

Glossary of Terms

ACA Affordable Care Act of 2010.

APM Alternative payment model: one of the value-based payment model options available for those who treat Medicare patients.

BCR Benefit-to-cost ratio: an alternative or supplement to ROI, and is calculated as the benefits divided by the costs; can be interpreted as “the benefits per dollar spent”.

Benchmark A value by which to compare and evaluate results or outcomes.

Care Delivery Systems Any organized group that attempts to provide care to individuals; examples include hospitals, clinics, emergency departments, and health systems.

CBO Community-based organization: an organization outside of traditional healthcare delivery systems that provides support services that may assist community-dwelling individuals to maintain health.

CEA Cost-effectiveness analysis: an economic method to establish the financial justification for a particular activity.

CLABSI Central line-associated bloodstream infections: a common quality measure that tracks the rate of this infection in healthcare settings.

CMS The Centers for Medicare and Medicaid Services.

Complex Adaptive Systems A type of system made up of independent but semiautonomous individuals who interact with each other in multiple ways.

CUA Cost–utility analysis: an economic method to establish the cost per quality-adjusted life years that a change in policy or activities would yield.

Discount Rate The annual percentage rate used to calculate the present value of future costs or benefits.

ED Emergency department.

FFS Fee-for-service: a health reimbursement policy by which providers and facilities are paid based on the services they provide, regardless of patient outcomes.

ICER Incremental cost-effectiveness ratio: a ratio of the difference in cost to the difference in QALYs in a cost-effectiveness or cost–utility analysis.

ICU Intensive care unit.

Implementation Science A field that endeavors to understand how innovations or changes are best implemented and sustained in healthcare delivery systems.

MACRA The Medicare Access and CHIP Reauthorization Act of 2015, which mandated the creation of an incentive program for providers where reimbursement was in part based on performance on quality measures.

Moral Hazard The tendency to either engage in more risky behavior or consume more healthcare services because of the presence of health insurance.

Net Benefits Benefits minus costs.

Payback Period The time until costs are covered by accumulating benefits.

Perspective The selected point of view for a given ROI analysis.

Population Health The health status and outcomes of a group of people instead of that of an individual.

QALY Quality-adjusted life years: a calculation of the total survival time adjusted to reflect the quality of life during that time.

Reliability An indication of how well a quality measure can detect differences in quality between entities.

ROI Return on investment.

Savings Per Patient Net benefits per patient affected.

Scope The selected time frame and affected population for an ROI analysis.

TPHO Third-party healthcare organization: a perspective that includes device, med-tech, and pharmaceutical companies and community services, including community-based organizations.

Validity An indication of how well a quality measure reflects the concept it is attempting to measure.

Index

A

Accountable care organizations (ACOs), 30
Affordable Care Act, 3
Attribution error, 96

B

Behavioral economics
 complex adaptive system, 92, 93
 system thinking and cognitive biases, 94
Blue Cross Blue Shield of Minnesota
 (BCBSMN), 9, 10

C

Care delivery, 12, 17
Central line-associated bloodstream infections
 (CLABSIs), 102, 153
Circumstances change, 138
CLABSI initiative, 138
CLABSI reduction initiative, 135
Clinicians, 86
CMS-funded value-based program, 141
CMS Hospital Readmission Reduction
 Program, 142, 144
CMS Hospital Value-Based Purchasing
 Program, 11
Community-based organizations (CBOs), 86
Complex adaptive system (CAS), 19, 92, 93
Complexity
 healthcare system, 17, 18, 20
 patient health, 22–27
Consumer Assessment of Healthcare Providers
 and Systems (CAHPS) survey, 34
Continuity of care, 12

Continuity, in health care
 components of health, 38
 episodic care vs. care continuum, 30
 health policy and payment, 36
 individual health status, 35
 policy and evaluations, 39
 population health and care delivery, 31
 patient role, 34
 patients' incentives, 33
 payers' incentives, 32
 providers' incentives, 33
Cost-effectiveness analysis (CEA), 2, 73
COVID-19, 40
COVID-19 pandemic, 11, 27
Credibility, 137

D

Discounting, 79
Doctors on demand, 11

E

Economics
 and asymmetric information, 64, 65
 demand for health insurance, 62, 63
 demand, supply, and prices, 56
 economic evaluation, of health
 outcomes, 59
 efficiency, 64
 implications of, 66, 68, 69
 intrinsic value, 55
 moral hazard and price sensitivity, 61
 utility, risk, and uncertainty, 58, 59
 value of equity, 61

- Efficiency, 64
 Emergency department (ED), 17
 Emotional value, 46
- F**
 Federal value-based programs, 10
 Fee-for-service (FFS) payment schemes, 22
 Financial support of care delivery, 20
 Financial value, 44
 Framing, 113
- H**
 Hawthorne effect, 95
 Hindsight bias, 96
 Human cognition, 95
- I**
 IKEA effect, 96
 Inconsistency, 12
 investments and acquisitions, 49
 value-based payments, 48
 Incremental cost-effectiveness ratio (ICER), 132
 Intrinsic value, 55
- M**
 Medicare Access and CHIP Reauthorization Act (MACRA), 3
 Medicare-covered patients, 142
 Medicare, Medicaid, health maintenance organizations (HMOs), 30
 Metrics, 143
 Motivations, 89
- O**
 Optimism bias, 96
- P**
 Palliative care, 30
 Patient outcomes, 13
 Patient-focused value, 44
 Payers, 22, 86, 88
 Pelzman effect, 97
 Primary care, 150
- R**
 Randomized controlled trials (RCTs), 26
 Ratings, 60
 Reimbursement, 21, 27
 Remote patient monitoring, 23, 30
 Return on investment (ROI) analyses, 75, 76
 Risk adjustment, 80, 81
- S**
 Self-management programs, 23
 Social and equitable value, 46
 Social determinants, 81
 Social services, 86
 Society's motivation, 88
 Standard gambles (SG), 60
 Standardizations, 155
- T**
 Technical research, 152
 Third-Party Healthcare Organization (TPHO), 5, 87
 Time period, 110
 Time trade-offs (TTOs), 60
- U**
 US healthcare system, 17
- V**
 Value
 emotional value, 46
 financial return, 135
 financial value, 44
 increased productivity/efficiency, 45
 patient-focused value, 44
 social and equitable value, 46
 Value assessment, 1, 7, 143
 assumptions, 116, 117
 benefit to cost ratio (BCR), 128, 129, 131, 132
 CEA/CUA and QALYs, 73, 74
 CLABSI value assessment, 104
 costs and benefits, 119–123
 design and interpretation of, 95, 96
 discounting, 79
 framework components, 103
 goal and objective, 114, 115
 history of, 71
 intended audience, 118
 interpretation and communication, 134, 135

- mental and behavioral health, 105, 107
 - payer audience, 146, 147
 - return on investment (ROI) analyses, 75, 76, 125, 127, 128
 - risk adjustment, 80, 81
 - Value-based reimbursement, 10
 - Blue Cross Blue Shield of Minnesota (BCBSMN), 9, 10
 - CMS Hospital Value-Based Purchasing Program, 8, 9
 - funding and acquisitions, 10
 - Veterans Health Administration (VHA) system, 30
 - Value, in health care
 - comprehensive and universal approach, 2
 - financial outcomes, 1
 - functional framework, 3
 - informative assessment, 2
 - patient outcomes and costs, 4
 - payers, 4
 - providers, 4
 - society, 5, 6
 - TPHOs, 5
 - Virtual health platforms, 23
- W**
- Willingness to pay (WTP), 59
- Z**
- Zipnosis, 11