Population Health Glossary

A

Accountable care. A concept in which healthcare providers assume financial risk for the health management and outcomes of a defined population.

Accountable Care Organization (ACO). A provider organization responsible for managing the health and care of a defined population of patients. Caregivers within the ACO are expected to provide effective, high-value care. The U.S. Centers for Medicare and Medicaid Services (CMS) certifies Medicare ACOs that meet requirements for the care of Medicare patients; certification assigns certain obligations and benefits to the ACO.

Alignment of incentives. Ensuring through financial incentives that healthcare providers, payers, and patients seek the highest quality care at the lowest sustainable cost.

Attribution. In accountable care, the assigning of a patient to a healthcare provider. The attributed provider is accountable for the cost and quality of care provided to the patient.

B

Behavior change framework. A positive behavior change model that helps caregivers plan patient engagement communications, resources, and technology to support patients in making choices that help them live healthy lives.

Best practices. Medical and healthcare techniques that have been demonstrated to be highly effective.

C

Capitation. A variety of payment arrangements generally based on a per-member-per-month (PMPM) dollar amount paid in advance.

Care management. Programs that help patients manage their own care, especially patients with chronic health conditions. The term “integrated care management” can be used to describe care management efforts that are coordinated operationally within an organization.

Centers for Medicare and Medicaid Services (CMS). The United States agency that oversees the Medicare and Medicaid programs.

Clinical programs. Multidisciplinary teams of experts that collaborate to review medical literature, evaluate processes and data, and develop evidence-based best practices and care process models. Caregivers apply these standards to tailor care to each patient.

Clinical services. Systemwide Intermountain Healthcare services that support the delivery of care. Intermountain has 15 clinical services.

CPI + 1%. The Intermountain and Select Health goal of being able to offer an average annual premium increase to commercial large employer clients equivalent to the Consumer Price Index (CPI) plus about 1%. Usually referred to as “near the general inflation rate.”

Current Procedural Terminology (CPT) code set. A set of codes describing diagnostic, medical, and surgical services that are used for financial, administrative, and research purposes by the healthcare industry. Created by the American Medical Association and maintained by the CPT Editorial Panel, the codes are issued each October.

D

Diagnosis-related groups (DRGs). Categories of medical procedures and care used by Medicare as a basis for paying hospitals. Designed by the U.S. government and based on the ICD, the categories identify standard services provided by hospitals.

E

Efficiency. Efforts to reduce the cost of units of care or processes such as supplies, equipment, and lab tests.

Engaging patients. Involving patients in decisions about their healthcare and encouraging them to make lifestyle decisions that promote health, prevent illness and injury, and use resources wisely.

Evidence-based medicine. Making clinical decisions based on the best available evidence gained from the scientific method. Intermountain uses evidence-based medicine to create protocols that help physicians provide excellent clinical care without the variation and waste that reduce quality and increase costs.

F

Fee-for-service (FFS). The payment arrangement in which providers are paid after they provide services to patients. This arrangement is prevalent in the U.S. and tends to encourage unnecessary services because additional services result in additional payments.

G

Geographic committees. Groups of physicians and administrators that help Intermountain physicians provide care in a population health model. The committees support physician engagement, education, and communication efforts, as well as helping to track healthcare measurements for populations served by specific health plans.

H

Health literacy. (Healthy People 2030 definitions of personal and organizational health literacy):

> Personal health literacy: The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
> Organizational health literacy: The degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Health pathway. A standard framework for the development and organization of a compilation of care process models, analytical tools, care coordination services, and reporting solutions. The framework forms Intermountain's defined care standard and recommended operations flow for the treatment and management of a designated clinical condition across the entire care continuum.

Health risk assessments (HRAs). Questionnaires completed by individuals that identify their health status and health risks by gathering information related to medical history, demographics, lifestyle, and attitudes. The questionnaire can be used to provide healthcare advice to a patient.

