AHEAD Hospital Operations Assessment: Glossary

Governance, Leadership & Strategic Alignment

Accountable Care Organization (ACO): a group of doctors, hospitals, and other healthcare providers who voluntarily come together to deliver coordinated, high-quality care to their Medicare patients, with shared financial accountability for total cost and quality outcomes. Accountable Care Organizations (ACOs) | CMS

Bundled Payments: a payment model in which a single, predetermined payment covers all services related to a specific episode of care (e.g., a surgical procedure and recovery), incentivizing providers to coordinate care and reduce unnecessary utilization. Bundled Payments | CMS

Fee for Service (FFS): a traditional healthcare payment model in which providers are reimbursed separately for each individual service, procedure, or visit rendered, with payment volume directly tied to the quantity of services delivered rather than patient outcomes or quality. Finding Medicare Fee-For-Service (FFS) Payment System Rules: Schedules and Resources | Congress

Quality Incentives (QI): financial rewards or adjustments tied to a provider's performance on defined quality metrics, such as patient outcomes, safety indicators, readmission rates, or adherence to evidence-based care standards, intended to motivate and reward higher-quality care delivery.

Quality/Value-Based Initiatives: programs, contracts, or organizational efforts designed to improve healthcare quality outcomes while managing costs, often tying payment or performance incentives to measurable clinical and operational results. CMS Quality Initiatives Overview | CMS

Responsible, Accountable, Consulted, Informed (RACI) Matrix: a project management tool used to clarify team roles and responsibilities for specific tasks or deliverables. RACI and RASCI Definitions | IT@Cornell

Change Management & Strategic Planning

Fixed Payment Envelope: the total predetermined amount of funding allocated to a hospital or health system under a global budget or capitated payment arrangement; the envelope does not automatically increase with service volume, creating an incentive to manage utilization and invest in preventive care.

Global Budget: a prospective, fixed total spending target set for a defined population or health system over a specific time period, typically one year; under the AHEAD model, global budgets are established for participating hospitals to shift financial incentives away from volume and toward value and population health. AHEAD Model | CMS

Key Performance Indicators (KPIs): quantifiable measures used to evaluate progress toward defined strategic, operational, or clinical goals; in the AHEAD model context, KPIs often track cost trends, quality outcomes, access, and care coordination performance.

Project Management Office (PMO): a department that standardizes project management methods, tools, and governance to support project success and resource sharing across the organization.

State Directed Payments (SDPs, also known as DPPs): CMS has permitted states to establish SDPs that direct Medicaid managed care plans to enhance rates (up to average commercial rates) for hospitals and other providers; support systemwide, value-based payment reforms; and enhance care quality. State Directed Payment Programs | Georgia Department of Community Health

Technical Assistance (TA): structured support provided to participating organizations—such as training, coaching, data reporting tools, and expert consultation—to help them build the operational, analytical, and clinical capabilities needed to succeed under alternative payment models like AHEAD.

Workforce Capacity & Readiness

Allied Health: a broad category of healthcare professionals—distinct from physicians, nurses, and APPs—who provide diagnostic, therapeutic, and support services; includes roles such as physical therapists, respiratory therapists, radiologic technologists, medical laboratory scientists, dietitians, and social workers.

Advanced Practice Providers (APPs): a collective term for clinicians including Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Registered Nurse Anesthetists (CRNAs), and Certified Nurse Midwives (CNMs) who provide a broad range of clinical services, often serving as primary care providers in rural and underserved communities.

Behavioral Health (BH) Clinicians: licensed mental health and substance use disorder professionals including psychiatrists, psychologists, licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and certified addiction counselors. Behavioral Health Workforce | SAMHSA

Intensive Care Unit (ICU)/Specialty Nurses: registered nurses with advanced training and certifications in high-acuity or specialty areas such as intensive care, oncology, cardiovascular, or surgical nursing.

