity, and involving the patient in decisions regarding services. “Nothing about me without me.”

**Patient Centered Medical Home-:** An approach to comprehensive primary care for adults, children and youth that facilitates partnerships between patients and their health care providers. Emphasizes care by a team of professionals, care coordination, and viewing the patient as a whole person addressing all of their health care needs including life style, behavioral health and preventive care.

**Pay for Performance:** A payment system where health care providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems

also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

**Payment Reform:** Refers to a range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.

**PEAK:** Program Eligibility and Application Kit. A Colorado state website that allows people to apply for Medicaid and other benefits (cash, food, etc.) on line. May also be used to renew Medicaid benefits. Coloradopeak.force.com

**Per member per Month:** Applies to a revenue or cost for each enrolled member each month. Payments to an HMO may be per member per month.

**POS- Point of Service Health Plan:** A blended health insurance plan that has some features of an HMO plan and some features of indemnity health insurance. The member may seek care outside the organization’s provider network but typically with a greater personal cost. POS can also refer to the place where care was delivered.

**Preauthorization:** Often a prerequisite set by a payer source for receiving payment for providing a service. Sometimes meant as a cost containment measure a provider or their designee must contact the payer source prior to providing the service and the payer source determines whether the service is medically necessary and covered under the plan. The payer source may provide an authorization number if the service is preauthorized.

**Pre-existing Condition:** A health condition (other than pregnancy) that was diagnosed and/or treated within the six months prior to when the member enrolled in the health benefit plan. The health reform law prohibits the denial of coverage or charging higher

premiums due to a pre-existing condition.

**Preferred Provider Organization (PPO):** An arrangement in which the health insurance plan contracts with a group of health care providers (doctors, hospitals, clinics, etc.) who become the primary providers for the plan’s members usually in exchange for a discounted rate for the services provided. A hybrid of an HMO in which members have more choice in providers but usually at greater personal cost.

**Premium:** The amount paid, often on a monthly or biweekly basis, for health insurance. The cost of the premium may be shared between employers and individuals.

**Presumptive Eligibility:** Presumptive eligibility allows children under 19 and pregnant women to get access to Medicaid or Child Health Plan Plus services without having to wait for their application to be fully processed. Qualified entities can also help families gather the documents needed to complete the full application process.

**Preventive Care Services:** Health care services intended for the prevention or early detection of health conditions that are performed on a patient without symptoms or

abnormal study results. The health reform law requires certain health plans to provide coverage without member cost-sharing for certain preventive services.

**Primary Care:** Provision of health care services by a single provider or organization responsible for addressing a large majority of health care needs, developing a sustained relationship and partnership with patients practicing in the context of the patient’s home community. A physician who engages in this is called a Primary Care Physician (PCP).

**Pulse:** The rate at which a person’s heart beats. Pulse may be called heart rate, which is the number of times the heart beats each minute (bpm). Both the rhythm and strength of the heartbeat can also be noted, as well as whether the blood vessel feels hard or soft. Changes in your heart rate or rhythm, a weak pulse, or a hard blood vessel may be caused by heart disease or another problem. “Normal” heart rate varies depending on age, medical condition and a number of factors but generally between 60-100 bpm is in the normal range for a resting heart rate for an adult.

**Qualified Health Plan:** Insurance plans that are sold through a Health Insurance Exchange must have been certified as meeting a minimum benchmark

of benefits (i.e., essential health benefits) under the health reform law.

**Regional Collaborative Care Organization (RCCO):** Colorado’s version of an accountable care organization. These organizations connect Medicaid beneficiaries with services and providers and coordinate care. There are seven RCCO (pronounced Rico) regions in Colorado.

**Relative Value Unit (RVU):** RVUs reflect the relative level of time, skill, training and intensity required of a physician to provide a given service. RVUs are a method for calculating the volume of work or effort expended by a physician in treating patients. A well patient visit, for example, would be assigned a lower RVU than an invasive surgical procedure. One possible method of calculating productivity and compensation for health care professionals.

