DOWNLOAD PDF INTRODUCTION TO HEALTHCARE DELIVERY SYSTEMS

Chapter 1 : Syllabus - Health Care Delivery Systems

CHAPTER 1 Introduction to Healthcare Delivery Systems 1 Objectives After reading this chapter, you should be able to: â€ Outline the dynamics affecting today's healthcare industry.

To reach me directly call me at Catalog Description Students examine the history and current functions of health and social services delivery systems in the United States. The focus of this course is on the current and potential future health services systems and their components. Course Objectives Upon completion of this course, the student is expected to be able to: Achieve a basic understanding of the major components of the current and potential healthcare delivery systems in the United States. Discuss the impact of selected cultures on the ability of healthcare providers and the U. Describe the communication styles of the primary U. State three areas the U. State three roles the student plans to develop to be a contributing member of the healthcare system. Keep in mind that this is not a computer literacy course; but students enrolled in online courses are expected to have moderate proficiency using a computer. Please visit our technical requirements page for additional information. FIU Policies Please review the policies page as it contains essential information regarding guidelines relevant to all courses at FIU and additional information on the standards for acceptable netiquette important for online courses. University Drop Dates for Spring Semester: Monday, March 18, Last day to drop a course with a DR grade. Last day to withdraw from the University with a WI grade. Class Conduct and Academic Integrity Florida International University is a community dedicated to generating and imparting knowledge through excellent teaching and research, the rigorous and respectful exchange of ideas, and community service. All students should respect the right of others to have an equitable opportunity to learn and honestly to demonstrate the quality of their learning. Therefore, all students are expected to adhere to a standard of academic conduct which demonstrates respect for themselves, their fellow students, and the educational mission of the University. All students are deemed by the University to understand that if they are found responsible for academic misconduct, they will be subject to the Academic Misconduct procedures and sanctions, as outlined in the Student Handbook. Misconduct includes, but is not limited to: Cheating â€” The unauthorized use of books, notes, aids, electronic sources; or assistance from another person with respect to examinations, course assignments, field service reports, class recitations; or the unauthorized possession of examination papers or course materials, whether originally authorized or not. Any student, who fails to give credit for ideas, expressions or materials taken from another source, including internet sources, is engaging in plagiarizing. Any student determined to have committed academic misconduct e. The full code of academic integrity for FIU can be found on the following website, and I encourage you to read the entire code by clicking here. Any student may request to be excused from class to observe a religious holy day of his or her faith.

Chapter 2 : Introduction to Health Services Systems Course Syllabus

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Overview of the American Healthcare System Introduction External forces of history, financial constraints, political landscape, current socioeconomic structure and consumer preferences shape the structure, or lack thereof, of the American health care systemâ€”often through health policy decisions about funding care, reimbursement, and regulation. Direct effects can be seen in the organization and delivery of care. A focus of our class will be the downstream effects on access, quality, cost, equity, and population health. These five elements of health care are the pillars of this course. The US has the trifecta of high cost, unequal access, and often below average outcomes compared to other highly developed nations. This module will provide an introduction to the American health care system AHCS , explore some of the complexities of health care delivery, and provide a glimpse of the historical evolution of the AHCS that has led to the great debate and need for health care reform today. We will differentiate between the traditional primary care and hospital-based paradigms and more preventive, out-patient and medical home community models. As you read, note the following: Increase in health care spending exceeds growth of US economy Small proportion of population uses most of resources Burden of health care costs on families Health care spending per capita in US compared to other countries Learning Objectives Identify and define the five course pillars. Distinguish between the elements of access in health care: Identify key terms in health care expenditures and demonstrate ability to match categories to actual data tables. Categorize cost containment strategies as price controls and utilization. Describe the current situation in US health care of high costs with poor outcomes and begin to relate to course pillars. Relate a current event to course concepts in written form. Health and Illness As we move through the readings and better understand the foundations of the American health care system, we are reminded that social and institutional values and beliefs that emphasized disease more than health and prevention contributed to our astronomical costs and slowed down our progress toward attainment of a manageable and affordable system. That depends on how you define health care. What type of services do you think should be incorporated into health care settings. What if our healthcare system kept us healthy? This health disadvantage prevails even though the United States spends far more per person on health care than any other nation. Health in International Perspective: Shorter Lives, Poorer Health "Making systems work is the great task of my generation of physicians and scientists. But I would go further and say that making systems work â€” whether in healthcare, education, climate change, making a pathway out of poverty â€” is the great task of our generation as a whole. How do we heal medicine? These problems are not a reflection on the many doctors, nurses and other professionals who work tirelessly to deliver the highest quality care they can. What is the medical care system? In this course we will discuss the AHCS as if it were a unified structure. At the same time we will point out the many ways in which it is not. Medical care is often understood as the more clinical aspects that take place in the traditional medical setting. Health is a much broader concept. The health care system extends far beyond the exam room and we will see this in upcoming week. For the purposes of this course we will use the term AHCS to refer to health services, health care delivery, public health, and traditional medical care The following table gives you an idea of the complexities of health care delivery in our country. We will be discussing all of these components over the course of this semester, so keep this chart handy. The American Health Care System as a Non-System Though the American health care system is a far cry from being a well-oiled machine, it does have various components that are interdependent and share common goals. These components do fit into a systems model, despite all its limitations. Shi and Singh use this systems framework to illustrate some basic foundations that support the interaction between input resources and output outcomes , as well as the underlying structure that supports the process dynamics, which evolve over time. Surely, the American health care system is far from perfect, but, then, by now you probably realize that no perfect system exists anywhere. Americans have access to a patchwork of subsystems like managed care, the Veterans Administration, and emerging IDSs that characterize health care delivery in the

