

## Section 0.5 Overview

# Glossary of Terms for CCC

This document provides definitions of commonly-used health care industry terms as used within the context of a community-based care coordination (CCC) program.

**Time needed:** Ongoing as needed

**Suggested other tools:** CCC Program Workflow and Tools

Term	Definition
<b>Accountable care organization (ACO)</b>	An accountable care organization (ACO) is group of coordinated health care providers which provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, etc.) and is accountable to the patients and the third-party payer for the quality, efficiency, cost, and appropriateness of the health care provided.
<b>Activities of daily living (ADL)</b>	The term ADL is used in health care to refer to daily self-care activities within an individual's place of residence, in outdoor environments, or both. ADLs are defined as "the things we normally do...such as feeding ourselves, bathing, dressing, grooming, work, homemaking, and leisure."
<b>Affordable Care Act (ACA)</b>	<p>The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or "Obamacare", is a federal statute signed into law in March, 2010. The ACA was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of health care for individuals and the government. It introduced a number of mechanisms – including mandates, subsidies, and insurance exchanges – meant to increase coverage and affordability.</p> <p>The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex. Additional reforms aim to reduce costs and improve health care outcomes by shifting the system towards quality over quantity through increased competition, regulation, and incentives to streamline the delivery of health care.</p>
<b>Business Associate Agreement (BAA)</b>	<p>A BAA is a contract between a health care entity and its associates who will use protected health information (PHI) for administrative, research, pricing, billing or quality-assurance purposes. Business associates can be providers of health care services as well as individuals or entities involved in legal, accounting, consulting, or financial services.</p> <p>See also: Protected health information (PHI)</p>
<b>Care coordination</b>	See: Community-based care coordination
<b>Care continuum</b>	See: Continuum of care
<b>Caregiver</b>	Caregiver refers to a family member or paid helper who regularly provides help and protection to someone, such as a child, an elderly person, or someone who is sick or chronically ill.

Term	Definition
<b>Care management</b>	Care management refers to evidence-based, integrated and coordinated health care services, and activities designed to help individuals with certain long-term conditions better manage their overall care and treatment. The care plan, developed collaboratively by the patient and care providers, is designed and executed to optimize the patient's health status and quality of life.
<b>Care team</b>	The care team includes health care professionals and support staff who, in a team approach, perform a variety of specialized functions designed to meet the physical, emotional, and psychological needs of the patient. The care team may include a physician nurse practitioner or physician assistant, registered nurse, care coordinator, medical assistant, and others.
<b>Case management</b>	<p>Case management focuses on delivering personalized services to patients to improve their care, and involves four steps: 1) Referral of new patients; 2) Planning &amp; delivery of care; 3) Evaluation of results for each patient and adjustment of the care plan; 4) Evaluation of overall program effectiveness and adjustment of the program.</p> <p>In the context of a health insurer, case management is defined as: "A method of managing the provision of health care to members with high-cost medical conditions. The goal is to coordinate the care so as to improve both continuity and quality of care and lower costs."</p>
<b>CCC patient plan</b>	The community-based care coordination (CCC) patient plan is developed and used by a care coordinator (CC) for planning and tracking CCC services for a patient. The CCC plan provides detailed information about a specific patient and is prepared from all currently-known information prior to meeting with the patient for the first time. It is then updated as more information about the patient is obtain – either from the patient during a CC visit, or from other sources.
<b>Centers for Medicare and Medicaid Services (CMS)</b>	<p><b>Medicare</b> is a health insurance program for persons age 65 or older and for persons under age 65 with certain disabilities. Medicare includes: Part A Hospital Insurance; Part B Medical Insurance; and Prescription Drug Coverage.</p> <p><b>Medicaid</b> is a social health care program for persons of all ages whose income and resources are insufficient to pay for health care.</p>
<b>Clinical quality measures (CQMs)</b>	<p>Clinical quality measures (CQMs) are tools that help measure and track the quality of health care services provided by eligible professionals and eligible hospitals within the health care system. These measures gauge providers' ability to deliver high-quality care. CQMs measure many aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and adherence to clinical guidelines.</p> <p>See <i>also</i>: Quality measures</p>
<b>Community-based care coordination (CCC)</b>	Community-based care coordination (CCC) refers to a partnership among health care professionals, clinics and hospitals, specialists, pharmacists, mental health professionals, and community services and resources working together to provide patient-centered, coordinated care.
<b>Community-based care coordinator (CC)</b>	Community-based care coordinator (CC) is a person in charge of coordinating health care for persons across the community, typically responsible for identifying those at risk and coordinating their care plans, arranging and tracking appointments, providing education, monitoring health status, promoting self-management, and facilitating other aspects health care.

