

Iowa Definitions Document

Term	Definition	Source
Accountable Care Organization	Organized groups of physicians, hospitals or other providers jointly accountable for caring for a defined patient population and can improve health care quality and efficiency. It is a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.	National Institute for Health Care Reform
Care Coordination	<p>A collaborative process that links children and families to services and resources in a coordinated manner to maximize the potential of children and provide them optimal health care. This process includes assessing, planning, implementing, and evaluating options and services to meet the child and family's individual needs. Care coordination is a vital component of the medical home. Building a sense of trust between families and the medical home and responding to their needs in a timely and coordinated manner is essential. Care coordination within a practice will:</p> <ul style="list-style-type: none"> • Facilitate access to services • Promote continuity of care • Promote families with support • Improve health, developmental, educational, vocational, psychosocial and functional outcomes • Maximize efficient and effective use of resources <p>Children and families with multiple needs and those that require multiple services, providers, and resources are examples of who needs care coordination. Examples of children and families with multiple needs and services include:</p> <ul style="list-style-type: none"> • New diagnosis and transition • School issues • Multiple specialty providers and frequent ER use • Unplanned inpatient admissions <p>Difficult psychosocial issues</p>	Medical Home Portal-Care Coordination, University of Utah, Department of Pediatrics. http://www.medicalhomeportal.org/clinical/practice/building-a-medical-home/care-coordination
Care Management	Care management addresses the programmatic and preventive service needs of a population. Care management is outcome-focused and monitors the population and service delivery system using data. Care management programs apply systems, incentives, and information to improve care and assist recipients and their system to become engaged in a collaborative process designed to manage medical/social/behavioral health conditions more effectively. This position is normal at a Registered Nurse level.	NC Department of Health and Human Services
Case Management	Case management is an activity that assists recipients in gaining access to necessary care and medical, behavioral, social, and other services appropriate to their needs. Case management should be individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused. The functions of case management include assessment, care planning, referral/linkage, and monitoring/follow up.	NC Department of Health and Human Services
Chronic Care	Health care services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.	HF 2539
Chronic Care Management	A system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the health care professional and patient relationship, and a chronic care plan emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.	HF 2539

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Chronic Care Plan	A plan of care between an individual and the individual's principal health care professional that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage the patient in the patient's own care and in clinical, social, or other interventions designed to minimize the negative effects of the chronic condition.	HF 2539
Chronic Disease	An established clinical condition that is expected to last a year or more and that requires ongoing clinical management. Chronic diseases are also known to be ongoing physical and mental conditions, such as diabetes, heart disease, cancer, asthma, and mental illness which may limit activities of daily living. They are often preventable and frequently manageable through early detection, improved diet, exercise, and treatment therapy.	HF 2539
Community Utility	A service offered in a community and is linked to patients through a patient-centered medical home. The medical home community utility concept follows the same logic as a public utility. It is a service that is provided to the community that everyone contributes to and everyone benefits from, and is something that cannot be accomplished efficiently or effectively alone, similar to electricity, water, and public transportation. A community utility is located in a central setting where there are navigators and experts on the available resources in a community. It is important to understand that medical home community utilities vary greatly, and every community in Iowa will have different resources available.	Community Utility Issue Brief (Iowa defined)
Health Coach	Health coaches guide others to address their health and, if need be, make behavioral changes to improve health. Health coaches also oversee the disease registry database, conduct pre-visit chart review, work with patients and families on self-management support, coordinate care across the care continuum, and are involved in quality improvement activities.	Mercy Clinics
Health Risk Assessment	Screening by a health care professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.	HF 2539
Medical home	<p>A team approach to providing health care that:</p> <ul style="list-style-type: none"> • originates in a primary care setting; • fosters a partnership among the patient, the personal provider, other health care professionals, and the patient's family when appropriate; • utilizes the partnership to access all medical and non-medical health-related services needed by the patient and family to achieve maximum health potential; and • maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and • includes the following characteristics: a personal provider; a provider-directed medical practice; whole person orientation; coordination and integration of care; quality and safety; enhanced access to health care; and payment. <p>The medical home system will strive to:</p> <ul style="list-style-type: none"> • reduce disparities in health care access, service delivery, and health status; • improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage within a sustainable health care system; and • provide a pragmatic method to document that each Iowan has access to health care. 	HF 2539
Primary Care	Health care which emphasizes providing for a patient's general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified.	HF 2539