

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT HEALTHCARE





ABOUT

This glossary is designed to provide Rhode Island's older adults and caregivers with a clear explanation of some commonly used terms in healthcare.

You can refer to this glossary and take it to appointments to help guide and better understand conversations about your health, and more importantly, confidently make decisions about the care you receive.

WHERE DID THESE TERMS COME FROM?

The terms in this glossary were chosen based on the suggestions received from several focus groups conducted with senior centers throughout the State, along with Integra's staff members who interact with Rhode Island's seniors on a daily basis.

This glossary consists of three parts: the first section includes terms that have been deemed the most pertinent for Rhode Island's older adults or caregivers to understand and are commonly used during doctor visits and when discussing healthcare. These terms include multiple definitions in an effort to fully explain the elements associated with each term.

The next section is based on different types of care Rhode Island older adults may require based on their needs and desires.

The last section includes different terms that are commonly used when referring to senior health insurance plans.

THANK YOU

We want to extend our sincere thanks to Kathleen Mckeon, Age-Friendly Rhode Island and Taylor Ward, Rhode Island Primary Care Physicians Corporation, Rhode Island College Healthcare Administration Program, and Integra Community Connect for their diligence, hard work, and contribution in developing this glossary. We truly appreciate the time and effort everyone has put into making this healthcare glossary.

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SECTION I: WORDS IN GENERAL

WHAT IS INTEGRA?

Integra is a community of doctors, advanced practice providers, nurses, social workers, pharmacists, community health workers, and other healthcare professionals who work together to ensure members have everything they need to lead a healthy and happy life. Integra is a partnership with Care New England Health System, Rhode Island Primary Care Physicians Corporation, and South County Health. When you receive your care from an Integra doctor or provider, you benefit from a team-based approach to care.

In addition to the benefits of team-based care, Integra members also have access to a number of programs designed to keep them healthy. Our dedicated team of healthcare professionals can connect members to community resources like rides to your doctor, housing and food services, fitness and wellness programs, and provide health education to help manage chronic conditions.

Our list of Integra providers can be found at **www.IntegraCare.org**

ADVANCE DIRECTIVES

An advance directive is a term for any document that provides guidance on the types of treatment you would want in the event of an unforeseen medical emergency. An advance directive is meant to help you plan ahead and is only used if you are not able to make or express your healthcare wishes yourself. Each state defines what type of advance directive is legally binding, even though you don't need a lawyer to complete one of these forms.

There are several ways you can make your preferences known, depending on your health condition or prognosis. All of these tools are voluntary and can be modified by you upon your request. Advance directives only apply to health decisions and do not affect financial matters.

To be valid, the forms must be signed by you and two witnesses who are not bound by blood or marriage, know you personally, and can attest that you voluntarily signed the document in their presence.

You should provide your physicians and care teams with the most up-to-date copies of your advance directives.

ADVANCE DIRECTIVES CAN INCLUDE:

Durable Power of Attorney for Healthcare

A durable power of attorney for healthcare is a legally binding document where another person is named as an agent to make health care decisions for you in the event you become unable to make or communicate your healthcare decisions. A durable power of attorney for healthcare is typically used if you become incapacitated and unable to handle matters or make decisions on your own.

Living Will

A living will is a legally binding document that declares your wishes about withholding or withdrawing life-sustaining* measures in the event of a terminal condition and is only used if you are unable to make or communicate your health decisions. A living will can include any specific instructions you choose.

*A life-sustaining measure is any medical procedure that only prolongs the dying process. It does not include any procedure considered necessary to provide comfort, care, or alleviate pain.

Medical Orders for Life-Sustaining Treatment (MOLST)

A MOLST form is a legally binding document that states the type of medical treatment or interventions a person would want right now, based on their current diagnosis and prognosis. Adults with terminal illnesses who are at end-of-life should have a MOLST form in place. MOLST forms require your physician's signature and are typically made while conferring with your physician.

Do Not Resuscitate Order (DNR)

A DNR order is a medical order written by a doctor to instruct medical providers not to perform cardiopulmonary resuscitation (CPR) in the event of an emergency, should you stop breathing or your heart stops beating. A DNR order is only specific to CPR and does not provide instructions for any other life-sustaining treatments. A DNR order is written by your physician only after discussing with you or your healthcare proxy, if applicable. Typically, a DNR order is written when you are at end-of-life, have a terminal prognosis, or when CPR will be detrimental based on your physical condition.

