



# Glossary of Terms

**Accountable Care Organization (ACO)**—a group of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care for Medicare patients. This health care delivery model has been implemented as part of the Affordable Care Act. The ACO model generally focuses on creating payment and delivery reforms that tie Medicare provider reimbursements to quality metrics, reductions in the total cost of care, and patient satisfaction. The goal of an ACO is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

**Activities of Daily Living (ADL)** - Sometimes referred to as ADLs, Activities of Daily Living include the key activities that we as human beings do as part of our normal day. These include such things as dressing, bathing, eating, walking, cooking and house cleaning.

**Acute Care** – Acute care is short-term and episodic, frequently provided in the hospital.

**Adult Day Services** - Also referred to as respite services, adult day services can be an enriching option for people living with family caregivers. These are often located within a senior housing community. Adult day services often provide supportive services, meal preparation, enriching activities and more throughout the day. At the end of the day, the person returns to his or her home.

**Aging in Place** - Sometimes also called “aging in community,” this refers to living at home rather than a nursing home.

**Area Median Income (AMI)** – 100% of the gross median household income for a specific Metropolitan Statistical Area, county or non-metropolitan area established annually by HUD.

**Assisted Living Housing** - Housing services designed to provide a variety of on-site supportive services. Assisted living typically includes such things as meals, laundry, bathing and dressing assistance and/or medication management. This might appeal to someone who wants independence, but also appreciates knowing that supportive services are available. It also allows residents to be part of a larger community.

**Assessment** – Determination of a person’s care needs, based on an evaluation of the person’s physical and psychological condition and ability to perform activities of daily living.

**Bundled Payments**—a payment methodology where a health care provider agrees to manage a defined group of services for a specified price. Already common within hospital payment as a Diagnosis-Related Group (DRG), current bundle payment initiatives are looking to expand services to additional hospital services and post-acute for an episode of care as a means of driving improved clinical integration and transitions management.

**Capitation (cap)**—a payment approach that defines a specific payment for a specific population for a specific period of time. This payment method is often used in terms of managing the average total cost of care for a defined population for a month, which is commonly referred to as per member per month (PMPM). This payment model is designed to encourage organizations to manage the cost of patient care by following best practices, eliminating duplication of services, and boosting efficiency.

**Care Manager** - Also sometimes called a case manager, this is a professional who plans, locates, monitors and coordinates appropriate social and medical services. This is called care management. Care managers are sometimes assigned by a state, or a person can purchase private care management services.

**Case Mix** - A method used in some states to determine patients' needs for health care resources within a nursing home. The assessment is based in part on functional ability to perform activities of daily living (ADLs), medical and psychiatric diagnosis.

**Centers for Disease Control and Prevention (CDC)** -The federal agency charged with tracking and investigating public health trends and funding the U.S. public health system. The stated mission of the CDC, is "To promote health and quality of life by preventing and controlling disease, injury, and disability."

**Centers for Medicare & Medicaid Services (CMS)** - CMS is the agency under the U.S. Department of Health and Human Services that finances and administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement Amendments (CLIA).

**Centers for Medicare & Medicaid Innovation (CMMI)**—Also known as the CMS Innovation Center, CMMI is a division within CMS that was established by the Patient Protection and Affordable Care Act (PPACA) and is tasked with developing and testing innovative care and payment models designed to improve the quality of care and reduce costs.

**Chronic Condition** – A disease or illness that lasts over a long period of time and typically cannot be cured.

**Chronic Care Management**—the coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients' self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

**Community Benefit** - Tax-exempt hospital are required to collaborate with public health agencies and other local organizations to identify health needs and develop strategies to improve health in the communities they serve.

**Community Development Block Grant (CDBG)** – Federal funding to help entitled metropolitan cities and urban counties meet their housing and community development needs. The program provides annual grants on a formula basis to carry out a wide range of community development activities directed toward neighborhood revitalization, economic development, and improved community facilities and services for low and moderate income people.

**Community Development Corporation (CDC)** – Entrepreneurial institution combining public and private resources to aid in the development of socio-economically disadvantaged areas.

**Community Health Needs Assessment** – Community Health Needs Assessments help hospitals and other organizations to better understand the needs and assets of their communities, in collaboration with local residents and stakeholders.

**Congregate Housing** - Also sometimes called assisted living, this is housing where people can live independently on their own, usually in one building, and share common areas, social activities and amenities and eat most meals in a communal dining area.