Term	Definition
<b>Community resources</b>	Community resources generally refer to social services that help patients manage their activities of daily living, such as transportation services, personal care, nutrition, etc. Many community resources are provided by local governmental agencies or charitable organizations. <i>Also known as:</i> Community services
<b>Community resource directory</b>	The community resource directory is a tool that supports care coordinators in identifying and utilizing a wide variety of community resources to help patients with health care-related needs. Community resources generally refer to social services that help patients manage their activities of daily living, such as transportation services, personal care, nutrition, etc. Many community resources are provided by local governmental agencies or charitable organizations. <i>See also:</i> Provider resource directory
<b>Community services</b>	<i>See:</i> Community resources
<b>Community team</b>	Community team refers to the organizations and individuals working together to coordinate care for patients in their community, build relationships to manage the health and well-being of populations, and, ultimately, achieve better care, better health, and lower cost.
<b>Continuum of care</b>	The continuum of care encompasses a comprehensive range of health care services meant to promote the health of an individual throughout the span of their lifetime. Services along the continuum include preventive health services, care management, acute care, post-acute care and long-term care. Each of the care settings along the continuum of care serves a specific purpose and meets the needs of specific types of patients. Matching patients' needs to the most appropriate care setting can maximize the efficiency and effectiveness of health care delivery. <i>Also known as:</i> Care continuum
<b>CPT code</b>	A CPT code is a numerical diagnostic code, defined in the publication <i>Current Procedural Terminology</i> , which is used to report medical procedures and services and to enable comparability in pricing, billing, and utilization review by physicians, health insurance companies, and accreditation organizations.
<b>Data analytics</b>	Data analytics is the process of extracting, analyzing, and modeling data with the goal of discovering useful information, suggesting conclusions, and supporting decision making. Data are often analyzed in real time, delivered to users in a visual way (e.g., using graphs, maps, models, etc.), and generally performed on a very large amount of data so as to be statistically valid.
<b>Electronic health record (EHR)</b>	An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. An EHR can: <ul style="list-style-type: none"> <li>• Contain a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results</li> <li>• Allow access to evidence-based tools that providers can use to make decisions about a patient's care</li> <li>• Automate and streamline provider workflow</li> </ul> EHRs are built to share information with other health care providers and organizations – such as laboratories, specialists, medical imaging facilities, pharmacies, emergency facilities, and school and workplace clinics – so they contain information from all clinicians involved in a patient's care.

