

GLOSSARY

Acronym/ Initials	Term	Definition
	1C1	The Centers for Medicare & Medicaid Services (CMS) contract section that details the hospital-related tasks, responsibilities, and accountabilities of Quality Improvement Organizations (QIOs).
	10-measure starter set	Clinical measures specified by the Medicare Modernization Act (MMA) that focus on three clinical topics: acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN).
	501(b)	The section of the Medicare Modernization Act (MMA) that requires a reduction in Medicare reimbursement (0.04%) to hospitals that do not submit quality data (for a set of 10 indicators established by the Secretary of the HHS as of November 1, 2003) that relate to the quality of care furnished by the hospital.
ACM	Appropriate Care Measure	An identified participant group (IPG) within the 8th Scope of Work (SoW) directed toward improving clinical performance. The ACM is a composite measure of the 10 core measures starter set defined by the Medicare Modernization Act (MMA) and used by the Hospital Quality Alliance (HQA) for public reporting. The ACM is patient-centered and designed to answer the question: “Did the patient receive <i>all</i> the care he or she should have received, based upon his or her clinical condition?” Teams will focus on reducing the gap between the care the patient <i>should have</i> received and the care the patient <i>did</i> receive.
AHA	American Hospital Association www.aha.org	The American Hospital Association (AHA) is the national organization that represents and serves all types of hospitals and health care networks, and their patients and communities.
AHRQ	Agency for Healthcare Research and Quality http://www.ahrq.gov	The Agency for Healthcare Research and Quality (AHRQ) provides evidence-based information on health care outcomes, quality, cost, use, and access. Information from AHRQ’s research helps people make more informed decisions and improve the quality of health care services. AHRQ was formerly known as the Agency for Health Care Policy and Research. Sister agencies include the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Centers for Medicare & Medicaid Services, and the Health Resources and Services Administration.
APU	Annual Payment Update	The Annual Payment Update is the annual percentage increase that CMS applies to Medicare reimbursement for eligible prospective payment service (PPS) hospitals. APU is also referred to as the “Annual Market Basket.”

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AsHHA	Arizona Hospital and Healthcare Association www.azhha.org	The Arizona Hospital and Healthcare Association is an organization of hospitals and health systems dedicated to providing leadership on issues affecting the delivery, quality, accessibility, and cost effectiveness of healthcare. The Association accepts and shares in the responsibility for improving the health status of the people of Arizona.
	Baseline	An observation or value that represents the background level of a measurable quantity. The baseline rate is used for comparison with values representing responses to experimental intervention or an environmental stimulus, usually implying that the baseline and response values refer to the same individual or system.
	Benchmarking	A process of measuring another organization's product or service according to specified standards in order to compare it with and improve one's own product or service. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same product or service (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).
	Best practices study	An examination of the methods by which optimal clinical outcomes are achieved.
CAH	Critical Access Hospitals	A Critical Access Hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures. Each hospital must review its own situation to determine if CAH status would be advantageous. CAHs are certified under a different set of Medicare Conditions of Participation (CoP) that are more flexible than the acute care hospital CoPs.
CART	CMS Abstraction & Reporting Tool	The data collection tool for hospital medical record abstraction provided by CMS at no cost to hospitals.
	Centers of Excellence	Tertiary care facilities that have established a reputation for quality in one or more areas. Their reputation tends to draw patients from extended geographical areas. Some third-party payers require that rare problems be treated or procedures be performed at centers of excellence to ensure lower cost and higher quality.
CDAC	Clinical Data Abstraction Center	The CMS-designated national service for all independent third-party hospital medical record abstraction.

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	Clinical Data Warehouse	The QIO Clinical Warehouse is a national repository that contains inpatient hospital data. It contains inpatient data abstracted and uploaded by a provider, or a vendor on behalf of the provider, for specific topics of care (e.g., acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention). Validation data from the CDAC is also stored in the QIO Clinical Warehouse. The data in the QIO Clinical Warehouse is used for public reporting, as well as for other reports and analysis.
CMS	The Centers for Medicare & Medicaid Services www.cms.gov	The HHS agency responsible for Medicare and parts of Medicaid.
CoP	Conditions of Participation	The various rules and procedures that a health care provider desiring to participate in a health care or insurance program is required to meet before participation is permitted. Independent certification that the requirements have been met is conducted routinely by an appropriate state or federal agency.
CPOE	Computerized Physician Order Entry	
CQI	Continuous quality improvement	A management approach to the continuous study and improvement of the processes of providing health care services to meet the needs of patients and other persons. CQI focuses on making an entire system's outcomes better by constantly adjusting and improving the system itself instead of searching out and getting rid of persons or processes whose practices or results are outside of established norms. CQI is often considered to be synonymous with "total quality management."
DRG	Diagnosis Related Group	The classification of hospitalized patients into clinically cohesive categories having homogeneous levels of resource utilization. Each patient is assigned a DRG based on principal and co-morbid diagnoses, and modified by the principal and secondary procedures obtained during the hospitalization, as well as by age, sex, and discharge status. Each DRG may be either surgical or medical in nature, depending on the care provided in-hospital.
	Evidence-based medicine	The practice of medicine, or the use of health care interventions, guided by or based on the scientific evidence in support of, or against, the use of those interventions.

