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Family Medical Care - George A. Silver - 1974

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Family Medicine - Betty E Cogswell - 2014-03-18

Here is an insightful review of the origins of family medicine as an AMA-approved specialty, including the difficulties in developing the role of family physician.

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Health Data in the Information Age - Institute of Medicine - 1994-01-01

Regional health care databases are being established around the country with the goal of providing timely and useful information to policymakers, physicians, and patients. But their emergence is raising important and sometimes controversial questions about the collection, quality, and appropriate use of health care data. Based on experience with databases now in operation and in development, Health Data in the Information Age provides a clear set of guidelines and principles for exploiting the potential benefits of aggregated health data--without jeopardizing confidentiality. A panel of experts identifies characteristics of emerging health database organizations (HDOs). The committee explores how HDOs can maintain the

they should adopt, how they can prepare for linkages with computer-based patient records, and how diverse groups from researchers to health care administrators might use aggregated data. Health Data in the Information Age offers frank analysis and guidelines that will be invaluable to anyone interested in the operation of health care databases.

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Best Care at Lower Cost - Institute of Medicine
- 2013-06-10

America's health care system has become too complex and costly to continue business as usual. Best Care at Lower Cost explains that inefficiencies, an overwhelming amount of data, and other economic and quality barriers hinder progress in improving health and threaten the nation's economic stability and global competitiveness. According to this report, the knowledge and tools exist to put the health system on the right course to achieve continuous improvement and better quality care at a lower cost. The costs of the system's current inefficiency underscore the urgent need for a systemwide transformation. About 30 percent of health spending in 2009--roughly \$750 billion--was wasted on unnecessary services, excessive administrative costs, fraud, and other problems. Moreover, inefficiencies cause needless suffering. By one estimate, roughly 75,000 deaths might have been averted in 2005 if every state had delivered care at the quality level of the best performing state. This report states that the way health care providers currently train, practice, and learn new information cannot keep pace with the flood of research discoveries and technological advances. About 75 million Americans have more than one chronic condition, requiring coordination among multiple specialists and therapies, which can increase the potential for miscommunication, misdiagnosis, potentially conflicting interventions, and dangerous drug interactions. Best Care at Lower Cost emphasizes that a better use of data is a critical element of a continuously improving health system, such as mobile technologies and electronic health records that offer significant potential to capture and share health data better. In order for this to occur, the National Coordinator for Health Information Technology, IT developers, and standard-setting organizations should ensure that these systems are robust and interoperable. Clinicians and care organizations should fully adopt these technologies, and patients should be encouraged to use tools, such as personal health information portals, to actively engage in their care. This book is a call to action that will guide health care providers; administrators; caregivers; policy makers; health professionals; federal, state, and local government agencies; private and public health organizations; and educational institutions.

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Catalog - National Library of Medicine (U.S.) - 1971

National Library of Medicine Current Catalog - National Library of Medicine (U.S.) - 1971

The Project Share Collection - - 1976
Cumulates abstracts which appeared in Journal of human services abstracts.

The Project Share Collection - - 1976
Cumulates abstracts which appeared in Journal of human services abstracts.

The Project Share Collection, 1976-1979 - Project Share - 1979

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My Child's Health Record - Josh Zeus - 2021-03-22
Keep good records of your child's health by tracking your baby's medical history, medical appointments and treatment. This Child's Health Notebook is exactly what all new parents need to record all things medical relating to their child. Keep a contact list of all physicians and track all prescribed medications, doctor appointments, immunizations, and family medical history. Provides plenty of space to record clear and concise medical history necessary for school, camp, college, insurance, change of doctors, and personal reference. Have peace of mind knowing that all of this important information is all in one place! Purchase a copy for yourself or a new parent-to-be! Features: Study Cover with a Beautiful Design Convenient 8.5" x 11" Size - Plenty of Space to Write Down Your Child's Medical History 107 Pages For more journals, planners, and log books like this one, click on the author's name below the title of this book.