Term	Definition
	<i>See also:</i> Electronic medical record (EMR)
<b>Electronic medical record (EMR)</b>	<p>An electronic medical record (EMR) is a digital version of a paper chart that contains all of a patient's medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment. An EMR allows providers to:</p> <ul style="list-style-type: none"> <li>• Track data over time</li> <li>• Identify patients who are due for preventive visits and screenings</li> <li>• Monitor how patients measure up to certain parameters, such as vaccinations and blood pressure readings</li> <li>• Improve overall quality of care in a practice</li> </ul> <p>However, the information stored in an EMR is not easily shared with providers outside of a practice. A patient's record might even have to be printed out and delivered by mail to specialists and other members of the care team.</p> <p><i>See also:</i> Electronic health record</p>
<b>Functional risk assessment</b>	<p>A functional risk assessment measures the extent of a patient's functional impairment, that is, "difficulty performing, or requiring the assistance of another person to perform, one or more of activities of daily living." Assessing a patient's functional status is very important because prevalence is high among older persons, and Activities of Daily Living (ADL) impairment is a strong predictor of lengthening hospital stays, functional decline, institutionalization, and death.</p> <p><i>See also:</i> Health risk assessment</p>
<b>Health and wellness services</b>	<p>Health and wellness services refers to medical care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease, discovery and identification of people at risk of development of specific problems, counseling, and other necessary intervention to avert a health problem. Screening tests, health education, and immunization programs are common examples of preventive care.</p> <p><i>Also known as:</i> Preventive care services</p>
<b>Health care home</b>	<i>See:</i> Patient-Centered Medical Home (PCMH)
<b>Health care reform</b>	<i>See:</i> Affordable Care Act (ACA)
<b>Health disparity</b>	<p>Health disparities are defined as inequalities that exist when members of certain population groups do not benefit from the same health status as other groups. In relation to cancer, for example, such differences occur when one group of people has a higher incidence of mortality rate than another, or when one group has a lower survival rate than another. Health disparities usually can be identified along racial and ethnic lines, indicating that African Americans, Hispanics, Asian Americans, and Native Americans have different disease and survival rates from other populations. Such disparities also can extend beyond race to include areas such as access to health care, socio-economic status, gender, and biological or behavioral factors.</p> <p><i>See also:</i> Social determinants of health</p>
<b>Health information exchange (HIE)</b>	<p>Electronic health information exchange (HIE) enables physicians, nurses, pharmacists, other health care providers, and patients appropriately and securely to access and share a patient's vital medical information electronically – improving the speed, quality, safety and cost of patient care. Timely sharing of vital patient information can better inform decision making at the point of care and allow providers to avoid medication errors and readmissions, improve diagnoses, and decrease duplicate testing.</p>

Term	Definition
	<p>Currently, there are three key forms of health information exchange: (1) Direct Exchange – the ability to send and receive secure information electronically between care providers to support coordinated care; (2) Query-based Exchange – the ability for providers to find and/or request information on a patient from other providers, often used for unplanned care; and (3) Consumer Mediated Exchange – the ability for patients to aggregate and control the use of their health information among providers.</p>
<p><b>Health Insurance Portability and Accountability Act (HIPAA)</b></p>	<p>HIPAA refers to the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of health care information, and help the health care industry control administrative costs.</p> <p>The <b>HIPAA Privacy Rule</b> provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other purposes.</p> <p>The <b>Security Rule</b> specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to ensure the confidentiality, integrity, and availability of electronic protected health information.</p> <p>See <i>also</i>: Protected health information (PHI)</p>
<p><b>Health literacy</b></p>	<p>Health literacy refers to “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” The American Medical Association reports that poor health literacy is a stronger predictor of a person’s health than age, income, employment status, education level, and race.</p>
<p><b>Health risk assessment (HRA)</b></p>	<p>A health risk assessment (HRA), in the context of a community-based care coordination program, is a short, focused tool used to understand particular attributes about a patient as related to a patient’s capacity to perform certain activities and to independently navigate the health care system. HRAs are often triggered by a suspicion of need rather than as a routine part of a medical or nursing practice.</p> <p>Common health risk assessments for care coordination include:</p> <ul style="list-style-type: none"> <li>• Depression Risk Assessment</li> <li>• Digital Literacy Assessment</li> <li>• Environmental Risk Assessment</li> <li>• Fall Risk Assessment</li> <li>• Functional Risk Assessment</li> <li>• Health Literacy Assessment</li> <li>• Medication Reconciliation</li> <li>• Social and Financial Risk Assessment</li> <li>• Substance Use Assessment</li> </ul>
<p><b>Huddle</b></p>	<p>A huddle (or “stand-up meeting”) is a short daily meeting of care team members to look at the day’s schedule, discuss potential challenges, and coordinate efforts to resolve potentially difficult and/or time-consuming issues. To conduct a “huddle,” the care team assembles at a predetermined time each day to look ahead on the schedule and anticipate the needs of the</p>