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	Expert opinion	An examination of performance and outcomes corresponding to existing assumptions, represented as guidelines and norms conducted by recognized highly qualified specialists (experts) or by a group of specialists.
FAH	Federation of American Hospitals www.fah.org	The FAH fosters the public good through the creation and delivery of quality health care for all people. The Federation’s members include investor-owned hospitals and other organizations involved in the delivery of health care services that share a common philosophy of providing high quality, affordable health care through free enterprise.
	Hospital Compare www.hospitalcompare.hhs.gov/	This Web site was created through the efforts of CMS and the HQA. Information is provided related to the recommended care that an adult should get if having surgery or being treated for a heart attack, heart failure, or pneumonia.
HCAHPS	Hospital Consumer Assessment of Health Plans Survey	The Centers for Medicare & Medicaid Services (CMS) has partnered with the federal Agency for Health Care Research and Quality (AHRQ) to develop a standardized instrument and methodology that can be used to collect and report information on patients’ experience with inpatient hospital care received. AHRQ developed the Consumer Assessment of Health Plans Survey (CAHPS), currently used to assess the care provided by health plans covering 123 million Americans. Using this experience and expertise, ARHQ has constructed an instrument, known as “HCAHPS,” for assessing patients’ experience with hospital inpatient care.
HCQIP	Health Care Quality Improvement Program	HCQIP is a program that supports the mission of CMS to assure health care security for beneficiaries. The mission of HCQIP is to promote the quality, effectiveness, and efficiency of services provided to Medicare beneficiaries.
HDC	Hospital Data Collection	Data collection is an integral part of CMS’s hospital quality improvement initiatives, which include the HQA.
HHS	Health and Human Services	HHS is the U.S. government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
HQA	Hospital Quality Alliance	The HQA is a public-private reporting initiative launched by the American Hospital Association (AHA), the Federation of American Hospitals (FAH), the Association of American Medical Colleges (AAMC), and CMS to provide information on the quality of care in hospitals that volunteered to report their data for selected clinical topics.

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HQI	Hospital Quality Initiative	CMS has several efforts in progress to provide hospital quality information to consumers and others and improve the care provided by the nation’s hospitals. These initiatives build upon previous CMS and QIO strategies to identify illnesses and/or clinical conditions that affect Medicare beneficiaries in order to promote the best medical practices associated with the targeted clinical disorders, prevent or reduce further instances of these selected clinical disorders, and prevent related complications.
HSAG	Health Services Advisory Group www.hsag.com	Arizona’s Quality Improvement Organization, founded in 1979, has a mission of positively affecting the quality of health care by providing information and expertise to those who deliver and those who receive health services.
IHI	Institute for Healthcare Improvement www.ihl.org	The IHI is a not-for-profit organization driving the improvement of health by advancing the quality and value of health care. Founded in 1991 and based in Cambridge, Massachusetts, IHI offers comprehensive products and services.
	Indicator	A key clinical value or quality characteristic used to measure, over time, the performance, processes, and outcomes of an organization or some component of health care delivery.
IoM	Institute of Medicine www.iom.edu	The IOM serves as an adviser to the nation to improve health by providing unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large.
IPG	Identified Participant Group	
JCAHO	Joint Commission on Accreditation of Healthcare Organizations	JCAHO is an independent, not-for-profit organization, established over 50 years ago. JCAHO—governed by a board of physicians, nurses, and consumers— sets the standards by which health care quality is measured in America and around the world. JCAHO evaluates the quality and safety of care for more than 16,000 health care organizations. To maintain and earn accreditation, organizations must have an extensive on-site review by a team of JCAHO health care professionals, at least once every three years. The purpose of the review is to evaluate the organization’s performance in areas that affect medical care. Accreditation may then be awarded based on how well the organizations met JCAHO standards.

