

APPENDIX 3 GLOSSARY

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| advance care planning | Practice guidance and documentation of patient/family preferences for care at the end of life or for patients who are unable to speak for themselves. |
| advance directive | A document in which patients can explain the type and extent of health care services they prefer if they become unable to make medical decisions. The document may identify another person who can make those decisions on behalf of the individual. Such medical care could include routine treatments and life-saving methods. Advance directives are frequently called living wills. |
| allergy | An adverse reaction to a substance. |
| critical factor | A factor identified as central to the concept being assessed within particular elements. |
| demographic information | Information that includes (at least) ethnicity, gender, marital status, date of birth, type of work, hours of work and preferred language. |
| diagnosis | A problem list of a condition, injury or other health issue. |
| documented process | Written statements describing procedures. Statements may include protocols or other documents that describe actual processes or blank forms the practice uses in work flow (e.g., referral forms, checklists, flow sheets). |
| electronic clinical summary | A summary of a visit that includes, when appropriate, diagnoses, medications, recommended treatment and follow-up. |
| emergency admission | An unscheduled medical or behavioral health care event that results in an emergency room visit or hospital admission. |
| evidence-based guidelines | Clinical practice guidelines based on scientific evidence; or in the absence of scientific evidence, professional standards; or in the absence of professional standards, expert opinion. See practice guidelines . |
| example | A document, report or prepared material that illustrates implementation of systems or processes by the practice. |
| factor | A scored item in an element. For example, an element may require the organization to demonstrate that a specific document includes four items. Each item is a factor. |
| important condition | A condition, including an unhealthy behavior, substance abuse or a mental health issue, with evidence-based clinical guidelines that affect a large number of people or consumes a disproportionate amount of health care resources. |
| materials | Prepared information that the practice provides to patients, including clinical guidelines and self-management and educational resources such as brochures, Web sites, videos and pamphlets. |

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| Meaningful Use requirements | <p>The CMS implementation of the American Recovery and Reinvestment Act (ARRA) of 2009 (Recovery Act) provides incentive payments to eligible professionals for adopting and demonstrating meaningful use of certified EHR technology.</p> <p>Criteria for meaningful use are electronically capturing health information in a coded format, using the information to track key clinical conditions, communicating the information for care coordination and reporting clinical quality measures and public health information.</p> <p>Stage 1 has 25 requirements, including <i>15 Core Requirements</i> that must all be met and <i>10 Menu Requirements</i>, 5 of which must be met.</p> |
| multi-site group | <p>A group with multiple practice sites that provide standardized systems across the practices. For a multi-site group, NCQA reviews some elements once and applies the results to all practice sites in the group.</p> |
| must pass elements | <p>Designated elements that a practice must pass at a score of $\geq 50\%$ to achieve NCQA Recognition.</p> |
| population management | <p>Assessing and managing the health needs of a patient population rather than individual patients, such as defined groups of patients (e.g., patients with specific clinical conditions such as hypertension or diabetes, patients needing tests such as mammograms or immunizations).</p> |
| practice | <p>One or more clinicians at a single geographic location who practice together and provide patient care at this location.</p> |
| practice guidelines | <p>Systematically developed descriptive tools or standardized protocols for care to support clinician and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.</p> |
| practice team | <p>A group of clinical and nonclinical staff (e.g., physicians, nurse practitioners, physician assistants, nurses, medical assistants, educators, schedulers) who manage patient care and population health by interacting with patients and working to achieve stated objectives.</p> |
| primary caregiver | <p>An individual who provides day-to-day care for a patient and must receive instructions about the patient's care.</p> |
| records or files | <p>Actual patient medical files or registry entries that document an action taken. The files are a source for estimating the extent of performance against an element.</p> |
| registry | <p>A searchable list of patient data that the practice proactively uses to assist in patient care.</p> |
| reports | <p>Aggregated data showing evidence of action; may include manual and computerized reports.</p> |
| risk factors | <p>Behaviors, habits, age, family history or other factors that may increase the likelihood of poor health outcomes.</p> |
| sample | <p>A statistically valid representation of the whole.</p> |

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| shared medical appointment | An appointment where multiple patients meet in a group setting for follow-up or routine care. |
| third available appointment | A measurement of the length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on the clinician's schedule. |
| treatment plan | A written action plan based on assessment data that identifies a patient's clinical needs, the strategy for providing services to meet those needs, the treatment goals and objectives. |
| vulnerable populations | Those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ definition). Vulnerable populations include people with multiple comorbid conditions or who are at high risk for frequent hospitalizations or ER visits. |