Term	Definition
	<p>patients coming to the clinic that day. For example, a patient may need a potassium test before he or she meets with the provider. Instead of waiting until the patient is in the exam room with the provider, the staff can send the patient to the lab immediately after checking in at the clinic. Then the clinic staff can adjust the schedule because they know the patient won't be using the original appointment slot, but will need a slot 30 to 45 minutes later after the test is conducted.</p>
<p><b>Medicare Shared Savings Program (MSSP)</b></p>	<p>The Medicare Shared Savings Program (MSSP) is a program established by CMS to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).</p> <p>MSSP is designed to improve beneficiary outcomes and increase value of care by:</p> <ul style="list-style-type: none"> <li>• Promoting accountability for the care of Medicare FFS beneficiaries</li> <li>• Requiring coordinated care for all services provided under Medicare FFS</li> <li>• Encouraging investment in infrastructure and redesigned care processes</li> </ul> <p>MSSP rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care.</p>
<p><b>Medication reconciliation</b></p>	<p>Medication reconciliation is the process of identifying the most accurate list of all medications that a patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. Medication reconciliation is especially critical during transition of care (TOC) from one setting to another.</p>
<p><b>Motivational interviewing</b></p>	<p>Motivational interviewing is a counseling method that facilitates and engages intrinsic motivation within the patient in order to change behavior. Motivational interviewing is non-judgmental, non-confrontational, and non-adversarial. The approach attempts to increase the patient's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question.</p> <p><i>See also:</i> Supportive communications</p>
<p><b>Open access</b></p>	<p>Open access is a scheduling process in which generally all appointments are treated equally and no appointments are booked weeks or months in advance. The process follows the principles of queuing theory that matches supply (provider availability) and demand (patient request for appointment).</p>
<p><b>Panel management</b></p>	<p>See: Patient empanelment</p>
<p><b>Patient action plan</b></p>	<p>A patient action plan is a patient-friendly, self-management tool negotiated between the patient and care coordinator which helps the patient make specific behavior changes to support his/her health care needs. A patient action plan outlines the steps the patient can take to attain a larger health goal, such as quitting smoking or losing weight. Action plans help patients integrate these steps or health behavior changes into their daily lives to achieve the goal, and they allow for patients to be actively involved in their own care.</p>

Term	Definition
<b>Patient-centered medical home (PCMH)</b>	<p>The patient-centered medical home (PCMH) (or health care home) is a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the simplest to the most complex conditions. It is a place in which patients are treated with respect, dignity, and compassion, and it enables strong and trusting relationships with providers and staff. The medical home is not a final destination; it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.</p> <p><i>Also known as:</i> Health care home</p>
<b>Patient empanelment</b>	<p>Patient empanelment is a carefully planned effort to identify a group of patients for whom a provider or care team is responsible; it is the act of assigning an individual patient to an individual primary care provider (PCP) and care team, with sensitivity to patient and family preferences.</p>
<b>Patient empowerment</b>	<p>Patient empowerment is a philosophy that patients are active participants in – not passive recipients of – the health care process, and to gain maximum health benefit should be well informed about all aspects of their health, wellness status, and disease state. Patient empowerment requires a patient to take responsibility for aspects of care such as respectful communications with one's care team, patient safety, evidence gathering, smart consumerism, and shared decision-making.</p> <p><i>See also:</i> Patient engagement, Patient self-management</p>
<b>Patient engagement</b>	<p>Patient engagement is a connection between patient, caregiver, and health care provider. An empathetic and trusted relationship is formed and mutual respect is fostered. Engaged patients and their family/caregiver are empowered and active in health care decisions.</p> <p><i>See also:</i> Patient empowerment, Patient self-management</p>
<b>Patient health diary</b>	<p>A patient health diary is a tool that helps patients and clinicians keep track of the patient's health status. It helps patients take control over their health issues, spot issues before they become too severe, and potentially take action before the issue requires attention by a health care provider. A written diary helps patients remember to take specific actions, and helps them recall specific results of self-monitoring when discussing their progress with their CC or provider.</p>
<b>Patient health record</b>	<p><i>See:</i> Personal health record (PHR)</p>
<b>Patient registry</b>	<p><i>See:</i> Registry</p>
<b>Patient self-management</b>	<p>Patient self-management refers to the tasks that a patient must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions. Self-management describes patient attitudes, skills, and behaviors. For example, the patient:</p> <ul style="list-style-type: none"> <li>• Has knowledge of his/her condition and/or its management</li> <li>• Adopts a self-management care plan agreed and negotiated in partnership with health professionals</li> </ul>

