
Certified Professional in Healthcare Virtual Assistants

Healthcare Administration Basics

A

Accountability: The responsibility for actions taken or decisions made within an organization. In healthcare administration, accountability is crucial to ensure that all staff members follow protocols and guidelines to provide high-quality care to patients.

Accreditation: The process by which an organization or program is evaluated against established standards to ensure quality and compliance. Healthcare facilities often seek accreditation from organizations like The Joint Commission to demonstrate their commitment to excellence.

Acute Care: Medical treatment provided for a short period to address urgent or severe health issues. Acute care settings include hospitals, emergency rooms, and urgent care centers.

Adherence: The extent to which a patient follows medical recommendations, such as taking prescribed medications or attending follow-up appointments. Adherence plays a significant role in determining the success of treatment plans.

Administration: The management of healthcare facilities, services, and staff to ensure efficiency, quality, and compliance with regulations. Healthcare administrators oversee daily operations, financial management, and strategic planning.

Admission Criteria: The specific requirements that must be met for a patient to be admitted to a healthcare facility. Admission criteria may include medical necessity, insurance coverage, and bed availability.

Advance Directives: Legal documents that allow individuals to specify their preferences for medical treatment in case they become unable to communicate their wishes. Advance directives typically include living wills and healthcare proxies.

Agency for Healthcare Research and Quality (AHRQ): A federal agency within the U.S. Department of Health and Human Services that conducts research to improve the quality, safety, efficiency, and effectiveness of healthcare services.

Algorithms: Step-by-step procedures or formulas used to solve problems or make decisions. In healthcare administration, algorithms can help streamline processes, such as determining patient eligibility for specific services.

Alternative Medicine: Medical treatments and practices that fall outside conventional healthcare, such as acupuncture, herbal remedies, and chiropractic care. Alternative medicine is sometimes used in conjunction with traditional treatments.

Ambulatory Care: Healthcare services provided on an outpatient basis, without the need for overnight

hospitalization. Ambulatory care settings include physician offices, clinics, and same-day surgery centers.

Antibiotic Resistance: The ability of bacteria to resist the effects of antibiotics, making infections harder to treat. Antibiotic resistance is a growing concern in healthcare and requires careful stewardship of antibiotic use.

Appointment Scheduling: The process of booking patient appointments with healthcare providers. Efficient appointment scheduling is essential to manage patient flow and minimize wait times.

Assessment: The evaluation of a patient's physical, mental, and emotional health to determine their needs and develop a treatment plan. Assessments may include physical exams, diagnostic tests, and interviews.

Assisted Living: Residential facilities that provide housing, meals, personal care, and support services for older adults or individuals with disabilities. Assisted living facilities offer varying levels of care based on residents' needs.

Automated External Defibrillator (AED): A portable device that delivers an electric shock to restore normal heart rhythm in cases of sudden cardiac arrest. AEDs are commonly available in public places like airports, schools, and sports facilities.

Authorization: Approval from a healthcare payer for specific medical services or procedures. Providers must obtain authorization before delivering certain treatments to ensure reimbursement.

B

Balance Billing: The practice of billing patients for the difference between the provider's charge and the amount covered by insurance. Balance billing is often used when providers are out-of-network with a patient's insurance plan.

Beneficiary: An individual who is eligible to receive benefits from a healthcare program, such as Medicare or Medicaid. Beneficiaries may be patients, family members, or caregivers.

Benchmarking: The process of comparing an organization's performance metrics against industry standards or best practices. Benchmarking helps identify areas for improvement and drive strategic decision-making.

Benefit Design: The structure of healthcare insurance plans, including coverage levels, copayments, deductibles, and out-of-pocket limits. Benefit design influences how patients access and pay for healthcare services.

Billing: The process of submitting claims to insurance companies or patients for healthcare services provided. Billing includes coding procedures, verifying insurance coverage, and collecting payments.

Biomedical Waste: Hazardous materials generated during healthcare activities, such as used needles, contaminated dressings, and expired medications. Biomedical waste must be properly disposed of to prevent the spread of infection.

Bioethics: The study of ethical issues related to healthcare, medical research, and biotechnology. Bioethicists

examine questions of patient autonomy, informed consent, and end-of-life care.

