

Taking charge of your healthcare:
your path to being an empowered patient.

Glossary of terms

<http://www.patientsafety.org/page/transtoolkit/>

*This glossary includes words **selected by consumers** to help their peers understand terms related to transitions out of an inpatient care environment.*

Activities of Daily Living (ADL): The actions a person does regularly to manage her or his life. These activities can include eating, dressing, bathing, using the bathroom, working or going to school, keeping one's home in order, managing money, transportation, and enjoyable activities.

Acute Illness: Illness or injury that lasts a short time.

Advance Directive: A legal document that tells your choices about the health care you would or would not want if you became unable to decide for yourself. An advance directive comes in two forms:

- A Power of Attorney for Health Care allows you to make choices about future care and appoint another person as your "health care agent" to make sure your wishes are carried out. Health care agents do not handle your financial decisions unless you appoint them to do so in a separate document.
- A Living Will allows you to make choices about your future care, but does not give anyone else the right to make health care decisions on your behalf.

Care Coordination / Case Management: A process that usually includes assessing a patient's needs, goals, and abilities; creating and carrying out a plan of care; and evaluating the patient's response to the plan of care.

Caregivers: Family, friends, partners or neighbors who provide needed services to the patient to assist in their comfort and help them manage their activities of daily living. Caregivers may provide physical, emotional, and financial help to people living with illness or disability (short-term or long-term). This may include providing personal care, carrying out medical procedures, managing a household, and interacting with the health care and social service systems on another's behalf.

Chronic Illness: Illness that lasts a long time or throughout a person's life. Chronic illnesses can be diagnosed in both children and adults and can often be managed with a variety of treatments.

Clinicians: Health professionals who care for patients including physicians, nurses, social workers, pharmacists, physician assistants, dietitians, physical therapists, speech therapists, and occupational therapists.

Disability: The inability to take care of oneself, do paid or volunteer work, go to school, or do other important activities because of physical, social or mental problems. Disabilities may last a short or long time.

Discharge: Process of leaving a hospital, rehabilitation facility, or other inpatient health care setting.

Discharge Planning: The process used by a social worker or other clinician to help patients move from one level of care to another, such as from a hospital to home. Discharge planning can include helping patients/clients get medical equipment, setting up home health care, and finding services in the community.

Electronic Medical Record: a computerized file in which clinicians record care and services they provide to patients. Because each health care organization (such as a hospital or a physician's office) or system (such as an insurance company) may have its own electronic medical record, patients may need to repeat information or confirm whether information is correct in the record at each location.

Evidence-based Medicine (EBM): Medical treatments which have been shown by high-quality, published research to have the best results. EBM is practiced by clinicians to give each patient the most effective care and treatment possible, based on national standards and up-to-date medical research.

Family Caregiver: a person who provides physical, emotional, or financial assistance to a relative or friend who is ill, elderly, or living with a disability. This may include providing personal care, carrying out medical procedures, managing a household, and interacting with the health care and social service systems on another's behalf.

Health Care Provider: Members of the treatment team. The group can include medical, holistic health and behavioral health professionals and other appropriately-trained individuals. A list of types of providers for their role is available via the [links section](#) of the toolkit.

HIPAA (Health Insurance Portability Accountability Act): This law makes it easier for people who lose or change jobs to get health care insurance and good insurance coverage for themselves and their family members, even if they or their family members had medical conditions before they change insurance plans (pre-existing conditions). The law also reaffirms the right of a patient to their health record and protects patient privacy by preventing health plans and providers from misusing personal health records (such as by sharing them with a patient employer).

Hospice Care: Supportive care of a terminally ill patient that can be provided at home, in residential or nursing facilities, and in the hospital. The goal of hospice care is not to cure the illness but to make people as comfortable as possible, physically, emotionally, and spiritually. Its literal meaning is "a place of shelter."

Hospitalist: Doctor who directs the general medical care and treatment of hospitalized patients.

Life-limiting Illness / Terminal Illness: A severe illness that is expected to get worse and to end the life of the patient.

Living Will: A document that records the type of care a person wants (or does not want) to receive in case of serious illness or at the end of life. Living wills do not address decisions regarding property or other valuables.

Long-term Care Insurance: Insurance that may cover the cost of personal care and other services given at home, in a nursing home, or in other settings when the insured person has a chronic disability or a long illness.

Medicaid: A program, funded by state and federal governments, that pays for certain health services, nursing home care, and (in most states) long-term care services provided at home or in the community. The program serves people with low incomes and limited savings or valuables, though who can receive services and which services are covered varies from state to state. Most often, eligibility is based on a patient's income and personal resources.

Medicare: A federal health insurance program for people who have chronic disabilities or are 65 or older.

Medical Error: Any preventable event (such as a mistake related to medication, a mistake in diagnosing or treating a condition, or a problem with medical equipment) that may cause or lead to unintended outcome or patient harm.

Palliative Care: Any form of care designed to relieve pain or side effects of treatment and improve quality of life.

Pain Intensity Scale: A communication tool to help patients explain the pain they are experiencing using pictures or other standard terms. A resource to help define and describe pain is available in the [links section](#) of the toolkit.

Patient and Family-Centered Care: An innovative approach to health care that is grounded in effective partnerships among health care patients, families, and providers. Patient- and family-centered care applies to patients of all ages, and it may be practiced in any health care setting.

Personal Health Record: A record patients can use to keep track of their health care experiences, diagnoses, medications, tests, and other health care services.

Quality of Care: Assessment of patient outcomes, which may include review for use of recommended guidelines and evidence-based practices as basis of plan for care.

Social Worker: A professional who can identify resources to help individuals, families, groups, and communities cope with social and emotional factors affecting their health and well-being.

Transitions of Care: The process of a patient leaving one care setting (such as a hospital, nursing home, assisted living facility, skilled nursing facility, primary care physician, home health, or specialist) and moving to another setting or to the patient's home. The transition of care often involves multiple persons. Transitions of care affect not only the patient but also clinicians. A good transition should be well planned and allow enough time to go smoothly.