Term	Definition
	<ul style="list-style-type: none"> <li>• Actively shares in decision-making with health professionals</li> <li>• Monitors and manages signs and symptoms of his/her condition</li> <li>• Manages the impact of the condition on physical, emotional, occupational and social functioning</li> <li>• Adopts lifestyles that address risk factors and promotes health by focusing on prevention and early intervention</li> <li>• Has access to, and confidence in the ability to use, support services</li> </ul> <p>See also: Patient empowerment, Patient engagement</p>
<b>Patient visit agenda</b>	<p>A patient visit agenda is a form that a provider's office asks the patient to complete – ideally in advance of a visit – that asks the patient to identify the primary reason for today's visit, lists other concerns the patient would like to discuss if there is time, and provides a checklist of things the patient might need but commonly forget to ask about, such as prescription refills, insurance referral forms, other forms, immunizations, and others.</p>
<b>Personal health record (PHR)</b>	<p>A personal health record (PHR) is an electronic tool used by patients to maintain and manage their health information in a private, secure, and confidential environment.</p> <p>PHRs:</p> <ul style="list-style-type: none"> <li>• Are managed by patients</li> <li>• Can include information from a variety of sources, including health care providers and patients themselves</li> <li>• Can help patients securely and confidentially store and monitor health information, such as diet plans or data from home monitoring systems, as well as patient contact information, diagnosis lists, medication lists, allergy lists, immunization histories, and much more</li> <li>• Are separate from, and do not replace, the legal record of any health care provider</li> <li>• Are distinct from portals that simply allow patients to view provider information or communicate with providers</li> </ul> <p>Properly designed and implemented, PHRs can help patients manage their health information and become full partners in the quest for good health.</p>
<b>Population health</b>	<p>Population health refers to the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups can be geographic populations (such as communities or nations) or other groups such as employees, ethnic groups, disabled persons, or any other defined group. It is an approach to health that aims to improve the health of an entire population. An important priority in achieving this aim is to reduce health inequities or disparities among different population groups due to, among other factors, the social determinants of health.</p>
<b>Population risk stratification</b>	<p>Population risk stratification is a systematic process for identifying and predicting patient risk levels relating to health care needs, services, and care coordination. The goal is to identify those at the highest risk or likely to be at high-risk, and prioritizing the management of their care to prevent poor health outcomes. It enables care teams to maximize the use of limited time and resources by prioritizing the needs of their patient population.</p>
<b>Preventive care services</b>	<p>See: Health and wellness services</p>
<b>Primary care provider (PCP)</b>	<p>Primary care provider (PCP) refers to the health care professional that provides regular, ongoing or day-to-day health care to a patient. Typically, this</p>



Term	Definition
	<p>provider acts as the first contact and principal point of continuing care for patients within a health care system, and coordinates with other specialist care that the patient may need. A PCP can be a primary care physician (general practitioner or family physician), a nurse practitioner (NP), or physician assistant (PA).</p>
<b>Protected health information (PHI)</b>	<p>Protected health information (PHI) is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual. PHI cannot be used for any purpose other than those for which it was obtained. The Health Insurance Portability and Accountability Act (HIPAA) obligates entities to sign a business associate agreement with their business associates before the associates begin to work with health information that should be protected from disclosure.</p> <p><i>See also:</i> Business associate agreement (BAA) and HIPAA</p>
<b>Provider resource directory</b>	<p>The provider resource directory is a tool that supports care coordinators in identifying and utilizing different types of providers to help patients with their health care needs. Examples include: primary care provider (PCP), hospital, emergency department (ED), skilled nursing facility, chiropractor, pharmacist, physical therapist, and many others.</p> <p><i>See also:</i> Community resource directory</p>
<b>Registry</b>	<p>A patient registry (Registry) is a collection of secondary data related to patients with a specific diagnosis, condition, or procedure that is used to track and report on a small sub population of patients with that specific condition. A registry can provide reminders to providers to check tests in order to reach quality goals. Registries support public and population health, as well as post-marketing surveillance of pharmaceuticals and medical devices.</p> <p><i>See also:</i> Electronic health record (EHR)</p>
<b>Remote patient monitoring (RPM)</b>	<p>Remote patient monitoring (RPM) refers to technology that enables monitoring of patients outside of conventional clinical settings (e.g., in the home). In RPM, physiological data are collected by sensors on peripheral devices such as a blood pressure cuff, pulse oximeter or glucometer, which are transmitted to health care providers or third parties via wireless telecommunication devices. Data are then evaluated for potential problems by a health care professional or via a clinical decision support algorithm, and patient, caregivers and health providers are immediately alerted if a problem is detected.</p>
<b>Quality measures</b>	<p>Quality measures are tools that measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.</p> <p><i>See also:</i> Clinical quality measures</p>
<b>Shared decision making (SDM)</b>	<p>Shared decision making (SDM) is the process whereby patients are provided evidence-based information on treatment choices and are encouraged to use the information in an informed dialogue with their providers to help them make health care decisions that best align with their values, preferences, and lifestyle. Providing care that is respectful of patient needs can lead to improved outcomes because the patient was engaged and empowered to make choices.</p>
<b>Social determinants of health</b>	<p>Social determinants of health are factors that contribute to a person's current state of health. These factors may be biological, socioeconomic,</p>