US. However, the systems framework does give us at least a starting place to attempt in an organized fashion to understand an extremely convoluted, confusing, and costly health care system, and perhaps, a place to begin our quest to find acceptable solutions to our problems. Atul Gawande is a surgeon and writer from the Boston area. Watch the video below for an academic and clinical perspective on our broken medical care systems. Focus in particular, to the questions below: What does he mean when he says this is not a system? What are the three steps for making systems work? Who are the cowboys? Who are the pit crews? If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment. If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, fewer factories would seek to monitor and improve production line performance and product quality. If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all. We will introduce these concepts today with an emphasis on access. Access in health care refers to the ability of individuals to obtain needed services. Healthy People described four components of health services access. Coverage Health insurance does not guarantee access, but it facilitates entry to health care services. In there were about 47 million non-elderly people without insurance. Why do we say non-elderly? Because Medicare coverage of the population 65 years and older provides a high level of coverage not seen in other age groups. It is important to remember this when thinking about insurance coverage and the uninsured. The Affordable Care Act ACA includes elements of insurance coverage through individual mandates, employer mandates postponed until , health insurance exchanges, subsidies for low-income Americans and Medicaid expansion only in some states for those in poverty are intended to increase access. We will return to the topic of Medicaid expansion in the states. Services Ideally access would start with continuity of care from a primary care provider PCP. It is less than ideal when the source of non-emergency care is in the emergency department. We will cover many of the other health care providers and care settings as the semester continues. Timeliness Timeliness encompasses waiting time at point-of-care delivery, and lag time between the decision to access a service and the actual receipt of that service. Timeliness is also an important aspect of quality. Increased use of mid-level practitioners PAs, NPs is seen as a potential solution. Innovating service models such as telemedicine and team models for primary care may also expand the reach of our existing workforce. How do we evaluate access? Measures of access to care may be individual or population based. These include the following: Identification of a usual source of care Report of going without care due to cost Receipt of preventive care immunizations, colonoscopy Insurance coverage Dental visit within one year Wait time to next appointment Preventable hospitalizations Time or stage at diagnosis for cancer Excess deaths those thought to be preventable through medical care The data for several of these measures came from the perspective of patients. When examining access from utilization remember that you are only capturing those who were able to get care. This measures the rate of MRI use for back pain in a clinical setting, not in the population. There is no relationship with Kaiser Permanente or Kaiser Industries. As we finish up on access please check to see how much you know about the uninsured in the U. This is a tool for self-assessment and does not factor into your grade. Resist the urge to look up the answers! At the end of the quiz you will be able to view your responses, the correct answers with feedback, and links for further information. The large number of uninsured people in the United States has been at the forefront of health policy discussion for decades, and in recent years has received increased attention with the passage of the health reform law in How much do you know about the uninsured population and the consequences of not having coverage? Take the quiz below to find out.

Chapter 3 : Introduction to health care in the U.S. | Khan Academy

Introduction to the Healthcare System. Hospitals, clinic and community health agencies can be very different from other work environments. Healthcare systems are complex and there are many things you need to know about types of hospital systems, patient care, insurance, healthcare providers and legal issues.