Block Grant: A fixed amount of funding provided by the government to states or localities for specific programs, such as Medicaid or public health initiatives. Block grants give recipients flexibility in how funds are allocated.

Board of Directors: A group of individuals responsible for overseeing the strategic direction and governance of an organization. The board of directors sets policies, approves budgets, and hires top executives.

Budgeting: The process of planning and allocating financial resources to meet organizational goals. Healthcare administrators develop budgets to control costs, monitor financial performance, and make informed decisions.

Business Continuity Planning: The process of preparing for and recovering from potential disruptions to business operations, such as natural disasters, cybersecurity breaches, or pandemics. Business continuity planning ensures that essential services can continue in adverse conditions.

Bylaws: Rules and procedures that govern the operation of an organization, such as a hospital or medical practice. Bylaws define the structure of the organization, the roles of members, and the decision-making process.

C

Capitation: A payment model in which healthcare providers receive a fixed amount per patient to cover all necessary services within a specific time frame. Capitation incentivizes providers to deliver cost-effective care and manage resources efficiently.

Case Management: The coordination of healthcare services for patients with complex medical needs to ensure continuity of care and optimal outcomes. Case managers work with patients, families, and providers to navigate the healthcare system.

Centers for Medicare & Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs. CMS sets regulations, reimburses providers, and monitors healthcare quality.

Certificate of Need (CON): A state regulatory process that requires healthcare providers to obtain approval before expanding facilities, adding services, or acquiring new equipment. CON laws aim to control healthcare costs and prevent unnecessary duplication of services.

Certification: Formal recognition of an individual's competence in a specific area of healthcare administration. Certification programs assess knowledge, skills, and experience to ensure that professionals meet industry standards.

Chronic Care Management: The ongoing provision of medical services to patients with long-term health conditions, such as diabetes, heart disease, or asthma. Chronic care management focuses on preventing complications and improving quality of life.

Claims Processing: The review and adjudication of healthcare claims submitted by providers for reimbursement. Claims processing involves verifying patient eligibility, coding services correctly, and resolving any billing errors.

Clinical Pathway: A multidisciplinary plan of care that outlines the optimal sequence of interventions for patients with a specific diagnosis or condition. Clinical pathways standardize treatment protocols and improve patient outcomes.

Clinical Trials: Research studies that evaluate the safety and efficacy of new medical treatments, drugs, or devices. Clinical trials follow strict protocols and ethical guidelines to protect participants and generate reliable data.

COBRA: The Consolidated Omnibus Budget Reconciliation Act, which allows individuals to continue their employer-sponsored health insurance coverage for a limited period after leaving a job or experiencing a qualifying event. COBRA requires participants to pay the full premium.

Collaborative Practice: The team-based approach to healthcare delivery that involves multiple providers working together to achieve optimal patient outcomes. Collaborative practice may include physicians, nurses, pharmacists, and other healthcare professionals.

Compliance: The adherence to laws, regulations, policies, and ethical standards in healthcare practices. Compliance programs ensure that organizations operate ethically, protect patient rights, and avoid legal penalties.

Computerized Physician Order Entry (CPOE): The electronic system that allows healthcare providers to enter and manage patient orders for medications, tests, and treatments. CPOE reduces errors, improves efficiency, and enhances communication among care team members.

Confidentiality: The protection of sensitive patient information from unauthorized access or disclosure. Healthcare providers must maintain confidentiality to build trust with patients and comply with privacy regulations.

Consent: Permission granted by a patient or their legal representative before receiving medical treatment, participating in research, or sharing personal health information. Informed consent ensures that individuals understand the risks and benefits of healthcare decisions.

Continuing Education: Professional development activities that help healthcare administrators stay current on industry trends, regulations, and best practices. Continuing education may include conferences, webinars, and certification programs.

Contract Negotiation: The process of discussing terms, conditions, and pricing with vendors, insurers, or other business partners to reach agreements that benefit all parties. Contract negotiation skills are essential for healthcare administrators to secure favorable terms and manage costs.

Coordination of Benefits (COB): The process of determining which insurance plan is primary and which is secondary when a patient is covered by multiple policies. COB rules prevent duplicate payments and ensure

that claims are processed correctly.