Term	Definition
	<p>psychosocial, behavioral, or social in nature. Scientists generally recognize five determinants of health of a population:</p> <ul style="list-style-type: none"> <li>• Biology and genetics. Examples: sex and age</li> <li>• Individual behavior. Examples: alcohol use, injection drug use (needles), unprotected sex, and smoking</li> <li>• Social environment. Examples: discrimination, income, and gender</li> <li>• Physical environment. Examples: where a person lives and crowded conditions</li> <li>• Health services. Examples: Access to quality health care and having/not having health insurance</li> </ul>
<b>Steering committee</b>	<p>A steering committee is a group formed to provide executive level leadership for a project, program, or strategic initiative. The committees is expected to “steer,” not to “manage,” the project or program. In general, a steering committee makes decisions about the general direction or priorities of a program, and to manage the general course of operations.</p> <p>For a CCC program, the steering committee primarily serves as a communication mechanism across disparate organizations participating in the CCC program, including the structured health care community of providers, the accountable care organization (or other mechanism organizing the CCC program), community resources, and the care coordinator.</p>
<b>Supportive communications</b>	<p>Supportive communications is a technique, often referred to as motivational interviewing, to invoke a desire for change in patients to make modifications to their lifestyles that will improve their health and wellness.</p> <p>See <i>also</i>: Motivational interviewing</p>
<b>Telehealth</b>	<p>Telehealth refers to the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Telehealth encompasses four distinct domains of applications. These are commonly known as:</p> <p><b>Live video (synchronous):</b> Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. This type of service also is referred to as “real-time” and may serve as a substitute for an in-person encounter when one is not available.</p> <p><b>Store-and-forward (asynchronous):</b> Transmission of recorded health history (for example, pre-recorded videos and digital images such as x-rays and photos) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.</p> <p><b>Remote patient monitoring (RPM):</b> Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support. This type of service can reduce readmission rates because it allows a provider to continue to track health care data for a patient once released to home or a care facility.</p> <p><b>Mobile health (mHealth):</b> Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and PDAs. Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks.</p>

Term	Definition
<b>Transition of care (TOC)</b>	Transition of care (TOC) is the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another setting or home.
<b>Triple Aim</b>	<p>The Triple Aim is a framework that describes an approach to optimizing health system performance. The goals of the Triple Aim are to:</p> <ul style="list-style-type: none"> <li>• Improve the patient experience of care (including quality and satisfaction)</li> <li>• Improve the health of populations</li> <li>• Reduce the per capita cost of health care</li> </ul>
<b>Variance (patient care variance)</b>	<p>In health care, a patient care variance is a deviation from a standard of practice or a specific care plan. A patient care coordination variance may be related to an action or outcome.</p> <p>A variance in an <i>action</i> can include:</p> <ul style="list-style-type: none"> <li>• Something performed that was not intended to be performed</li> <li>• Something performed at the wrong time</li> <li>• Something that was not performed that should have been performed</li> </ul> <p>A variance in an <i>outcome</i> is a result of an action that is different than expected.</p>

**For support using the toolkit**

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952-854-3306 • [info@stratishealth.org](mailto:info@stratishealth.org)

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