Definitions

Access
The ability to obtain needed medical care. Access to care is affected by insurance coverage, availability of providers, and the cost of care (Colorado Health Institute, 2013).

Affordable Care Act (ACA)
Passed 2010, this federal law contains several provisions for care coordination. The overall intent of the law is to is to facilitate access to quality, cost-effective care for all Americans. Care coordination is considered a strategy to attain this goal.

Accountable Care Collaborative (ACC)
A Colorado Medicaid program predating the ACA to improve Medicaid enrollees' health while reducing health care costs. Evolved out of a Colorado budget item, passed by the legislature in 2009. The program is built on three pillars: Regional Care Collaborative Organizations (RCCOs), Primary Care Medical Providers (PCMPs), and Statewide Data and Analytics Contractor (SDAC). The payment structure is fee-for-service and member-per-month payments. Additional bonuses can be achieved by meeting community-wide performance goals.

Accountable Care Organization (ACO)
Network of providers who work closely together to care for Medicare beneficiaries. Group works shares goals, coordinates care, and shares incentives for keeping system costs low. Sometimes called a health neighborhood. Incorporated primary care medical home model.

Acute Care
Short-term medical care for immediate illness or injury, also called episodic care. In contrast to chronic care management.

All-Payer Claims Database
A data warehouse of claims information from health plans in Colorado, managed by the Center of Improving Value in Health Care (CIVHC). Data sources are private, commercial, for-profit, and non-profit health plans, as well as Medicare and Medicaid.

Attribution

Match of a Medicaid enrollee with a primary care provider in a primary care medical home.

Bundled Payment

A single payment to a provider or group of providers for a specified episode or timeframe to deliver care for a patient.

Capitation

A prospective per member per month (PMPM) payment to provide services (in contrast to fee-for-service). This arrangement can be between purchasers (employer or the state) and a health plan or between a health plan and a provider. Capitation transfers financial risk.

Care Coordination (Current Consensus Definition)

"Care coordination is 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. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care*"* (McDonald et al., 2007).

Care Coordination (Working Definition)

Care coordination is the deliberate collaboration between participants involved in a patient's care to facilitate the appropriate delivery of health care services through information exchange and alignment of activities towards a shared goal.

Care Management

"*Care management* is a set of activities designed to assist patients and their support systems […] to improve patients' functional health status, enhance coordination of care, eliminate duplication of services, and reduce the need for expensive medical services" (Goodell, Bodenheimer, & Berry-Millet, 2009).

Case Management

Case management is a process of collaboration in the assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet individuals' and family's comprehensive health needs through communications and resources to promote quality, cost-effective outcomes (CSMA, 2014). Lamb (2014) adds clarification by describing case management as a "more intense version of care coordination" (p. 4).

Centers for Medicare & Medicaid Services (CMS)

This federal agency administers public insurance through Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Health Insurance Marketplace among other functions.

Chronic Care Management

Care for conditions lasting longer than 6 month (in contrast to acute or episodic care). Management of chronic conditions necessitates the involvement of a Primary care provider, the patient, and support services. Successful chronic care management relies on frequent communication, accurate information exchange among the health care team and coordination of services.

Community Health Workers

A.k.a health coaches, promotoras. Para-professionals trained to help patients make sound choices for better health. Community health workers often meet patients in their homes or neighborhoods, assist with shopping lists, physician appointments, filling prescriptions. Work under the motto, "never do anything for a patient that the patient can accomplish him or herself but help the client with real behavior change".

Discharge Planning

Discharge planning has been defined as developing an individualized discharge plan for the patient prior to leaving hospital, with the aim of containing costs and improving patient outcomes (Shepperd et al., 2013). This term is used in a narrow context in that it refers to institutional care only.

Patient Navigation

Patient navigation is a "process of helping patients to effectively and efficiently use the health care system when faced with one or more of these challenges: (1) choosing, understanding, and using health coverage or applying for assistance when uninsured; (2) choosing, using, and understanding different types of health providers and services; (3) making treatment decisions; and (4) managing care received by multiple providers" (U.S. Medical Library of Medicine, 2014). Parker et al. (2010) expand the conceptual definition of *patient navigation* by adding the social network and greater community as part the health care system.

Potentially Preventable Events

Hospital admissions, readmissions, and ED visits that could be avoided through appropriate and cost-effective care management (HCPF, 2012).

Transitional Care

Transitional care is a set of actions that are designed to ensure the coordination and continuity of health care to assist patients in their transfer between different locations or different levels of care within the same location (Colemna & Boult, 2003). According to the American Geriatric Society, *transitional care* refers to "a range of time-limited services […and] addresses the needs of patients during an acute episode of illness and complements high-quality primary or chronic care management" (Naylor, Feldman, Keating, Koren, Kurztman, Maccoy, & Krakauer, 2009).

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