CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Glossary of Terms

Interactive CO APCD Statewide Reports (www.civhc.org)

GENERAL TERMS	
Data Vintage	The Data Vintage refers to the specific payers and associated number of members included in the CO APCD by year. The Data Vintage also includes any special conditions or caveats related to the data that users should keep in mind when reviewing and utilizing the data.
Statewide	CO APCD population residing in Colorado.
Urban	CO APCD population residing in Colorado counties that are part of a Metropolitan Statistical Area.[1]
Rural	CO APCD population residing in Colorado counties that are not part of a Metropolitan Statistical Area. This includes residents of counties referred to as "frontier" counties.[2]
Geographic Profile	Profiles refer to measures displayed for distinct geographical areas. Profiles are available for Colorado counties and Health Statistics Regions.
County	Counties are the primary legal divisions of most states. Colorado has 64 counties in total.
Health Statistics Regions (HSR)	Geographic areas representing a group of adjacent counties in Colorado, or, less frequently, a single county. HSRs were derived by the Colorado Department of Public Health and Environment in partnership with state and local public health officials.[3]
All Payers	All Payers represents all health insurance plans included in the CO APCD (See Data Vintage). As of September 1st, 2017, this includes Commercial (large group, small group, individual, non-ERISA self-insured and some ERISA self-insured plans), Medicaid (both managed and fee-for-service), and Medicare Advantage. **Although the CO APCD does contain Medicare Fee-for-Service claims, it is NOT currently reflected in the statewide public interactive reports. Plans are underway to include Medicare Fee-for-Service results in future updates.**
Commercial	Commercial insurers are health insurance companies that cover individuals (either through their employer or individually, or on behalf of an employer) outside of the state Medicaid and federal Medicare programs.
Medicaid	Medicaid, also known as Health First Colorado, is a state run health insurance program that provides free or low-cost health insurance to eligible individuals. Medicaid data on this website includes both fee-for-service and managed Medicaid claims from private insurers. For more information on CO APCD Medicaid data vs. Medicaid data made available through the Colorado Department of Health Care Policy and Financing, click here.

[1] Colorado Rural Health Center (2016). *Colorado: County Designations, 2016.* Retrieved from http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2016/03/2016.CountyDesignations.pdf on July 13, 2017.
[2] Colorado Rural Health Center (2016). *Colorado: County Designations, 2016.* Retrieved from http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2016/03/2016.CountyDesignations.pdf on July 13, 2017.
[3] http://www.chd.dphe.state.co.us/HealthDisparitiesProfiles/dispHealthProfiles.aspx

Medicare Advantage	Medicare is the federal health insurance program for people who are 65 or older, people entitled to Social Security disability payments for two years or more, and people with End-Stage Renal disease, regardless of income. Some Medicare members choose to receive coverage through a private entity or Medicare Advantage insurance carrier. Medicare Advantage (also known as Part C) offers an expanded set of options for receiving health care compared to the original Fee-For-Service (FFS) Medicare program, and may include additional benefits.
Per Member Per Year (PPPY)	Per Member Per Year is a standard measure of average health care spending during a particular year among members with at least one month of insurance coverage, weighted by the number of months of coverage.
Per 1,000 Members	Per 1,000 Members is a standard way to measure the utilization of health care services during a particular year among members with at least one month of insurance coverage, weighted by the number of months of coverage.
Percent Change from Previous Year	Percent Change from Previous Year measures the percent difference between the value of a measure in one reporting year and the value in the previous year. A negative value indicates a decrease, a positive value indicates an increase, and 0% indicates there was virtually no change from one year to the next.
Average Annual Percent Change Across Multiple Years	Average annual percent change measures the percent difference in the value of a measure from one year to the next observed over multiple years. For example, the average percent change from 2012 to 2015 would be determined by averaging the observed percent changes from 2012-2013, 2013-2014, and 2014-2015.
Ratio to State Median	Ratio to State Median is constructed by dividing a county or HSR median value by the overall state median value. A ratio below 1.0 means that the county or HSR value is lower than the state median, and a ratio above 1.0 means that the county or HSR value is higher. For example, 0.85 reflects a value that is 15% below the state median whereas 1.15 reflects a value that is 15% above. A value of 1.0 means that the county or HSR value is not different from the state median.
COST OF CARE REPORT	
Cost	Cost, or Cost of Care, represents the amount (in dollars) that patients and health insurance plans paid (allowed amounts) to providers for health care services utilized during a particular year. The patient portion includes the amount of copays, deductibles and coinsurance due for the services used. However, the patient portion does not reflect what the individual actually paid, nor does it include any health insurance premiums paid by the patient or employer. Cost of Care is a measure of average spending Per Person Per Year and is displayed based on where a patient lives, not where they received care.
Who's Paying	Refers to a set of three standard cost measures reflecting who is paying what portion of the bill: Health Plan Cost, Patient Cost, and Health Plan and Patient Cost.
Health Plan Cost	The amount of dollars paid solely by the payer or health insurance plan, calculated Per Person Per Year (PPPY).
Patient Cost	The amount of dollars for which the patient is responsible, also known as "out-of-pocket" cost, calculated Per Member Per Year (PPPY). This includes all copay, deductible and coinsurance amounts identified as the patient's responsibility by the health insurance plan. It reflects what the patient owes, but may not always reflect the actual amounts paid by the patient.
Health Plan and Patient Cost	The combined dollar amount of Health Plan Cost and Patient Cost, calculated Per Member Per Year (PPPY).
Inpatient Services	Inpatient services refer to health care services received while admitted to a hospital, skilled nursing facility or another institution offering inpatient services.
Outpatient Services	Outpatient services are health care services received in a facility setting such as a hospital or clinic without being admitted.