Population Health: an approach to healthcare that focuses on improving health outcomes across a defined group of individuals—accounting for social determinants, chronic disease burden, and disparities—by coordinating care, managing risk, and addressing upstream factors beyond clinical settings. Population Health | CDC

Registered Nurses (RNs): licensed clinical professionals who provide direct patient care, care coordination, patient education, and chronic disease management. Registered Nurse | U.S. Bureau of Labor Statistics

Rural-Specific Constraints & Assets

Alternative Payment Models (APMs): payment arrangements that move beyond traditional fee-for-service reimbursement by linking payment to quality, outcomes, or total cost of care; examples include ACOs, bundled payments, global budgets, and capitation; participation in advanced APMs may qualify clinicians for incentive payments under the Quality Payment Program. Alternative Payment Models | CMS QPP

Broadband Access: high-speed internet connectivity sufficient to support telehealth, health information exchange, EHR use, and remote patient monitoring; lack of adequate broadband in rural communities is a

major barrier to digital health adoption and care coordination under value-based models. Rural Broadband & Health | Rural Health Information Hub

Locum Tenens: a staffing arrangement in which temporary physicians or other licensed clinicians are contracted on a short-term basis to fill gaps in coverage at hospitals or practices; widely used in rural settings to maintain service continuity when permanent staff are unavailable.

Quality Measurement & Clinical Performance

CPT II and Z codes: supplemental billing codes used for quality tracking and documentation: CPT Category II codes are optional performance measurement codes that capture clinical actions (e.g., blood pressure screening, tobacco counseling) without driving reimbursement; ICD-10-CM Z codes document social determinants of health (SDOH) factors such as housing instability, food insecurity, and lack of transportation, supporting population health analytics and payer reporting.

Electronic Health Record (EHR): a digital version of a patient's medical history, maintained over time by the treating provider and designed to be shared securely across settings; EHRs support care coordination, quality measurement, clinical decision support, and data reporting required by value-based payment programs.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): a standardized, nationally administered survey of adult inpatients measuring their perspectives on hospital care; results are publicly reported and used in Medicare value-based purchasing programs to assess patient experience of care. HCAHPS: Patients' Perspectives of Care Survey | CMS

Quality Improvement (QI) Projects: structured, time-limited initiatives that use systematic methods—such as Plan-Do-Study-Act (PDSA) cycles—to identify gaps in care processes and implement measurable improvements in clinical outcomes, patient safety, or operational efficiency.

Clinical Care Transformation & Population Health

Full Care Continuum: the complete spectrum of health services available to a patient across all settings and stages of care—from prevention and primary care through acute inpatient care, post-acute and long-term care, behavioral health, and palliative care.

Medication Reconciliation: a formal clinical process of comparing a patient's current medication orders against all medications the patient has been taking—across all settings and prescribers—to identify and resolve discrepancies; a key patient safety intervention required at transitions of care (e.g., admission, discharge, transfer). Medication Reconciliation - Patient Safety and Quality | NCBI Bookshelf

Narrow Networks: a payer or plan design that limits the number of in-network providers significantly compared to broad-network plans, typically in exchange for lower premiums; used in managed care and ACO arrangements to concentrate volume with higher-performing providers and reduce total cost of care.

Omnichannel: a care delivery and patient engagement strategy that integrates multiple communication and access channels—including in-person visits, telehealth, patient portals, mobile apps, phone, and text—into a seamless, coordinated experience for the patient, regardless of where or how they engage with the health system. An Overview of Omnichannel Interaction in Health Care Services - PMC

Point of Care Alerts: real-time clinical decision support notifications delivered within an EHR or care management platform at the moment of clinical interaction, prompting providers to take specific evidence-based actions such as ordering preventive screenings, reconciling medications, or closing care gaps.

Preferred Networks: a defined group of providers—physicians, specialists, hospitals, and ancillary services—with whom a payer or health system has established contracts offering lower cost-sharing for covered members; in value-based models, preferred networks are used to direct patients toward higher-quality, lower-cost care options.

Behavioral Health & Health-Related Social Needs

Non-Hospital Partnerships: formal or informal collaborative relationships between hospitals and external organizations—such as Federally Qualified Health Centers (FQHCs), community mental health centers, substance use treatment programs, social service agencies, and faith-based organizations—to extend care access, address social needs, and coordinate services outside the hospital setting.

Referral Agreements: documented contractual or operational arrangements between healthcare organizations establishing the terms, responsibilities, and processes for referring patients to specific providers or programs; in the AHEAD context, referral agreements with behavioral health, substance use, and social services organizations are essential for closing care gaps and addressing SDOH.

Community & Regional Collaboration

Admit, Discharge, Transfer (ADT) feed: a real-time electronic stream of patient data from a hospital's EHR system, alerting providers and care teams immediately when a patient's care status changes.

