Certified Specialist Programme in Healthcare Actuarial

Healthcare Systems and Providers

Healthcare Systems and Providers Glossary

Accountable Care Organization (ACO)
An ACO is a group of healthcare providers that work together to coordinate care for patients, with the goal of improving quality and reducing costs. ACOs are often paid based on the quality of care they provide rather than the quantity of services.

Acute Care
Acute care refers to medical treatment provided for a brief period of time for patients with acute illnesses or injuries. This type of care is typically provided in hospitals or emergency rooms.

Adverse Selection
Adverse selection occurs when individuals with higher risk profiles are more likely to enroll in a particular health insurance plan. This can lead to higher costs for the insurer and may result in higher premiums for all members of the plan.

Capitation
Capitation is a payment model in which healthcare providers are paid a fixed amount per patient per month, regardless of the services provided. This payment model is intended to incentivize providers to deliver cost-effective care.

Case Management
Case management is a collaborative process that involves assessing, planning, coordinating, and monitoring healthcare services for individuals with complex medical needs. Case managers work to ensure that patients receive appropriate care in a timely manner.

Chronic Care Management
Chronic care management involves the ongoing monitoring and treatment of patients with chronic conditions such as diabetes, heart disease, or asthma. This type of care is aimed at preventing complications and improving quality of life for patients.

Clinical Integration
Clinical integration refers to the coordination of care across different healthcare providers and settings to ensure that patients receive comprehensive and seamless care. This can involve sharing information, coordinating treatment plans, and aligning incentives.

Community Health Center
Community health centers are non-profit healthcare facilities that provide primary care services to underserved populations, regardless of their ability to pay. These centers play a critical role in improving access to care and addressing health disparities.

Coordinated Care
Coordinated care involves the organization and delivery of healthcare services in a way that ensures seamless transitions between different providers and settings. This approach is designed to improve patient outcomes and reduce costs.

Credentialing
Credentialing is the process of verifying the qualifications and experience of healthcare providers to ensure that they meet the standards required to deliver high-quality care. This process may involve verifying education, training, licensure, and professional references.

Diagnostic Related Groups (DRGs)
DRGs are a system used to classify inpatient hospital stays into groups based on the patient's diagnosis, procedures performed, age, and other factors. This classification is used to determine the payment rate for each case.

Electronic Health Record (EHR)
An EHR is a digital version of a patient's paper chart that contains information about their medical history, diagnoses, medications, test results, and treatment plans. EHRs are designed to improve communication and coordination among healthcare providers.

Evidence-Based Medicine
Evidence-based medicine involves using the best available research evidence to inform clinical decision-making and improve patient outcomes. This approach relies on scientific studies, clinical guidelines, and expert consensus to guide treatment choices.

Fee-for-Service
Fee-for-service is a payment model in which healthcare providers are reimbursed based on the number of services they deliver. This model can incentivize providers to deliver more services, regardless of the patient's outcomes.

Health Maintenance Organization (HMO)
An HMO is a type of health insurance plan that requires members to choose a primary care provider and obtain referrals to see specialists. HMOs typically have a network of providers who agree to provide services at a discounted rate.

Health Risk Assessment
A health risk assessment is a tool used to evaluate an individual's health status, lifestyle behaviors, and risk factors for chronic diseases. This assessment can help identify areas for intervention and guide preventive care efforts.

Home Health Care
Home health care involves the provision of medical services, such as nursing care, therapy, and assistance with daily activities, in the patient's home. This type of care is often used for individuals who are recovering from illness or surgery.

Hospitalist
A hospitalist is a physician who specializes in caring for patients while they are hospitalized. Hospitalists work closely with other members of the healthcare team to coordinate treatment and ensure continuity of care.

Long-Term Care
Long-term care refers to a range of services designed to support individuals who have chronic illnesses, disabilities, or other conditions that require ongoing assistance. This care can be provided in a variety of settings, including nursing homes and assisted living facilities.

Managed Care
Managed care is a healthcare delivery system that aims to control costs and improve quality by coordinating care and managing utilization. This system often involves insurance plans that require members to use a network of providers and obtain referrals for specialty care.

Medical Home
A medical home is a primary care practice that provides comprehensive, coordinated, and patient-centered care. This model emphasizes preventive services, care coordination, and shared decision-making between patients and providers.

Medically Necessary
Medically necessary refers to healthcare services that are required to diagnose or treat a patient's medical condition. These services must be appropriate, effective, and consistent with the standards of medical practice.

Medicare Advantage
Medicare Advantage is a type of Medicare plan offered by private insurance companies that provides both Part A (hospital insurance) and Part B (medical insurance) coverage. These plans often include additional benefits, such as prescription drug coverage.

Patient-Centered Care
Patient-centered care is an approach to healthcare that prioritizes the needs and preferences of the patient. This model emphasizes communication, shared decision-making, and collaboration between patients and providers.

Pay for Performance
Pay for performance is a reimbursement model that ties provider payments to quality metrics and performance outcomes. This model is intended to incentivize providers to deliver high-quality care and achieve better patient outcomes.

Population Health Management
Population health management involves the systematic analysis and management of health outcomes for a defined group of individuals. This approach focuses on improving the health of the entire population and reducing disparities in care.

Preferred Provider Organization (PPO)
A PPO is a type of health insurance plan that allows members to see any healthcare provider, but offers lower out-of-pocket costs for services provided by providers within the plan's network. PPOs do not require members to obtain referrals to see specialists.

Quality Improvement
Quality improvement involves the systematic process of identifying, analyzing, and implementing changes to improve the quality of healthcare services. This process often involves measuring performance metrics, identifying areas for improvement, and implementing evidence-based practices.

Readmission Rate
The readmission rate is the percentage of patients who are readmitted to the hospital within a certain period of time after being discharged. High readmission rates can indicate problems with care transitions, follow-up care, or care quality.

Risk Adjustment
Risk adjustment is a method used to account for differences in the health status of patients when comparing healthcare outcomes or costs. This process helps ensure that providers are fairly compensated for caring for patients with complex medical needs.

Telemedicine
Telemedicine is the remote delivery of healthcare services using technology, such as videoconferencing, remote monitoring, and mobile apps. This approach allows patients to access care from a distance and can improve access to specialists and reduce costs.

Utilization Review
Utilization review is the process of evaluating the appropriateness and necessity of healthcare services provided to patients. This process helps ensure that care is delivered efficiently and that resources are used effectively.

Value-Based Care
Value-based care is a healthcare delivery model that focuses on improving patient outcomes and reducing costs by rewarding providers for delivering high-quality, cost-effective care. This model emphasizes preventive services, care coordination, and patient engagement.

Wellness Program
A wellness program is a set of activities and initiatives designed to promote healthy behaviors and prevent chronic diseases among a population. These programs often include health screenings, education, incentives, and support for lifestyle changes.

Wraparound Services
Wraparound services are additional support services, such as transportation, housing assistance, and social work, provided to individuals with complex medical or social needs. These services are designed to address the underlying factors that can impact health and wellbeing.