Credentialing: The process of verifying a healthcare provider's qualifications, licenses, and experience to ensure they meet standards for delivering safe and effective care. Credentialing is essential for maintaining quality and patient safety.

Critical Access Hospital (CAH): A small rural hospital that meets specific criteria for federal reimbursement and regulatory flexibility. Critical access hospitals play a vital role in providing essential healthcare services to underserved communities.

Culture of Safety: An organizational commitment to prioritizing patient safety, reducing medical errors, and promoting a blame-free environment where staff can report concerns openly. A culture of safety fosters continuous improvement and enhances quality of care.

Customer Relationship Management (CRM): The strategic approach to managing interactions with patients, families, and other stakeholders to build loyalty, satisfaction, and trust. CRM systems help healthcare organizations personalize communication and improve patient engagement.

D

Data Analytics: The process of collecting, analyzing, and interpreting healthcare data to identify trends, patterns, and insights that inform decision-making. Data analytics is essential for quality improvement, population health management, and cost containment.

Data Breach: The unauthorized access, disclosure, or theft of sensitive information, such as patient records, financial data, or intellectual property. Data breaches can compromise patient privacy, damage reputation, and lead to legal consequences.

Decision Support Systems: Software tools that provide healthcare administrators with data-driven insights, recommendations, and predictions to facilitate strategic planning and decision-making. Decision support systems help leaders optimize resources, improve outcomes, and mitigate risks.

Deductible: The amount that a patient must pay out of pocket for covered healthcare services before insurance coverage begins. Deductibles vary by insurance plan and can influence patient behavior and healthcare costs.

Defensive Medicine: The practice of ordering unnecessary tests, procedures, or treatments to protect against potential malpractice claims. Defensive medicine can lead to overutilization of healthcare services and increased healthcare spending.

Delirium: A sudden and fluctuating change in mental status characterized by confusion, disorientation, and impaired cognition. Delirium is a common complication in hospitalized older adults and requires prompt evaluation and management.

Dependent Care Flexible Spending Account (DCFSA): A tax-advantaged account that allows employees to set aside pre-tax dollars to pay for qualified dependent care expenses, such as childcare or eldercare.

DCFSAs help reduce out-of-pocket costs for working parents.

Depression Screening: The process of assessing individuals for symptoms of depression using standardized tools or questionnaires. Depression screening helps identify at-risk patients, initiate timely interventions, and improve mental health outcomes.

Diagnosis-Related Group (DRG): A classification system used to determine reimbursement rates for inpatient hospital stays based on the patient's diagnosis, procedures performed, and other factors. DRGs incentivize hospitals to provide efficient and cost-effective care.

Direct Primary Care (DPC): A healthcare model in which patients pay a flat monthly fee to access comprehensive primary care services directly from a physician or practice. DPC eliminates insurance intermediaries and focuses on patient-provider relationships.

Discharge Planning: The process of coordinating post-hospital care and services for patients to ensure a smooth transition from the hospital to home or another care setting. Discharge planning reduces readmissions and promotes continuity of care.

Disease Management: The coordinated approach to caring for patients with chronic conditions to optimize health outcomes, prevent complications, and manage costs. Disease management programs focus on education, self-care, and support services.

Diversity and Inclusion: The practice of promoting equity, respect, and acceptance of individuals from diverse backgrounds in healthcare settings. Diversity and inclusion initiatives enhance cultural competence, reduce disparities, and improve patient outcomes.

Documentation: The recording of patient information, medical history, treatments, and outcomes in healthcare records. Accurate and thorough documentation is essential for communication, continuity of care, and legal compliance.

Drug Formulary: A list of prescription medications covered by a health insurance plan and their associated costs. Drug formularies help guide prescribing decisions, control costs, and ensure access to essential medications.

Durable Power of Attorney (DPA): A legal document that appoints an individual to make healthcare decisions on behalf of a patient who is unable to do so. Durable power of attorney ensures that patients' wishes are respected in case of incapacity.

E

Electronic Health Record (EHR): Digital records that contain a patient's medical history, diagnoses, medications, treatment plans, and other health information. EHRs facilitate secure sharing of data among healthcare providers and improve care coordination.