Because the largest public programs are directed to the aged, disabled, and low-income populations, they cover a disproportionate share of the chronically ill and disabled. However, they are also enormously important for children. Being uninsured, although not the only barrier to obtaining health care, is by all indications the most significant one. Those without health insurance or without insurance for particular types of services face serious, sometimes insurmountable barriers to necessary and appropriate care. Page Share Cite Suggested Citation: The Health Care Delivery System. The National Academies Press. Children without health insurance may be compromised in ways that will diminish their health and productivity throughout their lives. When individuals cannot access mainstream health care services, they often seek care from the so-called safety-net providers. These providers include institutions and professionals that by mandate or mission deliver a large amount of care to uninsured and other vulnerable populations. People turn to safety-net providers for a variety of reasons: Safety-net providers are also more likely to offer outreach and enabling services e. Yet the public and many elected officials seem almost willfully ignorant of the magnitude, persistence, and implications of this problem. Surveys conducted over the past two decades show a consistent underestimation of the number of uninsured and of trends in insurance coverage over time Blendon et al. The facts about uninsurance in America are sobering see Box 5â€”1. By almost any metric, uninsured adults suffer worse health status and live shorter lives than insured adults IOM, a. Because insurance status affects access to secure and continuous care, it also affects health, leading to an estimated 18, premature deaths annually IOM, a. Having a regular source of care improves chances of receiving personal preventive care and screening services and improves the management of chronic disease. When risk factors, such as high blood pressure, can be identified and treated, the chances of developing conditions such as heart disease can be reduced. Similarly, if diseases can be detected and treated when they are still in their early stages, subsequent rates of morbidity and mortality can often be reduced. Without insurance, the chances of early detection and treatment of risk factors or disease are low. Forty-two million people in the United States lacked health insurance coverage in Mills, This number represented about 15 percent of the total population of million persons at that time and 17 percent of the population younger than 65 years of age; 10 million of the uninsured are children under the age of 18 about 14 percent of all children , and about 32 million are adults between the ages of 18 and 65 about 19 percent of all adults in this age group. Nearly 3 out of every 10 Americans, more than 70 million people, lacked health insurance for at least a month over a month period. These numbers are greater than the combined populations of Texas, California, and Connecticut. More than 80 percent of uninsured children and adults under the age of 65 lived in working families. Contrary to popular belief, recent immigrants accounted for a relatively small proportion of the uninsured less than one in five. Insurance status is a powerful determinant of access to care: Research consistently finds that persons without insurance are less likely to have any physician visits within a year, have fewer visits annually, and are less likely to have a regular source of care. Children without insurance are three times more likely than children with Medicaid coverage to have no regular source of care. The uninsured were less likely to receive health care services, even for serious conditions. Research consistently finds that persons without insurance are less likely to have any physician visits within a year, have fewer visits annually, and are less likely to have a regular source of care 15 percent of uninsured children do not have a regular provider, whereas just 5 percent of children with Medicaid do not have a regular provider , and uninsured adults are more than three times as likely to lack a regular source of care. However, even when the uninsured receive care, they fare less well than the insured. For example, Hadley and colleagues found that uninsured adult hospital inpatients had a significantly higher risk of dying in the hospital than their privately insured counterparts. Emergency and trauma care were also found to vary for insured and uninsured patients. Uninsured persons with traumatic injuries were less likely to be admitted to the hospital, Page Share Cite