**Continuum of Care**—a range of clinical services provided to an individual or group, which may reflect treatment provided during a single inpatient hospitalization, or care for multiple conditions over a lifetime. The continuum provides a basis for analyzing long-term quality, cost, and utilization across all facilities from primary care and ER to post-acute and home health, ideally with shared medical records.

**Continuum of Care (2)** – for HUD-funded homelessness assistance programs, the local or regional entity that coordinates the submission of requests for federal funds

**Contract Rent** – The monthly rent agreed to between a tenant and landlord.

**Coordinated Care**—a care model approach that emphasizes a patient-centered, team-based strategy for delivering coordinated health care services.

**Continuing Care Retirement Communities (CCRCs)** - A CCRC is housing that provides everything from independent living to assisted living to nursing care. CCRCs, sometimes also called life care communities, typically require a significant down payment in addition to monthly service fees. However, in return, the person knows he or she will have access to nursing care in the CCRC if needed.

**Discharge Planner** - A health care professional who helps a patient with health care arrangements following their hospital stay.

**Demand** – The total number of households in a defined market area that would potentially move into proposed new or renovated housing units. These households must be of the appropriate age, income, tenure, and size for a specific proposed development. Components of demand vary and can include household growth, turnover, those living in substandard conditions, rent over-burdened households, and demolished housing units. Demand is project specific.

**Dual Eligible** - A person who is eligible for both Medicare and Medicaid benefits.

**Electronic Health Record / Electronic Medical Record (EHR / EMR)**—an electronic record of patient health information that may be stored on a computer or in the cloud, and can be retrieved by anyone who has access to the system.

**Emergency Response Systems** - Electronic monitors on a person or in a home that provide automatic response to medical or other emergencies.

**Evidence-Based Medicine (EBM)**—aims to apply the best available evidence gained from the scientific method to clinical decision making. It seeks to assess the strength of evidence of the risks and benefits of treatments (including lack of treatment) and diagnostic tests. EBM is identified through published best practices, clinical standards, and claims data to help clinicians learn whether or not any treatment will do more good than harm.

**Extremely Low Income** – Person or household with income below 30% of Area Median Income adjusted for household size.

**Fair Market Rent (FMR)** – Estimates established by HUD of the gross rents (contract rent plus tenant-paid utilities) needed to obtain modest rental units in acceptable condition in a specific county or Metropolitan Statistical Area. HUD generally sets FMR so that 40% of the rental units have rents below it. In rental markets with a shortage of lower priced rental units, HUD may approve the use of FMRs that are as high as the 50<sup>th</sup> percentile of rents.

**Fee-for-Service (FFS) Reimbursement**—currently the most prevalent health care payment system, it provides physicians and other health care providers with a payment on a per-unit or per-service basis. FFS tends to incent the treatment of conditions rather than the whole spectrum of a person's health and wellness.

**Geriatrics** - A specialty area in medicine that focuses on providing health care for seniors and the treatment of diseases associated with the aging process. Geriatricians typically are physicians accredited in geriatric medicine.

**Health Care Cloud**—a digital health care ecosystem in which health care stakeholders (doctors, pharmacies, labs, payers, and patients) can collaborate and exchange information in real time for faster, more effective health care. Because the cloud is accessed through the web, it can be used for remote collaboration.

**Health Data Analytics**—the process of aggregating and analyzing patient statistics to identify key trends and variability in the health and care of a given population. This may be used by providers to define and drive best practice standards or by insurance payers to establish payment rates and determine actuarial projections.

**Health Equity** - Healthy People 2020 defines health equity as "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

**Health Maintenance Organization (HMO)** – A type of health insurance plan that frequently limits coverage to care from physicians who work for or contract with the HMO. Except in an emergency, it usually won't cover out-of-network care. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

**Health Plan**—health maintenance organization, preferred provider organization, insured plan, self-funded plan, insurance company, or other entity that covers health care services. This term may also be used to refer to a benefits plan.

**Health Information Exchange (HIE)**—the mobilization of health care information electronically across organizations within a region, community, or hospital system. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged.

**Home-and community-based services (HCBS)** - Services provided to people in their homes by various types of providers. HCBS may include services such as case management, home delivered meals and other supportive services.

**Hope VI** – Federal program aimed at revitalizing severely distressed public housing by providing competitive grants to public housing authorities. Hope VI has been used extensively in the transformation of public housing to create mixed-income affordable housing.