While some of these options are legally binding in Rhode Island, you do not need an attorney to complete these forms.

Ask your healthcare provider for information on advance directives or go to **[Health.RI.gov/LifeStages/Death/About/AdvanceDirectives/](https://www.health.ri.gov/LifeStages/Death/About/AdvanceDirectives/)**



ANNUAL WELLNESS VISIT (AWV)

You may have noticed in recent years you have been invited to a wellness visit by your primary care physician.

An annual wellness visit, or annual wellness exam, is not the same as your annual physical. An annual physical is more extensive than a wellness visit. While an annual physical can include a full physical exam, bloodwork, and other tests, an annual wellness visit may just include things like checking your height, weight, and blood pressure. A wellness exam helps your doctor understand what's working for you and how to best support your continued well-being. It is a type of preventive care that is meant to be a two-way conversation between you and your healthcare provider. The purpose of this conversation is to discuss any of your concerns and get an update on your overall health. Wellness visits are intended to promote your overall health by reviewing any existing health issues you may have, identifying and mitigating any potential health risks, and connecting you to any resources or providers you may need. Instead of waiting until a health problem occurs, wellness visits allow your physician to make sure you're in good health and prevent any potential health issues from becoming problematic.

An annual wellness visit may not always be performed by your physician, but can sometimes also be done by a nurse, pharmacist, nurse practitioner, or physician assistant. Wellness visits are typically covered by your health insurance, especially if you have Medicare. However, not all expenses involved with the visit may be covered, such as certain lab work or tests. Most insurances cover one wellness visit per year and are separate from your annual physical or sick visits.

Because HIPAA* laws prevent physicians from sharing your information without your permission, it is important that you bring certain information to your annual wellness visit, especially if you see multiple providers.

To prepare for your wellness visit, you should bring:

- A list of all of your medications, including any vitamins, supplements or topical solutions or ointments
- The names of all of your healthcare providers, including doctors, pharmacists, therapists, home health agencies, and non-traditional providers
- Your immunization records, including flu, pneumonia, or COVID-19 shots
- Written questions or concerns you have about your health

Here are some potential things you can expect to happen at a wellness visit:

- Discussion about your health history, including your current diagnoses and any **comorbidities**
- Discussion about any advance directives you have in place
- Review of medications, immunizations, and any upcoming lab work
- Review of your healthcare team and any other doctors or specialists you may be seeing
- A **health risk assessment**
- Review of your **wellness schedule**

**HIPAA stands for Health Insurance Portability and Accountability Act. It is a federal law put in place to protect sensitive patient health information from disclosed without a patient's permission or knowledge.*

Activities of Daily Living (ADL's)

Activities of daily living is a term used in healthcare to refer to your daily self-care activities that are done on a day-to-day basis without assistance. Your ability to perform ADL's is typically used to help determine your medical status and long-term care need.

There are 6 activities of daily living:

- Eating, the ability to feed yourself
- Bathing, the ability to bathe/shower, brush your teeth, and groom yourself
- Dressing, the ability to dress/undress yourself
- Toileting, the ability to get to/from the toilet and clean yourself
- Mobility, the ability to stand, sit, walk, and transfer from one surface to another
- Continence, the ability to control your bladder and bowel functions

Body Mass Index (BMI)

Body mass index is a weight to height ratio used to indicate if you are underweight, normal weight, overweight, obese, or morbidly obese.

Comorbidities

A comorbidity is the presence of 2 or more medical conditions or diseases that occur simultaneously, especially when they interact with or affect each other.

Examples of comorbidities would be diabetes and hypertension, asthma and chronic obstructive pulmonary disease (COPD), or depression and anxiety.

Durable Medical Equipment (DME)

Durable medical equipment is any equipment that provides therapeutic benefit or an increase in quality of life to you due to a medical condition. It can be prescribed by a doctor and covered partially or in full by your insurance, or paid for out of pocket without a prescription, depending on the type of equipment needed.

A few examples of different durable medical equipment would be shower chairs, wheelchairs, walkers, oxygen concentrators, commodes, hospital beds, and prosthetics.