**Release of Information (ROI):** The divulgence of information by an entity to persons or organizations outside of that entity. In the medical field this usually requires a signed consent from the patient allowing the organization to share information. Release of medical information is governed by strict rules.

**Respiration (Rate):** The number of times per minute a person takes a breath. This rate is affected by a number of factors such as age, medical condition, etc. At rest, normal range for an adult is 12-18 breaths per minute. Children and infants have higher rates.

**Risk:** The chance or possibility of loss. Organizations that accept certain forms of payment, such as per member per month or capitation, assume a certain amount of risk that their costs may exceed the amount of payment they receive.

**Risk Sharing:**  A method by which medical insurance premiums are shared by plan sponsors and participants. In contrast to traditional indemnity plans in which insurance premiums belonged solely to insurance company that assumed all risk of using these premiums.

**Skilled Nursing Facility:** A skilled nursing facility is normally the highest level of care for older adults and younger people with chronic health conditions outside of a hospital. They provide what is called custodial care, including getting in and out of bed, and providing assistance with feeding, bathing, and dressing. They differ from other senior housing facilities (such as assisted living facilities) in that they also provide a high level of medical care. Skilled nursing care is available on site, usually 24 hours a day.

**Specialist:** A physician who devotes themselves to the study and care of a particular health care condition or group of conditions. This is as opposed to a generalist or primary care physician.

**Substance Use Disorder (SUD) Treatment:** Services, treatments and supports to help people with addictions and use of substances causing life problems that are intended to lessen emotional pain, family problems, physical risks, vocational problems and assist people to live healthier lives. These services are rendered by a variety of sources including licensed addictions counselors, medical doctors and lay people who may have experienced and overcome substance use problems (peer support). Treatment may include medications, counseling, support groups, 12 step and other programs.

**Temperature (body temperature):** Body temperature is a measure of the body's ability to generate and get rid of heat. In the US measured in degrees Fahrenheit (F) in many other countries in degrees Celsius (C).Can be measured several ways including orally, rectally, digitally on the skin or ear. Body temperature varies with several factors including age, time of day, method of measurement and activity level. In general above 100F (37.8C) is considered a fever. Most common cause of high body temperature is some type of infection.

**Triage:** The process of determining the priority of patients' treatments based on the severity of their condition. Triage may result in determining the order and priority of emergency treatment, the order and priority of emergency transport, or the transport destination for the patient.

**Triple Aim:** Term coinedas a result of the Affordable Care Act**.** The goal of health care reform is: improving the health of the population, enhancing the experience and outcomes for the patient, and reducing per capita cost of care.

**Urgent Care:** Urgent care is a category of [walk-in clinic](http://en.wikipedia.org/wiki/Walk-in_clinic) focused on the delivery of [ambulatory care](http://en.wikipedia.org/wiki/Ambulatory_care) in a dedicated medical facility outside of a traditional [emergency room](http://en.wikipedia.org/wiki/Emergency_department). Urgent care centers primarily treat [injuries](http://en.wikipedia.org/wiki/Injury) or [illnesses](http://en.wikipedia.org/wiki/Illness) requiring immediate care, but not serious enough to require an [ER](http://en.wikipedia.org/wiki/Emergency_department) visit.

**Utilization Management (UM):** The evaluation of the appropriateness, medical need and efficiency of [health care](http://en.wikipedia.org/wiki/Health_care) services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable [health benefits](http://en.wikipedia.org/wiki/Health_benefits_(insurance)) plan. In a managed care system a utilization manager decides whether a requested service meets medical necessity criteria and either authorizes or denies that service for payment.

**Vital Signs:** Usually refers to pulse, respiration rate, temperature and blood pressure.

**Weight (body weight):** A measure of a person’s mass measured in pounds (lbs) in the US and in kilograms (kg) in many other countries. Healthy body weight depends on a variety of factors such as age, gender, height, etc. Body mass index (BMI) is generally considered a more useful measure. A kilogram is 2.2 pounds; i.e. a 180 pound person weighs 82 kilograms.