**Hospice** - Hospice or palliative care is provided to enhance the life of a dying person. It can be held in a person's home or nursing home. Hospice care emphasizes comfort measures and counseling to provide social, spiritual and physical support to the person and his or her family.

**Housing Choice Voucher (Section 8 Program)** – Federal rent-subsidy program under Section 8 of the U.S. Housing Act, which issues rental vouchers to eligible households to use for the housing of their choice. The voucher payment subsidizes the difference between the gross rent and tenant's contribution of 30% of adjusted income, (or 10% of gross income, whichever is greater). In cases where 30% of the tenant's income is less than the utility allowance, the tenant will receive an assistance payment. In other cases, the tenant is responsible for paying his share of the rent each month.

**HUD Section 8** – Federal program that provides project-based rental assistance. HUD contracts directly with the owner for the payment of the difference between the contract rent and a specified percentage of the tenant's adjusted income.

**HUD Section 202** – Federal program that provides direct capital assistance (i.e., grant) and operating or rental assistance to finance housing designed for occupancy by elderly households who have incomes not exceeding 50% of Area Median Income. The program is limited to housing owned by 501c3 nonprofit organizations or by

limited partnerships where the sole general partners is a 501c3 nonprofit organization. Units receive HUD project-based rental assistance that enables tenants to occupy units at rents based on 30% of tenant income.

**Income Limits** – Maximum household income by county of Metropolitan Statistical Area, adjusted for household size and expressed as a percentage of the Area Median Income for the purpose of establishing an upper limit for eligibility for a specific housing program. Income limits for federal, state, and local rental housing program typically are established at 30%, 50%, 60% or 80% of AMI. HUD publishes income limits annually for households with one through eight people.

**Integrated Provider Organization (IPO)**—a corporate umbrella for the management of a diversified health care delivery system. The system may include one or more hospitals, a large group practice, and other health care operations. Physicians practice as employees of the organization or in a closely affiliated physician group.

**Long-Term Care** - The broad spectrum of medical and support services provided to persons who have a chronic illness or condition, and who are expected to need care services over a prolonged period of time.

**Low Income** – Person or household with gross household income below 60% or 80% of the Area Median Income adjusted for household size. Some programs use 60% AMI, while others use 80% AMI in their definition of income-eligible households.

**Low Income Housing Tax Credit** – A program to generate equity for investment in affordable rental housing authorized pursuant to Section 42 of the Internal Revenue Code, as amended. The program requires a certain percentage of units built be restricted for occupancy to households earning 60% or less of Area Median Income; the rents on these units be restricted accordingly.

**Medicaid** - A joint federal and state program that helps low-income individuals or families pay for the costs associated with long-term medical and custodial care, provided they qualify. Although largely funded by the federal government, Medicaid is run by the state where coverage may vary.

**Medicare** - A federally administered system of health insurance available to persons aged 65 and over. It pays for some rehabilitation services, but otherwise does not pay for long-term care. It has four parts A, B, C and D.

**Medicare Part A** - Hospital insurance that helps pay for inpatient care in a hospital or nursing home (limited-time rehab care following a hospital stay only), some home health care and hospice care.

**Medicare Part B** - This helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance. It does not pay for long-term care.

**Medicare Advantage (Part C)** - People with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations under Part C plans. Again, it pays for very limited long-term care services.

**Medicare Part D** - Prescription drug coverage that helps pay for medications doctors prescribe for treatment.

**Memory Care** - Specially designed supportive housing for people living with the challenges of Alzheimer's or dementia.

**Moderate Income** – Person or household with gross household income between 80% and 120% of Area Median Income adjusted for household size.

**Nursing Home** - Sometimes called a skilled nursing facility or care center, this is a licensed, hospital-like setting that provides 24-hour nursing and other health-related, services to people who require continued care.

**Nurse, Licensed Practical (LPN)** - A graduate of a state-approved practical nursing education program, who has passed a state examination and been licensed to provide nursing care under the supervision of a registered nurse or physician. An LPN administers medications and treatments.

**Nurse, Registered (RN)** - Nurses who have received a two-year associate degree, three-year hospital diploma, or four-year degree and passed a state-administered exam. RNs have completed more formal training than LPNs and have greater responsibility.

**Occupational Therapist** - Occupational therapists evaluate, treat, and consult with individuals whose abilities to cope with the tasks of everyday living are threatened or impaired by physical illness or injury.