Professional Services	Professional services are services delivered by a physician or other health care professional, such as a nurse practitioner, chiropractor, psychiatrist, or oncologist, received either in an inpatient (hospital) or outpatient (non-hospital) setting.
Pharmacy Services	Pharmacy services refer to prescriptions for generic or brand name medications that were filled by a pharmacy and paid for through a health insurance plan. CO APCD reported costs for Pharmacy Services do not include any rebates, discounts or other payments made by pharmaceutical companies to payers after prescription fulfillment.
CONDITION PREVALENCE	
Prevalence	Condition prevalence describes the percentage of individuals identified with a specific condition as determined by the Johns Hopkins Expanded Diagnosis Clusters (EDCs), a module of the Adjusted Clinical Groups (ACG) System software. Prevalence for a specific condition is calculated based on the number of individuals receiving one or more services related to that diagnosis, divided by the total number of eligible individuals. For more details, please refer to the methodology document.
Diabetes Type 1	Count of patients with a Diabetes Type I diagnosis divided by the total eligible population in the relevant geographic area.
Diabetes Type 2	Count of patients with a Diabetes Type II diagnosis divided by the total eligible population in the relevant geographic area.
Asthma	Count of patients with an Asthma diagnosis divided by the Total Eligible Population in the relevant geographic area.
Breast Cancer	Count of patients with a Breast Cancer diagnosis divided by the Total Eligible Population in the relevant geographic area.
Colorectal Cancer	Count of patients with a Colorectal Cancer diagnosis divided by the Total Eligible Population in the relevant geographic area.
Lung Cancer	Count of patients with a Lung Cancer diagnosis divided by the Total Eligible Population in the relevant geographic area.
Cervical Cancer	Count of patients with a Cervical Cancer diagnosis divided by the Total Eligible Population in the relevant geographic area.
Congestive Heart Failure	Count of patients with a Congestive Heart Failure diagnosis divided by the Total Eligible Population in the relevant geographic area.
Chronic Obstructive Pulmonary Disease (COPD)	Count of patients with a COPD diagnosis divided by the Total Eligible Population in the relevant geographic area.
Depression	Count of patients with a Depression diagnosis divided by the Total Eligible Population in the relevant geographic area.
Hypertension	Count of patients with a Hypertension diagnosis divided by the Total Eligible Population in the relevant geographic area.
UTILIZATION	
Utilization	Utilization rates measure the use of specific health care services, and are calculated as a rate per 1,000 people.
Unplanned Hospitalizations	Inpatient hospitalizations are unanticipated acute care inpatient hospitalization stays; not including anticipated admissions with a primary discharge diagnosis for things such as pregnancy and delivery, newborn, or injuries (except for complications of surgical and medical care); also not including definitively planned admissions, such as admissions for rehabilitation services, chemotherapy, transplants, or potentially planned admissions, such as those for common surgical procedures (e.g., hip replacements), cardiovascular procedures, or other surgical treatments that have no indication of acute complications.
Inpatient 30-Day Readmissions	Admissions to a hospital within 30 days after discharge for any reason (all cause). Includes planned and unplanned inpatient hospitalizations.
Outpatient Visits	Visits to an ambulatory care setting such as a physician office, urgent care or clinic. Includes outpatient services performed in hospital-owned facilities, but does not include Emergency Room visits.

Emergency Room Visits	Emergency Room visits are instances where care is provided in an emergency room setting (Free-Standing or Hospital-based). Includes visits with at least one emergency room revenue code, procedure code or place of service code, but does not include emergency room visits that result in an inpatient hospital stay in the same period.
Observation Stays	Observation stays are hospital visits where a person is kept for evaluation and medical services but not admitted to the hospital. Does not include observation stays that were part of Emergency Room visits or outpatient surgeries.
Professional Claims	Claims for services delivered by a physician or other health care professional, such as a nurse practitioner, chiropractor, psychiatrist, or oncologist, and are received in either an inpatient, outpatient or medical office health care setting.
Management Visits	A subset of all professional claims, these are face-to-face visits with a provider with an eligible specialty. Some specialty examples include Family Medicine, Pediatrics, Obstetrics & Gynecology, Ophthalmology, Urology, Psychiatry and Neurology, Orthopedic Surgery, Plastic Surgery, Nurse Practitioner. Refer to methodology notes for more details.
Pharmacy Scripts, All	Prescriptions filled for a generic or brand medication, including refills.
Pharmacy Scripts, Generic Only	A subset of the overall pharmacy scripts category, these are prescriptions filled for a generic medication, including refills.
QUALITY MEASURES	
Appropriate Medication for Asthma	Percentage of patients 5 to 64 years old identified as having persistent asthma and appropriately prescribed medication (at least one asthma controller) during the previous year. For more details, please refer to the methodology document.
Breast Cancer Screening	Percentage of women 51 to 74 years old who had a mammogram to screen for breast cancer during the previous two years. For more details, please refer to the methodology document.
Cervical Cancer Screening	Percentage of women 21 to 64 years old with one or more screenings for cervical cancer during a defined period. For more details, please refer to the methodology document.
Colorectal Cancer Screening	Percentage of patients 50 to 75 years old who had one of three types of screening for colorectal cancer. For more details, please refer to the methodology document.
Diabetes A1c Screening	Percentage of patients with primary Diabetes Types I or II who received the HbA1c test in a clinical encounter during the previous year. For more details, please refer to the methodology document.