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Journal of Human Services Abstracts - - 1978

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Health Planning Reports Title Index - United States. Bureau of Health Planning - 1981

Health Planning Reports Title Index - United States. Bureau of Health Planning - 1981

Health planning reports subject index - United States. Health Resources Administration - 1979

Health planning reports subject index - United States. Health Resources Administration - 1979

Family Medical Care Under Three Types of Health Insurance - Columbia University. School of Public Health and Administrative Medicine - 1962

Family Medical Care Under Three Types of Health Insurance - Columbia University. School of Public Health and Administrative Medicine - 1962

Health Planning Reports: Subject index. 4 v - United States. Health Resources Administration - 1978

Health Planning Reports: Subject index. 4 v - United States. Health Resources Administration - 1978

The Patient Centered Value System - Anthony M. DiGioia - 2017-09-11
Imagine: You are a hospital Chief Executive Officer, Chief Financial Officer, medical or nursing director, patient safety specialist, quality improvement professional, or a doctor or nurse on the front lines of patient care. Every day

The Patient Centered Value System - Anthony more engaged in their care so they would fare better both in the hospital and after discharge; their care could be safer and more seamlessly coordinated; patients should be ready for discharge sooner and readmitted less often; your bottom line stronger; your staff more fulfilled. You enter into new payment models such as bundling with an uneasy awareness that your organization is at risk because you don't know what the care you deliver actually costs. Like most healthcare leaders, you are also still searching for a way to deliver care that will help you to achieve the Triple Aim: care that leads to improved clinical outcomes, better patient and family care experiences, and reduced costs. Sound familiar? If so, then it's time to read *The Patient Centered Value System: Transforming Healthcare through Co-Design*. This book explains how to introduce the Patient Centered Value System in your organization to go from the current state to the ideal. The Patient Centered Value System is a three-part approach to co-designing improvements in healthcare delivery—collaborating with patients, families, and frontline providers to design the ideal state of care after listening to their wants and needs. Central to the Patient Centered Value System is seeing every care experience through the eyes of patients and families. The Patient Centered Value System is a process and performance improvement technique that consists of 1) Shadowing, 2) the Patient and Family Centered Care Methodology, and 3) Time-Driven Activity-Based Costing. Shadowing is the essential tool in the Patient Centered Value System that helps you to see every care experience from the point of view of patients and families and enables you to calculate the true costs of healthcare over the full cycle of care. Fundamental to the Patient Centered Value System is the building of teams to take you from the current state of care delivery to the ideal. Healthcare transformation depends not on individual providers working to fix broken systems, but on teams of providers working together while breaking down silos. The results of using the Patient Centered Value System are patients and families who are actively engaged in their care, which also improves their outcomes; providers who see the care experience from the patient's and family's point of view and co-design care delivery as a result; the tight integration of clinical and financial performance; and the realization of the Triple Aim. ?

M. DiGioia - 2017-09-11

Imagine: You are a hospital Chief Executive Officer, Chief Financial Officer, medical or nursing director, patient safety specialist, quality improvement professional, or a doctor or nurse on the front lines of patient care. Every day you're aware that patients and families should be more engaged in their care so they would fare better both in the hospital and after discharge; their care could be safer and more seamlessly coordinated; patients should be ready for discharge sooner and readmitted less often; your bottom line stronger; your staff more fulfilled. You enter into new payment models such as bundling with an uneasy awareness that your organization is at risk because you don't know what the care you deliver actually costs. Like most healthcare leaders, you are also still searching for a way to deliver care that will help you to achieve the Triple Aim: care that leads to improved clinical outcomes, better patient and family care experiences, and reduced costs. Sound familiar? If so, then it's time to read *The Patient Centered Value System: Transforming Healthcare through Co-Design*. This book explains how to introduce the Patient Centered Value System in your organization to go from the current state to the ideal. The Patient Centered Value System is a three-part approach to co-designing improvements in healthcare delivery—collaborating with patients, families, and frontline providers to design the ideal state of care after listening to their wants and needs. Central to the Patient Centered Value System is seeing every care experience through the eyes of patients and families. The Patient Centered Value System is a process and performance improvement technique that consists of 1) Shadowing, 2) the Patient and Family Centered Care Methodology, and 3) Time-Driven Activity-Based Costing. Shadowing is the essential tool in the Patient Centered Value System that helps you to see every care experience from the point of view of patients and families and enables you to calculate the true costs of healthcare over the full cycle of care. Fundamental to the Patient Centered Value System is the building of teams to take you from the current state of care delivery to the ideal. Healthcare transformation depends not on individual providers working to fix broken systems, but on teams of providers working together while breaking down silos. The results of using the Patient Centered Value