Health Risk Assessment

A health risk assessment is a screening tool that helps you and your provider identify and understand your health risks and monitor your health status over time. A health risk assessment typically includes a questionnaire, an assessment of health status, and personalized feedback about actions that can be taken to reduce risks, maintain health, and prevent disease.

A health risk assessment can include:

- Discussing your current diagnoses and comorbidities
- Checking your vital signs
- Checking your height, weight, and body mass index (BMI)
- A fall risk assessment and any durable medical equipment (DME) you may use
- Depression or cognitive screening
- Questions about your health habits and lifestyle choices, such as diet, exercise, smoking habits, alcohol consumption
- Your home safety and ability to perform activities of daily living (ADL's) such as bathing or toileting

Prescreening

Prescreening is any method used to detect potential health disorders or diseases, specifically when you do not have any symptoms of disease. The goal for prescreening is early detection in order to implement lifestyle changes or to implement disease surveillance, should you be at-risk. Screening tests are not considered diagnostic but are used to identify those who should have additional testing to determine the presence or absence of disease.

Wellness Schedule

A wellness schedule is a list of all of the screenings or **prescreenings** you should have during the next 5 to 10 years. These screenings can include things like prostate exams or mammograms. Many of these are screenings are free under Medicare. Medicare requires physicians to provide a wellness schedule to patients during their annual wellness visits.

PATIENT PORTAL

A patient portal is an app or website that allows you 24-hour password-protected access to your personal health information from your primary care doctor, specialists, or other healthcare providers. You can typically log into your portals from a computer, tablet, or smartphone.

You typically are granted access to a patient portal during an office visit with your respective provider, where your identity has already been verified. Access is free and you will need to set up an account and create a password to ensure your portal stays private and secure. Because many healthcare providers do not use the same patient portal, you may have a different portal with different log in information for each of your healthcare providers. If you have a child under 18 years old, you may also be given access to your child's patient portal too.



While not every patient portal is the same or has the same features, they are essentially online tools that can help you:

- Track provider visits
- View test or lab results
- Request prescription refills
- Make non-urgent appointments
- Update or view your insurance and contact information
- View your immunization records, allergies, diagnoses, or medications
- View upcoming or past appointments
- Make payments or view past payments and outstanding balances
- Ask your provider questions through secure email
- Complete medical forms
- View educational materials pertinent to you
- View medical records and visit summaries
- Receive reminders and alerts for upcoming appointments, lab work, or immunizations

Some portals even offer e-visits, where you can have an online visit with your doctor for minor issues, like rashes or small wounds. With e-visits, you can get a diagnosis, treatment, or even prescription all online while saving yourself a trip to your provider's office. But always remember, patient portals are for non-urgent issues. Should you have an urgent or time-sensitive issue, call your provider's office.

You can always request office visit notes through a formal record request.

If you are not enrolled in a patient portal, or are having difficulty using your patient portal, you may want to talk to your healthcare provider.

SOCIAL DETERMINANTS OF HEALTH (SDOH)

Social determinants of health are the economic and social conditions that influence the places you live, learn, work, and play. It's your social determinants of health, along with your individual health risk factors such as genetics, that influence your health outcomes. Social determinants of health outline how your overall health is made up of more than just your mental and physical well-being, and actually includes a variety of factors that contribute to, and are just as important as, your health outcomes. Many social determinants of health are intertwined and impact one another.

These factors can have a major impact on your overall health, which is why it is so important for your healthcare provider to have an understanding of your social determinants.

Below are some common categories of social determinants of health and some examples of how they can impact a person's health outcome:

Neighborhood

This refers to where you live and includes factors such as crime rates, the quality of housing and infrastructure, access to nutritious foods, and access to physical activity.

For example, if you live in a rural area, your neighborhood may not have sidewalks or parks nearby to make exercising easily accessible, which can negatively impact your physical activity level.

Healthcare

This refers to various factors related to your health, which includes your level of health literacy, access to primary care and specialists, access to health insurance, and access to medication.

For example, if you are prescribed a medication that you cannot afford or do not have access to transportation to get to the pharmacy, you may not take the medication regularly or at all.

Education

This refers to things like access to up-to-date course materials, student-to-teacher ratios, language skills and literacy, high school graduation rates, and enrollment rates in higher education.