Suggested Citation: For children, too, being uninsured tends to reduce access to health care and is associated with poorer health. Untreated ear infections, for example, can have permanent consequences of hearing loss or deafness. Many people who are counted as insured have very limited benefits and are exposed to high out-of-pocket expenses or service restrictions. Three areas in which benefits are frequently circumscribed under both public and private insurance plans are preventive services, behavioral health care treatment of mental illness and addictive disorders , and oral health care. When offered, coverage for these services often carries limits that are unrelated to treatment needs and are stricter than those for other types of care King, Cost-sharing requirements for these services may also be higher than those for other commonly covered services. Access to care for the insured can also be affected by requirements for cost sharing and copayments. Cost sharing is an effective means to reduce the use of health care for trivial or self-limited conditions. Numerous studies, starting with the RAND Health Insurance Experiment, show that copayments also reduce the use of preventive and primary care services by the poor, although not by higher-income groups Solanki et al. The same effects have been shown for the use of behavioral health care services Wells et al. Cost sharing may discourage early care seeking, impeding infectious disease surveillance, delaying timely diagnosis and treatment, and posing a threat to the health of the public. The committee encourages health care policy makers in the public and private sectors to reexamine these issues in light of the concerns about bioterrorism. This committee was not constituted to make specific recommendations about health insurance. However, the committee finds that both the scale of the problem and the strong evidence of adverse health effects from being uninsured or underinsured make a compelling case that the health of the American people as a whole is compromised by the absence of insurance coverage for so many. Assuring the health of the population in the twenty-first century requires finding a means to guarantee insurance coverage for every person living in this country. Adequate population health cannot be achieved without making comprehensive and affordable health care available to every person residing in the United States. It is the responsibility of the federal government to lead a national effort to examine the options available to achieve stable health care coverage of individuals and families and to assure the implementation of plans to achieve that result. Safety-Net Providers Absent the availability of health insurance, the role of the safety-net provider is critically important. Increasing their numbers and assuring their viability can, to some degree, improve the availability of care. That committee further identified core safety-net providers as having two distinguishing characteristics: The organization and delivery of safety-net services vary widely from state to state and community to community Baxter and Mechanic, The safety net consists of public hospital systems; academic health centers; community health centers or clinics funded by federal, state, and local governmental public health agencies see Chapter 3 ; and local health departments themselves although systematic data on the extent of health department services are lacking IOM, a. A recent study of changes in the capacities and roles of local health departments as safety-net providers found, however, that more than a quarter of the health departments surveyed were the sole safety-net providers in their jurisdictions and that this was more likely to be the case in smaller jurisdictions Keane et al. Safety-net service providers, which include local and state governmen Page Share Cite Suggested Citation: Services provided by state and local governments often include mental health hospitals and outpatient clinics, substance abuse treatment programs, maternal and child health services, and clinics for the homeless. In addition, an estimated 1, public hospitals nationwide Legnini et al. These demands can overwhelm the traditional population-oriented mission of the governmental public health agencies. Furthermore, changes in the funding streams or reimbursement policies for any of these programs or increases in demand for free or subsidized care that inevitably occur in periods of economic downturn create crises for safety-net providers, including those operated by state and local governments see the section Collaboration with Governmental Public Health Agencies later in this chapter for additional discussion. Intact but Endangered IOM, a: The convergence and potentially adverse consequences of these new and powerful dynamics lead the committee to be highly concerned about the future viability of the safety net. Although safety net providers have proven to be both resilient and resourceful, the committee believes that many providers may be unable to survive the current environment. Taken alone, the growth in Medicaid managed care enrollment; the retrenchment or elimination of key direct and indirect subsidies that providers have relied upon to help finance uncompensated

care; and the continued growth in the number of uninsured people would make it difficult for many safety net providers to survive. Taken together, these trends are beginning to place unparalleled strain on the health care safety net in many parts of the country. The committee believes that the effects of these combined forces and dynamics demand the immediate attention of public policy officials. Intact but Endangered IOM, a , aimed at ensuring the continued viability of the health care safety net see Box 5â€”2. All federal programs and policies targeted to support the safety net and the populations it serves should be reviewed for their effectiveness in meeting the needs of the uninsured. Given the growing number of uninsured people, the adverse effects of Medicaid managed care on safety-net provider revenues, and the absence of concerted public policies directed at increasing the rate of insurance coverage, the committee believes that a new targeted federal initiative should be established to help support core safety-net providers that care for a disproportionate number of uninsured and other vulnerable people. NEGLECTED CARE The committee is concerned that the specific types of care that are important for population healthâ€”clinical preventive services, mental health care, treatment for substance abuse, and oral health careâ€”are less available because of the current organization and financing of health care services. Many forms of publicly or privately purchased health insurance provide limited coverage, and sometimes no coverage, for these services. Clinical Preventive Services The evidence that insurance makes a difference in health outcomes is well documented for preventive, screening, and chronic disease care IOM, b. Such services include immunizations and screening tests, as well as counseling aimed at changing the personal health behaviors of patients long before Page Share Cite Suggested Citation: The importance of counseling and behavioral interventions is evident, given the influence on health of factors such as tobacco, alcohol, and illicit drug use; unsafe sexual behavior; and lack of exercise and poor diets. These risk behaviors are estimated to account for more than half of all premature deaths; smoking alone contributes to one out of five deaths McGinnis and Foege, Coverage of clinical preventive services has increased steadily over the past decade. In , about three-quarters of adults with employment-based health insurance had a benefit package that included adult physical examinations. Two years later, the proportion had risen to 90 percent Rice et al. The type of health plan is the most important predictor of coverage RWJF, Although the trend toward inclusion of clinical preventive services is positive, such benefits are still limited in scope and are not well correlated with evidence regarding the effectiveness of individual services. Public Health Service, has endorsed a core set of clinical preventive services for asymptomatic individuals with no known risk factors. However, the USPSTF recommendations have had relatively little influence on the design of insurance benefits, and recommended counseling and screening services are often not covered and, consequently, not used Partnership for Prevention, see Box 5â€”3. As might be expected, though, adults without health insurance are the least likely to receive recommended preventive and screening services or to receive them at the recommended frequencies Ayanian et al. Having any health insurance, even without coverage for any preventive services, increases the probability that an individual will receive appropriate preventive care Hayward et al. Studies of the use of preventive services by Hispanics and African Americans find that health insurance is strongly associated with the increased receipt of preventive services Solis et al. However, the higher rates of uninsurance among racial and ethnic minorities contribute significantly Page Share Cite Suggested Citation: Yet about half of all pregnancies and nearly a third of all births each year are unintended. One out of five employer-sponsored plans does not cover childhood immunizations, and one out of four does not cover adolescent immunizations although these are among the most cost-effective preventive services. For example, African Americans and members of other minority groups who are diagnosed with cancer are more likely to be diagnosed at advanced stages of disease than are whites Farley and Flannery, ; Mandelblatt et al. Medicare Coverage of Preventive Services Preventive services are important for older adults, for whom they can reduce premature morbidity and mortality, help preserve function, and enhance quality of life. Unfortunately, the Medicare program was not designed with a focus on prevention, and the process for adding preventive services to the Medicare benefit package is complex and difficult. Unlike forms of treatment that are incorporated into the payment system on a relatively routine basis as they come into general use, preventive services are subject to a greater degree of scrutiny and a demand for a higher level of effectiveness, and there is no routine process for making such assessments. Box 5â€”4 lists the preventive

