Appendix 2

Glossary

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advance directive	A document in which members 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 (e.g., about routine treatments and life-saving methods). Advance directives are frequently called "living wills."
adverse reaction	A noxious or unintended reaction to a drug that is administered in standard doses by the proper route for the purpose of prophylaxis, diagnosis or treatment.
allergy	An adverse reaction to a substance.
alternative type of clinical encounter	A scheduled meeting between the patient and a clinician, using a mode of real-time communication in lieu of an in-person office visit; for example, standalone communication or a combination of telephone, video chat and secure instant messaging.
appointment wait times	The period between the date/time a patient makes an initial request for an appointment and the actual appointment date/time) for both urgent and routine care. ***Note:*** *"Cycle times" (i.e., time from scheduled appointment to the patient actually being seen by the clinician) are not considered appointment wait times in these standards.*
care coordination measure	A metric that uses an aspect of clinical performance or patient experience to identify "better" performance or "worse" performance, with respect to "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."
eCQM	Electronic Clinical Quality Measure. The electronic specifications of a Clincal Quality Measure that help measure and track the quality of health care services.These measues use electronic health records or other health information technology systems to report health care performance.
clinical summary	A summary of a visit that can be provided to patients/families/caregivers through a personal health record, a patient portal on the practice's Web site, secure e-mail, electronic media (e.g., a CD or USB fob [electronic memory stick/flash drive]) or a printed copy. The summary, as defined by CMS, contains: 1. The patient's name. 2. The provider's name and office contact information. 3. The date and location of the office visit. 4. The reason for the office visit. 5. A list of current problems. 6. A list of current medications. 7. A list of current medications the patient is allergic to. 8. Procedures performed during the visit. 9. Immunizations or medications administered during the visit.

10. Vital signs taken during the visit (or other recent vital signs).
11. Laboratory test results.
12. A list of diagnostic tests pending.
13. Clinical instructions.
14. Future appointments.
15. Referrals to other providers.
16. Future scheduled tests.
17. **Demographic information** maintained in certified electronic health record technology (CEHRT) (sex, race, ethnicity, date of birth, preferred language).
18. Smoking status.
19. Care plan fields, including goals and instructions.
20. Recommended patient decision aids (if applicable to the visit).

care plan

A plan for day-to-day medical care and services. The plan can include:

- A summary of medical information (e.g., history of hospitalizations, procedures, tests).
- A list of providers, medical equipment and medications for patients with special health care needs.
- Obstacles to transitioning to an adult care clinician.

Arrangements for release and transfer of medical records to the adult care clinician.

certified EHR

An electronic health record that demonstrates compliance with the capability, functionality, and security specifications required by the Office of the National Coordinator for Health Information Technology (ONC).

- Information on obtaining an ONC Certification ID at https://chpl.healthit.gov/#/overview
- A list of Certified Health IT Products at https://chpl.healthit.gov/#/resources
- Information on security risk assessment guidance by HealthIT.gov at https://www.healthit.gov/providers-professionals/security-risk-assessment

concept

An overaching foundation on which a practice builds a medical home.

competency

A brief description of criteria subgroup, organized within the broader concept. This level is used for organization of the criteria into more meaningful groupings.

core criterion

A criterion identified as central to the concept being addressed and must be met in order to earn PCMH recognition.

criterion

A brief statement highlighting PCMH requirements.

de-identify

Removal of individual identifiers. Under the HIPAA Privacy Rule, protected health information is de-identified if all individual identifiers are removed. There are 18 categories of identifiers that include name; street address and zip code; telephone and fax number; dates (except year) directly related to a person, including date of birth and dates of service; e-mail address and Web URL; Social Security Number; medical record number and account number; vehicle identifiers, including license plate number; device identifiers and serial number; and any other unique identifying number, characteristic or code.