Health savings accounts (HSAs). Medical savings accounts for people enrolled in high-deductible health plans (HDHPs). HSA funds are not taxable income and can be used to pay for qualified medical expenses. HSAs are owned by individuals and encourage people to save for future healthcare expenses.

High-deductible health plan (HDHP). A health insurance plan with a higher deductible than a traditional plan. The higher deductible (typically $1000–$5000 for individuals) allows the plan to offer lower premiums. An individual enrolled in an HSA must also be enrolled in an HDHP.

Hot-spotting. Identifying patients in special need of care management or geographic or clinical areas of higher-than-normal utilization.

I

Institute for Healthcare Improvement (IHI). A Cambridge, Massachusetts organization founded in 1991 with the mission to foster continual healthcare improvement. The IHI defined the Triple Aim goals of population health, care quality, and cost management.

Institute of Medicine (IOM). An independent, not-for-profit organization that provides unbiased health policy advice to policymakers and the public. Part of the National Academies, the IOM was founded in 1970 and is funded by the U.S. government. In 1998, an IOM committee defined three major categories of substandard care: overuse, underuse, and misuse.

International Statistical Classification of Diseases and Related Health Problems (ICD).
A code set created by the World Health Organization that classifies medical conditions such as symptoms, illnesses, diseases, and causes of injuries. The tenth edition, the ICD-10, was implemented in 2014.

L

LiVe Well. Intermountain programs for prevention, wellness, and care management offered to patients, health plan members, consumers, and employees.

M

Medicaid product. A managed Medicaid plan called Select Health Community Care that covers medical and pharmacy services. The plan is available to Utah Medicaid members in Weber, Davis, Salt Lake, and Utah counties. The Utah Department of Health Medicaid program provides mental health, dental, long-term care, transportation, and chiropractic services.

Medical home. A concept that places the patient at the center of a team of caregivers, typically led by the patient's primary care physician. The Intermountain implementation of medical home is called Personalized Primary Care, offered by Intermountain Clinics. Select Health supports Personalized Primary Care at affiliated physician clinics.

Medicare Advantage. Privately operated plans licensed by the federal government for Medicare-eligible enrollees. These plans are alternatives to the public Medicare health insurance program and offer certain advantages to patients. Select Health Advantage plans are available in Utah and Idaho.

Mental health integration (MHI). Part of Intermountain's Personalized Primary Care program, MHI delivers evidence-based care and improved outcomes to patients with mental and behavioral health needs. MHI helps primary care and mental health providers to collaborate on prevention and early diagnosis, integration of care processes, enhancement of information systems and reporting methods, and partnerships with community resources.

Misuse. Using healthcare resources in ways that negatively affect clinical quality and patient safety. One of the categories of substandard care identified by the Institute of Medicine.

O

Overuse. Providing unnecessary tests or treatments to patients that may be ineffective or harmful. Also referred to as overtreatment, overuse is one of the categories of substandard care identified by the Institute of Medicine.

P

Patient engagement. Engaging patients more effectively in optimizing their health, minimizing health risks, choosing appropriate treatment options, and complying with treatment plans. Intermountain patient engagement programs include Shared Decision-Making and LiVe Well.

Patient Protection and Affordable Care Act (PPACA or ACA). Informally known as "Obamacare," this legislation enacted in 2010 is considered to be the most far-reaching health care reform since Medicare and Medicaid were created in 1965.

Payers. Organizations that pay for healthcare including insurance companies, businesses paying for employee healthcare, and government health insurance programs. Payers may be private (non-government) or public (government).

Persistency. A chronic Hierarchical Condition Category (HCC) accepted by CMS in both 2018 and 2019. HCC means that a patient with a documented and accepted chronic illness in 2018 has the same documented and accepted chronic illness in 2019.

Personalized primary care. Intermountain's version of the patient-centered medical home concept in which a patient's care is coordinated by the primary care physician and clinic staff.

Physician payment model. A payment model for physicians participating in risk-sharing networks that continues to pay for volume of care along with rewarding quality, patient experience, and management of the overall cost of care.