For example, if you did not graduate high school, you may not go on to obtain a job that pays you enough to live above the poverty line. This in turn can impact your ability to afford things like housing or transportation.

Economic Stability

This refers to the various economic factors such as employment rates, poverty levels, food insecurity, or housing instability.

For example, if you do not have a steady job, paying for fresh produce may not be possible, causing you to feed your family cheaper, less healthy alternatives like fast food and foods that are highly processed.

If you are experiencing any of these issues, you can contact The Point at **(401) 462-4444** or go to **www.unitedwayri.org/get-help/point/**



SECTION II: TYPES OF CARE

ACUTE CARE

Acute care is short-term treatment for a severe injury or episode of illness, an urgent medical condition, or recovery from surgery. Examples of acute care can include emergency/urgent care, emergency surgery, critical/intensive care, or short-term stabilization.

CUSTODIAL CARE

Custodial care is non-medical personal care, such as bathing and grooming or meal preparation. Someone does not have to be a medical professional or medically trained to provide custodial care, and it can be done in places like adult day centers, assisted living facilities, and in your home.

FAMILY CARE GIVER

A family care giver is anyone who regularly assists in providing one or more types of care for a family member or friend. Care givers may live with the care recipient, or nearby. In the course of our lives, most of us will become care givers to someone at some point.

HOSPICE CARE

With hospice care, medical providers will discontinue curative treatments and focus on treating symptoms to provide comfort during end of life; typically, 6 months or less. Hospice addresses everything from physical, social, mental, and spiritual needs of the patient, as well as the family and caregivers. Should your condition change or improve, you can “graduate” off of hospice or utilize hospice services for an unlimited amount of time, contingent upon a physician recertifying you every 6 months and verifying that you meet specified hospice criteria. Hospice service is also fluid, meaning you can elect to be taken off of hospice at any time, should your wants or needs change. Hospice services can be provided in a hospital, or wherever you reside; whether that be a residential house, an assisted living facility, nursing home, etc.

INPATIENT CARE

Inpatient care consists of 24-hour care and an admission to a healthcare facility such as a hospital or skilled nursing facility.

LONG TERM CARE (LTC)

Long term care is an umbrella term that describes the care or assistance provided if you can no longer complete **activities of daily living** on your own due to your physical or mental health. It includes a variety of services that help meet both your medical and non-medical needs, for example meal preparation or delivery, in-home personal care, or friendly visiting for socialization. Long term care can be done in your home or at places like retirement communities and nursing homes.

OUTPATIENT CARE

Outpatient care is a broad term that includes any type of medical care, procedures, or treatments that do not require an overnight stay at a healthcare facility.

PALLIATIVE CARE

Palliative care is for anyone with a chronic condition, regardless of age or life expectancy. Palliative care focuses on pain and symptom management while you receive treatment for your condition or disease. Palliative care is an extra focus of care and can be provided anywhere and in conjunction with other treatments.

RESPIRE CARE

Respite care provides short-term relief for caregivers. It can be arranged for just an afternoon, for several days, or weeks. Care can be provided at home, in a healthcare facility, or at an adult day center.

SKILLED CARE

Skilled care is nursing or therapy care that can only be performed by or under the supervision of a licensed medical professional, such as a registered nurse or physical therapist, when your condition needs to be treated, managed, observed or evaluated. Skilled care can also be done when you need education on how to manage your condition and can be done in places like hospitals, skilled nursing facilities, and even in your home.

SECTION III: UNDERSTANDING INSURANCE

COINSURANCE

Coinsurance is the percentage of cost for a covered health service that the insured (you) is responsible to pay only after you've met your **deductible**. Coinsurance percentages vary depending on your insurance company and contribute to your **out-of-pocket maximum**.

COPAY

A copay is a specified out-of-pocket dollar amount, versus a percentage of the bill, paid by the insured (you) for covered services at the time of service. Copays must be paid by the insured before any policy benefit is payable by an insurance company and do not usually contribute towards your **deductible** but do typically contribute to your **out-of-pocket maximum**. Not all services require a copay, but insurance companies typically charge copays for services such as emergency room or urgent care visits, specialists, and some prescriptions.

DEDUCTIBLE

A deductible is a fixed dollar amount the insured (you) must pay each year, or benefit period, before your health insurance benefits begin to cover the costs. Once you've met your deductible, you typically only pay **coinsurance** for any services that are covered by your insurance plan and continue to pay coinsurance until you meet your **out-of-pocket maximum** for the year.