Community-Based Organization (CBO): a local, typically nonprofit or non-governmental entity driven by community residents to address specific local needs, such as food insecurity, housing, education, or healthcare.

Community Health Needs Assessment (CHNA): a systematic process used by non-profit hospitals to identify and analyze the health needs, gaps, and resources of their communities. Community Health Needs Assessment | IRS

Community Health Workers (CHWs): trusted frontline public health professionals who bridge the gap between healthcare/social services and the community.

Health Information Exchange (HIE): the electronic, secure sharing of patient medical records and health information between different healthcare organizations, such as hospitals, clinics, labs, and pharmacies. Health Information Exchange | Medicaid

Medicaid Alignment & State Policy Readiness

Alternative Payment Models (APMs): payment arrangements that move beyond traditional fee-for-service reimbursement by linking payment to quality, outcomes, or total cost of care; in the Medicaid context, state-specific APMs may include managed care value-based purchasing, directed payment programs, and Medicaid Delivery System Reform Incentive Payment (DSRIP)/transformation waivers.

See also: Alternative Payment Models under Rural-Specific Constraints & Assets. Medicaid Alternative Payment Models | CMS

Payer Alignment Workgroup: a collaborative body convening multiple payers—including Medicare, Medicaid, and commercial insurers—along with providers and state agencies to align payment methodologies, quality measures, and data standards; under the AHEAD model, multi-payer alignment workgroups are central to achieving coherent total cost of care targets and reducing conflicting incentives across payers. Multi-Payer Alignment | CMS AHEAD

State Directed Payments (SDPs): CMS has permitted states to establish SDPs that direct Medicaid managed care plans to enhance rates (up to average commercial rates) for hospitals and other providers; support systemwide, value-based payment reforms; and enhance care quality. See also: SDPs under Change Management & Strategic Planning. State Directed Payment Programs | Georgia Department of Community Health

Payment Model Experience & Contracting Capacity

Accountable Care Organization (ACO): a group of doctors, hospitals, and other healthcare providers who voluntarily come together to deliver coordinated, high-quality care to their Medicare patients, with shared financial accountability for total cost and quality outcomes. See also: ACO under Governance, Leadership & Strategic Alignment. Accountable Care and Accountable Care Organizations | CMS

Bundled Payments for Care Improvement / BPCI Advanced (BPCI/BPCI-A): CMS episode-based payment models in which a single, retrospective or prospective bundled payment covers a defined clinical episode (e.g., joint replacement, sepsis, cardiac care); BPCI-A is an Advanced APM qualifying model that places participants at financial risk for total episode costs. BPCI Advanced | CMS

Clinically Integrated Network (CIN): a formal collaborative arrangement among otherwise independent physicians, hospitals, and other healthcare providers that jointly develop and implement programs to improve care quality and efficiency; CINs provide the organizational and contractual infrastructure for value-based contracting with payers.

Contractual Care Management Agreement with Primary Care Providers (PCPs): a formal written agreement between a hospital or health system and primary care physicians (PCPs) or practices that defines shared responsibilities, workflows, and expectations for care management activities—such as care transitions, chronic disease management, and high-risk patient outreach—often including financial arrangements tied to performance.

Contracted Partnerships with Community Based Organizations (CBOs) - housing, food security, behavioral health: formal agreements between hospitals or health systems and community-based organizations (CBOs) working in domains such as housing assistance, nutrition and food access, and behavioral health services; these partnerships operationalize non-clinical drivers of health interventions and are increasingly required or incentivized under value-based payment models.

Hospital Global Budgets (HGB): a budget methodology that establishes fixed annual spending budgets and can be population-based or facility-based. Hospital global budgets are designed to moderate cost growth while not penalizing hospitals for utilization reductions and offering providers greater funding flexibility for care delivery.