Population health. A healthcare delivery model based on value that compensates providers for using evidence-based care, enhancing the patient experience, and helping patients maintain better health. In this model, providers are prepaid for caring for a population for a fixed time, with measures to ensure high-quality outcomes.

Population health management. Managing the health of a defined population. In accountable care, providers assume financial risk for the health status and care outcomes of the population.

Population health operations committees. Committees that help manage the health and medical costs of populations covered by health insurance products.

Promoting health. Enhancements to prevention, wellness, and care management programs that help manage the need and demand for healthcare. These programs include weight management, fitness, smoking cessation, mental and behavioral health, and care management for chronic conditions. In addition, improved benefit design encourages patients to take greater responsibility for their health.

Providers. People and organizations that provide care to patients including hospitals, physicians, physician clinics, and advance practice professionals.

R

Risk. In accountable care, assuming the financial risk for the health management of a defined population.

S

Scientific method. A four-step process that uses a combination of deductive and inductive reasoning:

- Defining a problem and hypotheses.
- Collecting data through observation and experimentation.
- Testing the hypothesis.
- Revising the hypothesis.

Select Health Share®. Select Health's first commercial health plan product based on Intermountain's population health principles. Offered to large employers since January 2016, the plan includes a three-year contract with guaranteed premium rates. Under the plan, Select Health provides a budget to Intermountain for the ongoing health and clinical outcomes of plan members. Services are provided by Intermountain hospitals and physicians in the shared accountability network, who have agreed to commitments designed to improve quality, enhance the patient experience, and manage costs.

Shared accountability. Intermountain Healthcare's approach to achieving population health and helping people live the healthiest lives possible. In this model, healthcare providers, payers, and consumers collaborate to achieve better health, better care, and more affordable costs. There are three strategies for achieving these goals:

- Evidence-based care
- Patient engagement
- Aligning financial incentives for healthcare stakeholders

Shared accountability advocates. Planners and communications professionals that promote shared accountability, make presentations, answer questions, and provide access to resources.

Shared commitments. A contractual agreement with providers who participate in Intermountain's shared-risk networks to support a high-value healthcare delivery model. The commitments focus on:

- Clinical excellence, integration, and improvement.
- Patient access.
- Accountability, operational commitment, and mutual respect.

Shared decision-making. A collaborative process involving the sharing of relevant, evidence-based information on treatment options, eliciting informed patient preferences, and ensuring that these preferences are integrated into treatment choices and care plans. Patient benefits of this process include:

- Higher patient satisfaction.
- Greater compliance with treatment plans.
- Improved clinician efficiency.
- Appropriate use of health resources.

T

Teleservices. A growing field of medicine in which healthcare is provided via electronic communication channels that allow the caregiver to be physically remote from the patient.

Transparency. Providing access to information about clinical outcomes, service, and costs to providers, patients, and other healthcare consumers. Improving transparency builds trust with patients and helps them make more informed decisions.

Triple Aim. A concept developed by the Institute for Healthcare Improvement (IHI) that defines three goals for healthcare:

- Improve the health of the defined population.
- Enhance the patient care experience (including quality, access, and reliability).
- Control or reduce cost increases.

U

Underuse. Failure to provide care that would be beneficial to patients. Also referred to as undertreatment, underuse is one of the categories of substandard care identified by the Institute of Medicine.

Utilization. Considered the main driver of healthcare spending, utilization refers to the amount of healthcare services and products used. In population health, there are typically two types of utilization:

- Population utilization: The number of health episodes per patient.
- Intracase utilization: The number of processes used within each health episode.

Utilization management (UM). Evaluation of the medical necessity, appropriateness, and efficiency of healthcare services, procedures, and facilities under applicable evidence-based standards, conditions of participation, or compliance requirements. Management techniques may include a utilization review, a retrospective evaluation of whether care was provided appropriately.

V

Value. Generally defined as the ratio of benefits to costs (value = benefits/costs). In accountable care, the fee-for-value model means providers have an incentive to maximize benefits while minimizing costs.