DIAGNOSTIC RELATED GROUP (DRG)

A diagnostic related group is how Medicare and some other health insurance companies categorize hospitalization costs and determine how much to reimburse the hospitals for your stay, regardless of how much cost was actually incurred. Rather than pay the hospital for each specific service or treatment it provides, Medicare and some private insurers pay a predetermined amount based on our diagnostic related group. Diagnostic related groups determine costs based upon things like a patient's age, sex, primary and secondary diagnoses, prognosis, surgical procedures, or treatments performed. Currently, there are 767 DRG's in 2021.

DRUG FORMULARY

A drug formulary is a list of generic and brand-name prescription drugs that are covered, either in whole or in part, by your health insurance plan. Drug formularies are typically divided between three to five categories, or tiers, and are placed into these tiers based on the type of drug. Drugs in lower tiers will cost less and those in higher tiers will cost you more. Should you need a drug not included in your health insurance's drug formulary list, you will be responsible for the entire cost of the drug, but in this case your provider will usually prescribe an alternative drug.

DUAL ELIGIBILITY

Dual eligibility is when you qualify for both Medicare and Medicaid benefits. This usually occurs when you already qualify for Medicare benefits but due to your income, you cannot afford the remaining costs, such as deductibles or copayments. Medicare will cover medical costs first, while Medicaid is the payer of last resort and will generally cover any costs Medicare will not cover partially or in-full.

EXPLANATION OF BENEFITS (EOB)

An explanation of benefits is essentially a receipt from your health insurance company that outlines the services that were provided to you and billed to your insurance company by your provider. It breaks down what the charges are, what is covered by your insurance company, and what you will most likely be responsible for paying. These are typically mailed to you and will say on the envelope and document itself "THIS IS NOT A BILL."



MANAGED CARE

Managed care is a health care delivery system organized to manage cost, utilization, and quality of care. Managed care uses things like provider networks, prescription drug tiers, and provider oversight. Typically, with managed care you agree to visit only certain providers and hospitals that are within your managed care network. Should you see a provider that is outside of your managed care network, your health insurance may not cover the costs or may cover them at a lower rate.

The two most common types of managed care are plans are:

- **Health Maintenance Organization (HMO)** manages your care by requiring you to see in-network providers. They require referrals from your primary care physician, who coordinates your care, before going to any other provider or specialist and do not cover you if you see a provider outside of the network. HMO's tend to cost less but offer you less flexibility.
- **Preferred Provider Organization (PPO)** allow you to see any provider you wish, whether they are in or out of network, although you may pay less if your provider is in-network. You also may not need a referral from your primary care specialist before seeing another provider or specialist. PPO's tend to cost more but offer you more freedoms.

OPEN ENROLLMENT

Open enrollment is the period of time, typically between 1 and 3 months, when a health insurance provider allows you to choose a new insurance plan or make changes to your current one. If you don't make changes to your current plan or sign up for a new plan during open enrollment, you won't have another opportunity to do so until the next open enrollment period, unless you experience a qualifying event, which include:

- Involuntarily losing your current health insurance due to losing or quitting a job or getting divorced
- Moving out of your current plan's service area
- Getting married
- Having a baby or adopting a child
- Reaching a certain age

OUT-OF-POCKET MAXIMUM

An out-of-pocket maximum is a set dollar amount, determined by your insurance company, that the insured (you) will pay for any healthcare services that are covered by your insurance company.

PRIOR AUTHORIZATION

A prior authorization is a utilization management process used by some health insurances to determine if they will cover a prescribed procedure, service, or medication. Your prescribing provider must obtain approval from your health insurance before performing a certain procedure or prescribing a specific medication. Without prior authorization, your health insurance may not cover the specific service or operation, leaving you with the bill. This process is intended to act as a safety and cost-saving measure.

SENIOR HEALTH INSURANCE PLANNING (SHIP)

The Senior Health Insurance Planning is a free health insurance counselling service for Medicare beneficiaries, their families, and their caregivers. SHIP counselors are trained to educate you on and answer your questions about eligibility questions and problems related to Medicare, including prescription drug cover under Medicare Part D, managed care options, long-term care planning, and health insurance decisions. SHIP and its counselors are not affiliated with any insurance company and does not sell or solicit any specific type of insurance.

