



## Glossary: Healthcare Quality

Quality measurement is integral to achieving the triple aim of effective care, affordable care and healthy communities in the U.S. Hub tools such as this glossary can help you navigate this complex topic.

Term	Acronym	Definition
<b>Activities of Daily Living</b>	ADLs	Activities people tend to do every day with little or no assistance. The six basic ADLs are: eating, bathing, dressing, toileting, walking, and continence.
<b>Adverse Event</b>	AE	Unintended physical injury resulting from or contributed to by medical care (includes the absence of indicated treatment) that requires additional monitoring, treatment, or hospitalization or that results in death.
<b>Clinical Practice Guideline</b>	CPG	Standard of care based on current, high-quality evidence that outlines the recommended course of care. Also called Evidence-Based Medicine (EBM)
<b>Consumer Assessment of Health-care Providers and Systems</b>	CAHPS	A series of patient surveys rating health care experiences. The key aspects of CAHPS surveys are: nurse communication, doctor communication, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of environment, quietness of environment, overall rating and willingness to recommend.
<b>Diagnostic Errors</b>		Error or delay in diagnosis; failure to employ indicated tests; use of outmoded tests or therapy; failure to act on results of monitoring or testing.
<b><u>FDA's MedWatch</u></b>		This program has responsibility to oversee the safety and effectiveness of prescription drugs. This reporting system is also the place to report medical device-related adverse events and problems.
<b>Healthcare-Acquired Infections</b>	HAI	Infections that are not associated with the reason for which a person went to the hospital or sought health care.
<b>Hospital Acquired Conditions</b>	HAC	Conditions which occur in the hospital, cause injury to patients and could reasonably have been prevented through the application of evidence-based guidelines. Defined by CMS and are used by public and private payers in hospital reimbursement.
<b>Hospital Inpatient Quality Reporting Program</b>	Hospital IQR	A pay for quality reporting program which requires hospitals to submit data on quality of care provided in inpatient settings or receive a 2% reduction in their annual payment update.
<b>Hospital Outpatient Quality Reporting System</b>	Hospital OQR	A pay for quality reporting program which requires hospitals to submit data on quality of care provided in outpatient settings or receive a 2% reduction in their annual payment update.

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<b>Iatrogenic Harm</b>		Refers to when a patient acquires a new illness or is injured by services provided by medical provider. See <i>Medical Harm</i> .
<b>Medical Error</b>		An act of commission (doing something wrong) or omission (failing to do something right) leading to an undesirable outcome or significant potential for such an outcome.
<b>Medical Harm</b>		Unintended physical injury resulting from or contributed to by medical error or hospital acquired infection.
<b>Medication Errors</b>		A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.
<b>Morbidity</b>		How frequently a condition or illness occurs in a given population.
<b>National Quality Forum</b>	NQF	A not-for-profit, membership-based organization that sets national priorities and goals for performance improvement and convenes experts to endorse national consensus standards.
<b>Never Events</b>		Preventable medical errors that should never occur, such as wrong-site surgeries or death or injury caused by a medication error. Many insurers no longer pay for the additional costs associated with these preventable errors. See <i>Serious Reportable Events</i> .
<b>Near Miss</b>		Any event that could have had adverse consequences but did not and was indistinguishable from fully fledged adverse events in all but outcome.
<b>Nosocomial Infections</b>		See <i>Healthcare-Acquired Infections</i>
<b>Patient Experience Measures</b>		The full range of patient interaction with the health care system from scheduling to interactions with providers. Often measured through CAHPS.
<b>Physician Quality Reporting System</b>	PQRS	Voluntary quality reporting program in which eligible professionals and group practices report quality of care information to Medicare.
<b>Potentially Avoidable Complication</b>	PAC	Any medical event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage the patient. As defined by Altarum, PACs include hospital-acquired conditions, patient safety indicators as enumerated by AHRQ, avoidable readmissions, healthcare-acquired infections; medication errors and more, to the extent this type of harm can be identified by claims data.

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Patient Reported Outcome	PRO	Any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else.
Patient Reported Outcomes Measurement Information Systems	PROMIS	A patient reported outcomes measurement tool that uses information technology, psychometrics, and qualitative, cognitive and health survey data of patient reported outcomes that have major impact on quality of life.
Patient Safety Indicator	PSI	The Patient Safety Indicators are a set of 26 indicators developed by the U.S. Agency for Healthcare Research and Quality to provide information on safety-related adverse events occurring in hospitals following operations, procedures, and childbirth.
Quality Adjusted Life Year	QALY	A generic measure of disease burden which includes both the quality and quantity of life lived. Used to assess the value of a medical intervention. A year in perfect health is considered equal to 1.0 QALY. The value of a year in ill health would be discounted.
Serious Reportable Event	SRE	Largely, if not entirely, preventable clinical events that cause serious patient harm designed to help access, measure and report performance in providing safe care. Universally defined terms created by the National Quality Forum (NQF). See <i>Never Events</i> .
Standard of Care		Care that is delivered in accordance with clinical practice guidelines or other evidence-based care protocols.