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Official Gazette of the United States Patent and Trademark Office - - 2007-04-10

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Hospital and Healthcare Facility Design -

Richard L. Miller - 2002

A state-of-the-art blueprint for architects, planners, and hospital administrators, Hospital and Healthcare Facility Design provides innovative ideas and concrete guidelines for planning and designing facilities for the rapidly changing healthcare system.

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Behavioral Sciences Research in Mental Health - - 1983

Behavioral Sciences Research in Mental Health - - 1983

Medical Care Economic Risk - Panel on Measuring Medical Care Risk in Conjunction with the New Supplemental Income Poverty Measure - 2013-01-24

The United States has seen major advances in medical care during the past decades, but access to care at an affordable cost is not universal. Many Americans lack health care insurance of any kind, and many others with insurance are nonetheless exposed to financial risk because of high premiums, deductibles, co-pays, limits on insurance payments, and uncovered services. One might expect that the U.S. poverty measure would capture these financial effects and trends in them over time. Yet the current official poverty measure developed in the early 1960s does not take into account significant increases and

coverage, out-of-pocket spending, and the financial burden imposed on families and individuals. Although medical costs consume a growing share of family and national income and studies regularly document high rates of medical financial stress and debt, the current poverty measure does not capture the consequences for families' economic security or their income available for other basic needs. In 1995, a panel of the National Research Council (NRC) recommended a new poverty measure, which compares families' disposable income to poverty thresholds based on current spending for food, clothing, shelter, utilities, and a little more. The panel's recommendations stimulated extensive collaborative research involving several government agencies on experimental poverty measures that led to a new research Supplemental Poverty Measure (SPM), which the U.S. Census Bureau first published in November 2011 and will update annually. Analyses of the effects of including and excluding certain factors from the new SPM showed that, were it not for the cost that families incurred for premiums and other medical expenses not covered by health insurance, 10 million fewer people would have been poor according to the SPM. The implementation of the patient Protection and Affordable Care Act (ACA) provides a strong impetus to think rigorously about ways to measure medical care economic burden and risk, which is the basis for Medical Care Economic Risk. As new policies - whether part of the ACA or other policies - are implemented that seek to expand and improve health insurance coverage and to protect against the high costs of medical care relative to income, such measures will be important to assess the effects of policy changes in both the short and long term on the extent of financial burden and risk for the population, which are explained in this report.

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answer to the question, "What is geriatrics and One might expect that the U.S. poverty measure would capture these financial effects and trends in them over time. Yet the current official poverty measure developed in the early 1960s does not take into account significant increases and variations in medical care costs, insurance coverage, out-of-pocket spending, and the financial burden imposed on families and individuals. Although medical costs consume a growing share of family and national income and studies regularly document high rates of medical financial stress and debt, the current poverty measure does not capture the consequences for families' economic security or their income available for other basic needs. In 1995, a panel of the National Research Council (NRC) recommended a new poverty measure, which compares families' disposable income to poverty thresholds based on current spending for food, clothing, shelter, utilities, and a little more. The panel's recommendations stimulated extensive collaborative research involving several government agencies on experimental poverty measures that led to a new research Supplemental Poverty Measure (SPM), which the U.S. Census Bureau first published in November 2011 and will update annually. Analyses of the effects of including and excluding certain factors from the new SPM showed that, were it not for the cost that families incurred for premiums and other medical expenses not covered by health insurance, 10 million fewer people would have been poor according to the SPM. The implementation of the patient Protection and Affordable Care Act (ACA) provides a strong impetus to think rigorously about ways to measure medical care economic burden and risk, which is the basis for Medical Care Economic Risk. As new policies - whether part of the ACA or other policies - are implemented that seek to expand and improve health insurance coverage and to protect against the high costs of medical care relative to income, such measures will be important to assess the effects of policy changes in both the short and long term on the extent of financial burden and risk for the population, which are explained in this report.