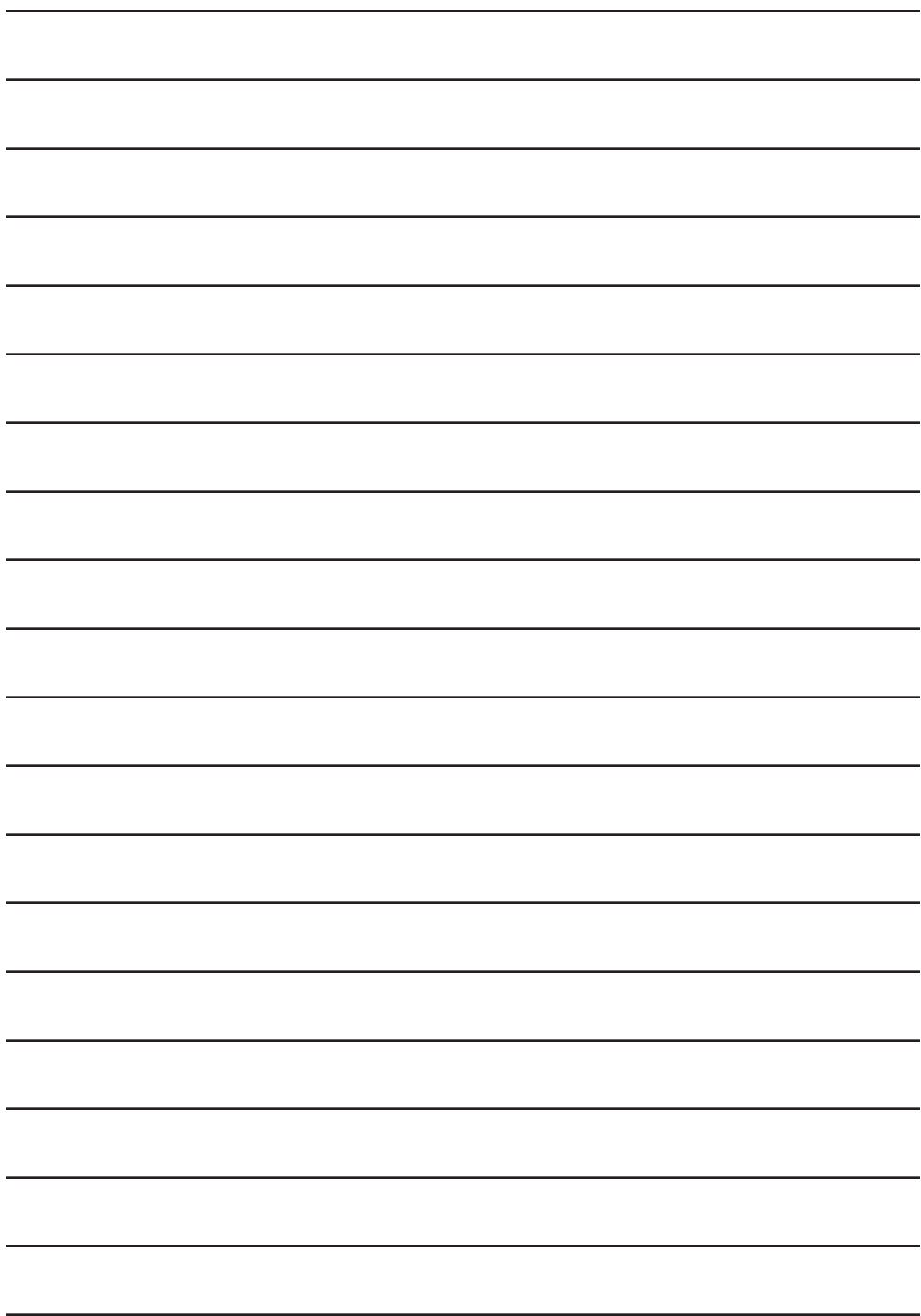
If you are interested in speaking with someone from SHIP call **1(888) 884-8721**.



For more information on Integra Community Care Network, call **(401) 430-2000** or use your smartphone's camera to scan the QR code to visit **www.IntegraCare.org**

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Belong. Be Well.