demographic information	Information that includes at least ethnicity, gender, marital status, date of birth, type of work, hours of work and preferred language.
diversity	A meaningful characteristic of comparison for managing population health that accurately identifies individuals within a non-dominant social system who are underserved. These characteristics of a group may include, but are not limited to, race, ethnicity, gender identity, sexual orientation, disability (both physical and mental) and religious affiliation. ***Note:*** *There are many resources available on diversity in healthcare, learn more:* *http://www.ivygroupllc.com/executive-leader/dimensions-of-diversity/* *https://my.clevelandclinic.org/ccf/media/Files/Diversity/diversity-toolkit.pdf?la=en*
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). Documented processes include an effective date.
elective criterion	A criterion that demonstrates capabilities and functions above and beyond that of a typical practice. Practices can choose among the items to tailor their activities to the community and population served. 1 or 2 credits can be earned for each elective, with the goal of achieving at least total 25 credits.
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 healthcare event that results in either an emergency room visit or in 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.
evidence of implementation	A document, report, prepared material or virtual demonstration that illustrates implementation of systems or processes by the practice.
legal guardian or health care proxy	An individual designated by the patient or family or by the courts to make health care decisions for the patient if the patient is unable to do so.
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.
multi-site group	Three or more practice sites using the same systems and processes, including an electronic medical record system shared across all practice sites. For a multi-site group, NCQA reviews some criterion once and applies the results to all practice sites in the group.
no show appointments	A scheduled appointment that is not kept, unexpectedly and without notification.

no show rates	A specific ratio that compares the number of appointments scheduled versus no-show appointments. Number of patients who did not keep their pre-scheduled appointments during a specific period of time (i.e., a session or a day) divided by the number of patients who were pre-scheduled to come to the center for appointments during the same period of time
PHI	Protected health information. PHI is associated with an individual's past, present or future physical or mental health or condition, or with the provision of or payment for health care to a person, and identifies the individual. Under the HIPAA Privacy Rule, there are 18 categories of identifiers (e.g., name, street address, email address, telephone number, social security number, medical record number, health plan beneficiary or account number, birth date, dates of service and five-digit zip code). Age is not PHI, except for individuals older than 89 years; HIPAA allows the age for these individuals to be aggregated into a single category of "age 90 or above."
population management	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).
practice guidelines	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.
practice team	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.
primary caregiver	An individual who provides day-to-day care for a patient and must receive instructions about the patient's care.
records or files	Patient medical files or registry entries that document an action taken. The files are a source for estimating performance on a criterion.
registry	A searchable list of patient data that the practice proactively uses to assist in patient care.
reports	Aggregated data showing evidence of action; may include manual and computerized reports.
risk factors	Behaviors, habits, age, family history or other factors that may increase the likelihood of poor health outcomes.
sample	A statistically valid representation of the whole.

shared decision-making aid

Provides detailed information without advising the audience to choose one decision over another and helps prepare patients to make informed, values-based decisions with their care team.

Note: *More information and resources can be found through the International Patient Decision Aid Standards Collaboration (IPDASC).*

social determinants of health

Conditions in the environment that affect a wide range of health, functioning and quality-of-life outcomes and risks.

Examples of social determinants include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets).
- Access to educational, economic, and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it).
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media).
- Culture.

More information on social determinants of health can be found on the Healthy People 2020 Web site at www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39.

social functioning

A person's ability to engage in social interactions, interpersonal relationships, and indepent living daily activities. One way this can be assessed is through social functioning questionaires or assessments.

Example of one questionnaire that can be used to assess social functioning: http://studylib.net/doc/7105191/the-social-functioning-questionnaire-is

standardized tool

A means of collecting information, using a current, evidence-based approach, that has been developed, field-tested and endorsed by a national or regional organization.

virtual review

A live, online method of evaluation conducted via screen sharing technology.

vulnerable populations	People 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).
walk-in access	An approach to patient appointment scheduling that allows established patients to be seen by a member of the care team during regular office hours, without prior notice.
qualified behavioral health care manager	A trained person responsible for coordinating and supporting mental health care within the clinic and for coordinating referrals to clinically indicated services outside the clinic. It is recommended that the care manager has the training and meets the clinical licensure requirements to provide brief psychosocial interventions appropriate for primary care settings. Typical licensures include: • Licensed mental health counselor. • Licensed marriage and family therapist. • Licensed social worker. • Registered nurse (BSN recommended). • Nurse practitioner. • Licensed psychologist. For more information on behavioral health care managers: https://aims.uw.edu/resource-library/care-manager-role-and-job-description