Emergency Medical Treatment and Labor Act (EMTALA): Federal legislation that requires hospitals to provide emergency medical care to anyone seeking treatment, regardless of ability to pay or insurance.

status. EMTALA ensures access to emergency services for all individuals.

Employee Assistance Program (EAP): Workplace benefits that offer confidential counseling, support, and resources to help employees manage personal or work-related challenges. EAPs promote mental health, work-life balance, and employee well-being.

Employee Health Insurance: Coverage provided by employers to help employees pay for medical expenses, such as doctor visits, prescriptions, and hospitalizations. Employee health insurance is a common benefit offered as part of compensation packages.

Empowerment: The process of enabling individuals to take control of their health, make informed decisions, and advocate for their needs. Empowerment enhances patient engagement, self-management, and health outcomes.

End-of-Life Care: Medical, emotional, and spiritual support provided to individuals with terminal illnesses or life-limiting conditions. End-of-life care focuses on comfort, dignity, and honoring patients' wishes.

Enrollment: The process of signing up for health insurance coverage, benefits, or programs. Enrollment may involve completing forms, selecting plans, and providing personal information to establish eligibility.

Environmental Services: The department responsible for cleaning, sanitizing, and maintaining the physical environment of healthcare facilities. Environmental services staff play a critical role in infection control and patient safety.

Epidemiology: The study of patterns, causes, and effects of diseases in populations. Epidemiologists use data analysis to identify risk factors, track outbreaks, and inform public health interventions.

Episode of Care: The complete cycle of healthcare services provided to a patient for a specific condition or treatment. An episode of care may include diagnosis, treatment, follow-up care, and rehabilitation.

Ethics Committee: A multidisciplinary group within a healthcare organization that addresses ethical issues, conflicts, or dilemmas related to patient care, research, or organizational policies. Ethics committees provide guidance, education, and support to stakeholders.

Exclusions: Services, treatments, or conditions that are not covered by a health insurance plan. Exclusions may include experimental procedures, cosmetic surgery, and certain pre-existing conditions.

Experience Rating: The method used by insurers to adjust premium rates based on an individual or group's claims history, risk factors, and utilization patterns. Experience rating helps insurers assess the likelihood of future costs and set pricing accordingly.

Extended Care Facility: A residential facility that provides long-term care, rehabilitation, and support services for individuals with chronic illnesses, disabilities, or functional limitations. Extended care facilities may include nursing homes, assisted living centers, and memory care units.

External Quality Review Organization (EQRO): An independent entity that evaluates the quality, access, and

outcomes of healthcare services provided to Medicaid beneficiaries. EQROs help states assess managed care plans and improve performance.

F

Facility Planning: The strategic process of designing, constructing, and renovating healthcare facilities to meet current and future needs. Facility planning considers factors like population growth, technology advancements, and regulatory requirements.

Fall Prevention: Strategies and interventions aimed at reducing the risk of falls and fall-related injuries in healthcare settings, especially among older adults or patients with mobility issues. Fall prevention programs include environmental modifications, staff training, and patient education.

Federal Employees Health Benefits Program (FEHBP): The health insurance program that offers coverage to federal employees, retirees, and their families. FEHBP provides a range of plan options and benefits to meet diverse healthcare needs.

Federal Register: The official journal of the U.S. government that publishes proposed rules, regulations, and notices related to federal agencies and programs. The Federal Register allows public input and transparency in the rulemaking process.

Fiscal Intermediary: A third-party organization contracted by the Centers for Medicare & Medicaid Services to process Medicare claims, reimburse providers, and conduct audits. Fiscal intermediaries help ensure accurate payments and compliance with Medicare regulations.

Flexible Spending Account (FSA): An employer-sponsored benefit that allows employees to set aside pre-tax dollars to pay for qualified medical expenses not covered by insurance. FSAs help individuals save money on healthcare costs and reduce taxable income.

Formulary: A list of prescription medications covered by a health insurance plan and their associated costs. Formularies help guide prescribing decisions, control costs, and ensure access to essential medications.

Freestanding Facility: A healthcare facility