

A Guide to Healthcare Buzzwords and What They Mean: Part One (A through L)

Welcome to our guide to Healthcare Buzzwords!



ACO

An acronym for “Accountable Care Organization”, an ACO is a model of healthcare delivery in which a group of healthcare providers agree to accept payment for their services based on the aggregated health outcomes of the patients they see, as opposed to the total number of services performed. ACOs reward providers in a “fee for health” model, as opposed to a traditional “fee for service” model. Although the term ACO can apply to a variety of types of organizations, regulations for establishing ACOs to participate in the Medicare Shared Savings Program specifically were included in the Patient Protection and Affordable Care Act of 2010.

Big Data

“Big Data” is a blanket term used to describe the tremendous amount of raw data that we create as part of our everyday lives. As we become more proficient in capturing, storing, and analyzing these massive data sets – and the increasingly complex tools needed to do so – there is tremendous hope in the ability for industries to glean insights from the mountain of data they already have. Healthcare, with the tremendous

amount of data that is already collected and stored in the form of medical records, is considered one of the areas with the most to gain from advances in “Big Data” tools.

CCHIT

An acronym for “Certification Commission for Healthcare Information Technology”, CCHIT is one organization authorized by the Office of the National Coordinator of the Department of Health and Human Services to certify Electronic Health Record products for quality, security and interoperability. This certification is necessary for providers to receive “stimulus” funds from Medicare or Medicaid as reimbursement for achieving “Meaningful Use” of the EHR. Other organizations providing certifications include Drummond Group, ICSA Laboratories, Inc. and InfoGuard Laboratories, Inc.

Cloud vs. Closet

The “Cloud” versus the “Closet” is a way of defining the two most common ways of managing and sharing software products in a medical practice. The “Closet” is the traditional model where a server is installed, often into an extra closet where the phone system is also kept that runs the Practice Management and/or Electronic Medical Record software on the desktops in the practice. Generally, the practice owns their own software and hardware, and pays for it upfront as a capital expense. In the “Cloud” model, which is rapidly gaining favor, a constant Internet connection allows the server hardware to be kept offsite in the vendor’s data center. The software is paid for on a monthly, operational expense basis, and security, upgrades and maintenance are all outsourced to the vendor.

EMR/EHR

Acronyms for “Electronic Medical Record” and “Electronic Health Record.” The two terms are generally used interchangeably to describe any software that documents medical services delivered between providers and patients. There is however a general distinction between the two, highlighted [in this blog post from the ONC](#). An Electronic Medical Record generally refers to the digitized version of a paper record that is kept in an office as a record of the patient’s services from that provider. In other words, only the patient’s interactions with the providers of that office. An Electronic Health Record on the other hand generally refers to the complete history of a patient’s life and conditions as they visit different providers in different health settings. With the EHR’s focus on health as opposed to medicine, and portability with the patient as opposed to static and office-based, EHR tends to be the “official” term used by the ONC.

eRx

“eRx” is an abbreviation for “e-prescribe”, or the ability to transmit information from a provider to a pharmacy and back to facilitate filling prescriptions with a completely electronic process. By eliminating the paper scripts and the patients having to take them to their pharmacy, eRx facilitates more accurate, timely information between prescriber and pharmacy, and ensures that the information is accurately logged into the patient’s EHR. The ability to e-prescribe is a component of achieving Meaningful Use for providers to receive stimulus funds.

HDHP

An acronym for “High Deductible Health Plan”, an HDHP is a type of insurance coverage where more of the initial cost of

care is shifted to the responsibility of the patient. Using higher deductibles, as well as co-pays or co-insurance, high-deductible health plans are often combined with Health Savings Accounts to provide health coverage at lower premiums for patients and/or employers. As health insurance costs continue to rise, HDHPs are becoming more popular as a coverage model.

HIE #1 (Health Information Exchange)

A Health Information Exchange is a central hub where different health providers and locations can “exchange” electronic medical information so that a patient’s medical history is available to any provider or care setting in which the patient receives treatment. The exchange allows for the health data to be shared across different types of software in different places, so access to the exchange insures access to the most accurate patient data available. Health Information Exchanges are being set up in regional, state and national settings, and were a key part of Patient Protection and Affordable Care Act (PPACA or ACA) of 2010.

HIE #2 (Health Insurance Exchange)

A Health Insurance Exchange is a controlled marketplace where consumers can compare and purchase health insurance, as well as find out about any subsidies or tax benefits they can take advantage of to offset the cost of coverage. Each state has the option of setting up their own state-level exchange, or participating in the federally-run exchange. The exchange also sets minimum coverage levels for each state, and mandates that insurance companies disclose actuarial percentages and coverage levels of similar plans so that consumers can make informed decisions about coverage.

HIM

Health Information Management is the field of study that deals with overseeing and maintaining health care information for a patient population. Although HIM refers to the management of both paper-based and electronic health records, the field increasingly focuses on the storing, securing, and disclosing of electronic data. Issues like ethics, health informatics, and health information policy are changing the way Health Information Management is viewed in the larger context of the healthcare system.

HIPAA

An acronym for the “Health Insurance Portability and Accountability Act of 1996”, HIPAA is a federal statute that was designed to regulate health insurance to make it easier to “carry” coverage with you after leaving a job, as well as to set standards for the protection and transmission of protected health information. HIPAA was appended by the HITECH Act of 2009 to set disclosure reporting requirements in the case of a breach as well as define business associates as entities covered under HIPAA. Generally, when people refer to “HIPAA Requirements” they are talking about the privacy restrictions of the two bills.

HSA

An acronym for “Health Savings Account”, an HSA is a specialized bank account that allows its holder to defer federal tax liability in order to save for future medical expenses. Money deposited in an HSA is not subject to Federal Income Tax. HSAs, like a flexible spending account, or a health reimbursement account are combined with a high deductible health plan to replace traditional health insurance with money from the HSA covering short term costs and helping

with patient responsibilities while the HDHP covers catastrophic injuries or illness.

ICD-10

ICD-10 is an abbreviation for “International Statistical Classification of Diseases and Health Related Problems, 10th revision”. The ICD system is the set of alphanumeric codes that are used to classify diseases and bill medical payers for services. The United States currently uses the ICD-9 system, but is set to switch to the new standard on October 14, 2014. ICD-10 is much more complex than ICD-9, with almost five times as many available codes, and a much more specific hierarchy. ICD-10 is also referred to as “**I-10.**”

Interoperability

Interoperability is the concept that information stored in EHR software should be usable by any other software package. Interoperability is key to coordinating and improving care, because the health information is worthless without the software compatibility to share it between providers. This “breaking down of barriers” between different EHR software packages is crucial not only to sharing health information, but to creating a thriving and innovative healthcare information technology marketplace. Examples are a hospital system EMR’s interoperability with a private practice EMR, and both system’s EMR interoperability with a reference laboratory’s Information System.

IPA

An acronym for “Independent Practice Association”, an IPA is a group of independent physicians, or groups representing independent physicians to contract their services to managed care organizations and payers. IPAs can be formed to

collaborate on care in a region, promote the political effectiveness of the independent physician, as well as to negotiate professional fees for their members, although it is important to note that the IPA does not negotiate on behalf of its members for services delivered outside managed care agreements because of federal trade laws.

What are some of the buzzwords you are hearing, wondering about, and maybe even growing tired of? Let us know in the comments!