Merit-Based Incentive Payment System (MIPS): a CMS quality payment pathway for eligible clinicians under the Quality Payment Program that adjusts Medicare payments based on composite performance scores across four categories: Quality, Promoting Interoperability, Improvement Activities, and Cost. MIPS Overview | CMS QPP

MSSP - Upside Only (Medicare Shared Savings Program – Track 1 / Basic Track, Levels A–C): an ACO participation track in which providers share in a portion of savings generated below the benchmark but bear no financial risk for losses; designed as an entry point for organizations new to risk-based contracting. Shared Savings Program | CMS

MSSP - Two-Sided Risk (Medicare Shared Savings Program – Enhanced Track / Basic Track Levels D–E): an ACO participation track in which providers share in savings and also bear responsibility for a portion of losses if spending exceeds the benchmark; required for organizations seeking to qualify as an Advanced APM under the Quality Payment Program. Medicare Shared Savings Program | CMS

Pay-for-Performance: a payment approach that ties a portion of provider reimbursement to achievement of defined quality, efficiency, or outcome benchmarks; providers meeting or exceeding targets receive bonus payments or avoid penalties, creating financial incentives aligned with higher-value care. Pay for performance for hospitals | NIH

Primary Care Per Member Per Month (PMPM): a prospective, capitated payment made on a monthly basis to a primary care practice for each attributed patient, intended to cover the costs of comprehensive primary care services; shifts payment from volume to the ongoing relationship and management of a patient's health, supporting investment in care management and population health infrastructure.

Shared Savings/Risk-Based Agreement: a contract between a payer and a provider organization (such as an ACO or CIN) that establishes a spending benchmark; if actual costs fall below the benchmark, the provider retains a share of the savings (shared savings); if costs exceed the benchmark, the provider is responsible for a portion of the excess (shared risk or downside risk).

Value-Based Care (VBC): a healthcare delivery and payment model that rewards providers based on patient health outcomes, quality of care, and cost efficiency. Value-Based Care | CMS

Health, Data & Analytics

Digital Subscriber Line (DSL): a modem technology that uses existing telephone lines to transport high-bandwidth data, such as multimedia and video, to service subscribers.

Electronic Clinical Quality Measure (eCQM): a standardized, logic-based quality measure expressed in a computable format that can be calculated directly from EHR data; eCQMs are used to automate quality reporting for programs such as the Inpatient Quality Reporting (IQR) program, the Hospital Value-Based Purchasing program, and state Medicaid quality initiatives. Electronic Clinical Quality Measures | CMS

Electronic Exchange: the secure, digital transmission of health information—including clinical records, lab results, imaging reports, and care summaries—between providers, payers, and patients using standardized protocols; foundational to care coordination, transitions of care management, and population health analytics under value-based models. Health Information Exchange | HealthIT.gov

Electronic Health Record (EHR): a longitudinal digital record of a patient's health information designed to be accessed and shared across multiple providers and care settings; supports care coordination, clinical decision support, quality measurement, and regulatory reporting. See also: EHR under Quality Measurement & Clinical Performance.

Electronic Medical Record (EMR): a digital record of a patient's health information used and maintained within a single provider organization or practice; unlike an EHR, an EMR is typically not designed for sharing outside the originating organization. The terms EMR and EHR are often used interchangeably, though EHR implies broader interoperability. EHR vs. EMR: What's the Difference? | HealthIT.gov

Fast Healthcare Interoperability Resources Application Programming Interfaces (FHIR APIs): modern, web-based data exchange interfaces built on the HL7 FHIR standard that enable secure, standardized access to patient health data across platforms; required under CMS interoperability rules and central to enabling patient access, payer-to-payer data exchange, and real-time analytics. FHIR Overview | HL7 International

Health Information Technology (HIT): the electronic systems used by healthcare professionals to share, store, and analyze health information.

Health Level Seven Interfaces (HL7 Interfaces): electronic integration protocols based on HL7 messaging standards (particularly HL7 v2) that enable different clinical and administrative systems—such as EHRs, lab systems, radiology platforms, and ADT systems—to exchange structured data in near real time. HL7 Standards | HL7 International

Quality Reporting Document Architecture (QRDA): an HL7 Clinical Document Architecture (CDA)-based XML document standard used to submit eCQM data to CMS and other entities; QRDA Category I files contain individual patient-level quality data, while QRDA Category III files contain aggregate measure results for a reporting period. QRDA Overview | eCQI Resource Center

Trusted Exchange Framework and Common Agreement (TEFCA): a CMS/Office of the National Coordinator for Health Information Technology (ONC) initiative establishing a common set of principles, terms, and technical requirements for nationwide health information exchange; TEFCA enables providers, payers, and patients to securely share data across networks using designated Qualified Health Information Networks (QHINs). TEFCA | HealthIT.gov