services currently covered by Medicare. The level of use of preventive services among older adults has been relatively low CDC,

Chapter 4 : Overview of the American Healthcare System

Introduction to Health Care Delivery Systems Course Description. This MS in Health Care Informatics course provides an overview of the health care delivery system, professional roles, care delivery models, and relevant regulatory environment in the United States.

Explain the evolution of the health care systems in the United States. Identify the social, legal, and economic factors that affect the delivery of health care. Explain the development of the health information profession from its beginnings until the present and into the future. Identify the various types of health services professionals and their training, practice requirements, and practice settings. Identify and describe the regulators of healthcare, including government and nongovernment entities. Describe the basic organization of the various types of hospitals, the levels of services they provide, and the sources of financing. Describe the various types of ambulatory care facilities, the levels of services they provide, and the sources of financing. Describe the various types of long-term care institutions, the levels of services they provide, and the sources of financing. Describe the types and recipients of mental and rehabilitative health services, and the sources of financing. Describe the historical development of healthcare reimbursement in the United States. Describe the critical health policy issues in the U. Explain the differences among licensure, accreditation and certification. Explain and identity the functions and components of the health record and health record data quality. Differentiate between the various health information media such as paper, computer, or web-based. Identify manual and automated techniques used in storage and maintenance of health records. Compare the format and content of various types of outpatient health records as well as documentation requirements for accreditation, certification and licensure. Explain the coding and classification systems used in hospitals and healthcare organizations. Understand the basic concepts and terms associated with the electronic health record EHR. Discuss documentation requirement for various hospitals and health care organizations. Describe the health information management department functions and purpose.

Chapter 5 : Colorado Tech Course Catalog - CTU | SmartCatalog

on the delivery of health care services. 5. Compare and contrast specialized record requirements in the various health care delivery settings. 6. Appreciate the role of the health information professional in the provision of health care. 7. Distinguish between the various health care organizations responsible for providing health care. 8.

Chapter 6 : Virginia's Community Colleges: Introduction to the Health Care Delivery System - HIT

CHAPTER 1: INTRODUCTION TO HEALTHCARE DELIVERY SYSTEMS Many illnesses such as the ones mentioned earlier require continuous and prolonged treatment. Therefore, the need for geriatric specialists, especially in highly populated elderly communities, will grow.

Chapter 7 : HAD - Introduction to U.S. Healthcare Delivery - 4 Credits

1. Explain the evolution of the health care systems in the United States. 2. Identify the social, legal, and economic factors that affect the delivery of health. care. 3. Explain the development of the health information profession from its beginnings. until the present and into the future. 4.

Chapter 8 : Introduction to Healthcare Delivery Systems

US Healthcare Delivery System a set of connected things/parts forming a complex whole, in particular that is also a set of interacting or inter dependent components forming an integrated whole (racedaydvl.com).

Chapter 9 : Introduction to the Healthcare System

a system of payment rates to health care providers in which il a program in which the costs of appropriate health care goods an illness that comes on suddenly and is generally of short du.