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	Market Basket	The cost of the mix of goods and services (including personnel costs but excluding non operating costs) comprising routine, ancillary, and special care unit inpatient hospital services.
	Measurement	The systematic process of data collection, repeated over time or at a single point in time.
MMA	Medicare Modernization Act	The amendment to Title XVIII of the Social Security Act that provides for a voluntary program of prescription drug coverage, an amendment to the Internal Revenue Code of 1986 to allow individual deductions for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes. The U.S. Senate and House of Representatives enacted the MMA in December 2003.
MoU	Memorandum of Understanding	A document providing a general description of the responsibilities that are to be assumed by two or more parties in their pursuit of some goal(s). More specific information may be provided in an associated SoW
NCQA	National Committee for Quality Assurance www.ncqa.org	A nonprofit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Set (HEDIS) data reporting system.
NIH	National Institutes of Health www.nih.gov	NIH is a part of the U.S. Department of Health and Human Services and is the primary federal agency for conducting and supporting medical research.
	Outcome indicator	An indicator that assesses what happens or does not happen to a patient following a process, agreed-upon desired patient characteristics to be achieved, or undesired patient conditions to be avoided.
	Performance measure	A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services.
	Practice guidelines	Descriptive tool(s) or standardized specification(s) for care of the typical patient in the typical situation, developed through a formal process that incorporates the best scientific evidence of effectiveness with expert opinion.

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	Process improvement	A methodology utilized to make improvements to a process using continuous quality improvement methods.
	Process indicator	A gauge that measures a goal-directed interrelated series of actions, events, mechanisms, or steps.
PPS	Prospective Payment System	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).
QIO	Quality Improvement Organization	QIOSs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations. The program also safeguards the integrity of the Medicare trust fund by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care. There is a national network of 53 QIOs that are responsible for each U.S. state, territory, and the District of Columbia. QIOs function under the direction of the Centers for Medicare & Medicaid Services. Health Services Advisory Group is the QIO for Arizona.
QNet	QualityNet Exchange www.qnet.org	QNet helps to improve the quality of health care for Medicare beneficiaries by providing for the safe, efficient exchange of information regarding their care. Established by the Centers for Medicare & Medicaid Services (CMS), QNet Exchange is the only CMS-approved site for secure communications and data exchange.
RFR	Reduction in failure rate	Failure rate is defined as the gap between the current performance percentage and 100 percent performance on a performance measure.
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Updates	
RO	Regional office	CMS has 10 regional offices that work closely together with Medicare contractors in their assigned geographical areas on a day-to-day basis.
	Roadmap	An Executive Summary from CMS that outlines its vision and aims for quality improvement.

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ROSC	Rural Organizational Safety Culture Change	An identified participant group (IPG) within the 8th Scope of Work (SoW) directed toward engaging hospital senior leadership to assess the safety climate of the hospital. IPG participants must be CMS-designated PPS or CAH rural facilities.
	Rural	Counties not within a Metropolitan Statistical Area (MSA) are considered rural.
SCIP	Surgical Care Improvement Project	An identified participant group (IPG) within the 8th Scope of Work (SoW) directed toward fostering system improvement in the provision of surgical care.
SIOC	Systems Improvement and Organizational Culture Change	An identified participant group (IPG) within the 8th Scope of Work (SoW) directed toward engaging hospital senior leadership in the use of information technology.
SoW	Scope of Work / Statement of Work	Used by CMS to designate the 3-year contract that guides Quality Improvement Organizations. The 8th Scope of Work began in the fall of 2005.
	Transformational change	Defined by CMS as “every patient receiving the right care every time” and where care meets the six Institute of Medicine aims. The IOM’s six aims for the 21st-Century Health Care System are that health care should be <i>safe, effective, patient centered, timely, efficient, and equitable</i> .
	UB-92	An electronic format of the CMS-1450 paper claim form that has been in general use since 1993.
	Urban	Areas consisting of one or more counties that contain a city of 50,000 or more habitants and have a total population of at least 100,000 (75,000 in New England.)
	Validation	The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.
	Vendor	A JCAHO-approved performance measurement system that provides data collection tools and support to hospitals that must submit core sets to JCAHO quarterly. Vendors are able to submit the same hospital-collected clinical data to the QIO Clinical Warehouse.