**Ombudsman** - An ombudsman is a consumer advocate. The Ombudsman Program is a government/community-supported program that advocates for the rights of all people who use long-term care services.

**Palliative Care** - Also often referred to as hospice care, these are pain management services to provide comfort to those with life-threatening illness.

**Patient-Centered Medical Home (PCMH)**—an approach to providing comprehensive primary care for patients by facilitating partnerships between patients and their primary care provider (PCPs). It is designed to encourage the PCP to coordinate, but not necessarily directly provide, all aspects of a patient's care, including emergency room and post-discharge care.

**Per Member Per Month (PMPM)**—the average cost for a defined membership for a defined set of service over the course of a month. A full risk-bearing organization may be paid by insurers on a PMPM basis.

**Permanent Supportive Housing** – an affordable housing model most often designed for persons with disabilities who may have been homeless; it offers individualized support services based on a resident's goals, including support for successful tenancy to prevent a return to homelessness

**Population Health**—the health of a defined population which includes not only the amount of services they receive, but the general well-being of that group.

**Post-Acute Care** - Care provided after a hospital stay in a rehabilitation center or nursing home.

**Preventative Care**—health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term.

**Primary Care Physician (PCP)**—a physician, the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics. An obstetrician/gynecologist sometimes is considered a primary care physician, depending on coverage.

**Private Pay** - A term often used to describe those who pay for their own services or care or whose services or care is paid for by their family or another private third party, such as an insurance company. The term is used to distinguish from those whose services and care are paid for by governmental programs (Medicaid, Medicare, and Veterans Administration).

**Project-Based Rent Assistance** – Financing from a federal, state, or local program allocated to a property or specific number of units in the property. It is available to each income-eligible tenant of the property or an assisted unit.

**Referral**—the recommendation by a physician and/or health plan for a patient to receive care from another physician or organization.

**Rehabilitation** - Therapy treatments and recuperation. Rehabilitation can also include speech therapy and/or occupational rehabilitation, which helps individuals regain the skills they need to manage activities of daily living and/or work.

**Respite Care** - Scheduled short-term nursing care provided on a temporary basis to an individual who needs this level of care but who is normally cared for through home and community-based services. It provides relief for caregivers while providing proper care for the individual.

**Risk Analysis**—the process of evaluating expected medical care costs for a prospective group against what revenue or premium an organization would bring in on their account.

**Risk Sharing**—a reimbursement method where a provider shares in the financial risk of managing the patient's care. An example of risk sharing is capitation. In an Accountable Care Organization, the provider takes greater accountability for managing the amount of expenses for a given population.

**Self-Funding, Self-Insurance**—a health care program in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan. Accountable Care Organizations can be self-insured. In some cases, organizations taking steps to becoming an ACO will measure their own employee population before moving to broader community.

**Senior Housing** - Housing for seniors that includes independent living, assisted living and/or memory care. Supportive services are provided via a contract between the customer and service provider.

**Service Enriched Housing** - residents in service enriched housing have access to a variety of supportive services, primarily through referral by a Resident Services Coordinator

**Skilled Nursing Facility (SNF)** - Sometimes also called a nursing home or care center, it provides 24- hour nursing care for chronically-ill or short-term rehabilitative residents.

**Social Determinants of Health** - Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

**Stop-Loss Insurance**—insurance coverage taken out by a health plan, self-funded employer, or Accountable Care Organization to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness).

**Sub-Acute Care** - A level of care designed for the individual who has had an acute health care event (episodic) and needs nursing or rehabilitation but does not need the intensive diagnostic or invasive procedures of a hospital.

**Subsidy** - Monthly income received by a tenant or by an owner on behalf of a tenant to pay the difference between the apartment's contract rent and amount paid by the tenant toward rent.

**Triple Aim or Three-Part Aim**—The Centers for Medicare & Medicaid Services and The Institute for Healthcare Improvement (IHI) devised goals for improving the health care system. The three critical objectives include: 1)

improve the health of the population; 2) enhance the patient experience of care (including quality, access, and reliability); and 3) reduce, or at least control, the per capita cost of care.

**Utilization**—the extent that the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per 100 or 1,000 people eligible for the service.

**Very Low Income** – Person or household whose gross household income does not exceed 50% of Area Median Income adjusted for household size.

---

**Note:** Some definitions were derived from relevant websites maintained by the U.S. Department of Health and Human Services, the U.S. Department of Housing and Urban Development, and the Robert Wood Johnson Foundation.