Geriatric Medicine - C.K. Cassel - 2012-12-06

With the appearance of a textbook as comprehensive as this one, it is clear that the field of geriatrics is coming of age. The broad scope of these volumes shapes a substantial

why should we be interested in it?" As I see it, there are at least five reasons. First, the scientific or intellectual reason: gerontology is the study of aging from the biologic, psychological, and social perspectives. There is increasing interest in the fascinating insights into the biologic mechanisms of aging, errors in protein synthesis, DNA repair mechanisms, alterations of the neuroendocrine system, changes in the immune system, genetic controls, and somatic mutations. Second, the demographic reason: this is the century of old age. There has been a 26-year gain in the average life expectancy. This gain compares with that acquired from 3,000 years B.C. (the Bronze Age) to the year 1900, which was about 29 years. Therefore, in one century, there has been a gain in the average life expectancy almost equal to 5,000 previous years of human history. In 1830, one of three newborn infants survived beyond 60 years of age.

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Communication about the Heart Failure Trajectory in Patients, their Families and Health Care Professionals - Lisa Hjelmfors - 2018-03-14

activity, () the three least frequently discussed the field of cardiology regarding the need for improved delivery of palliative care in patients with heart failure (HF). Professional guidelines have drawn attention to the importance of discussing the heart failure trajectory with patients and their families. These discussions can include, for example, talking about the prognosis, expectations for the future, and care at the end-of-life. It seems difficult for health care professionals to choose the right time for initiating these discussions. They often avoid these conversations because they are afraid of taking away hope and make the patients and their families anxious. Aim: The overall aim of this thesis was to improve communication about the heart failure trajectory in patients, their families, and health care professionals. Design and methods: This thesis includes five studies using different designs and data collection methods. Study I has a cross-sectional design using a questionnaire to collect data to describe heart failure nurses' perceptions of and practice in discussing prognosis and end-of-life care with heart failure patients. Study II has a descriptive and comparative design, where a survey was performed to describe Swedish and Dutch heart failure nurses' reasons for discussing or not discussing prognosis and end-of-life care with patients. Study III has an inductive and exploratory design, where HF patients participated in focus groups or individual interviews. Data was collected based on their perceptions of communication about the heart failure prognosis. Study IV was a small-scale ethnographic study describing and evaluating the delivery of a simulation when teaching third-year nursing students about end-of-life care at a Swedish university. Study V used co-design in which patients with HF from primary care, their family members and health care professionals (physicians and nurses) from palliative and HF care were invited to be constructive participants in the design process of a communication intervention. Health care professionals participated in a first feasibility testing of the intervention. Results: Most Swedish HF nurses had discussed prognosis (96%) and end-of-life care (84%) with a HF patient at some point in clinical practice. The nurses often reported that a physician was to have the main responsibility for such discussions (69%), but that the nurse was also believed to have a role to play (I). Prognosis and end-of-life care were, together with sexual

topics in HF clinics in both Sweden and the Netherlands (II). In conversations with 1,809 Swedish and Dutch HF patients, prognosis was discussed with 38% of the patients and end-of-life care was discussed with 10%. In study III, patients expressed different experiences of and preferences for communication about their HF prognosis. Many patients described that the health care professionals had not provided them with any prognosis information at all. The patients had different understandings of HF as a chronic illness, which had an impact on their preferences for communication about their prognosis (III). The simulation training described in the ethnographic study (IV) was part of an end-of-life care simulation during the last term of the 3- year bachelor degree level nursing education program, where students learn and practice basic palliative care. The students felt that the simulation training was a good opportunity to practice handling end-of- life situations as it gave them a chance to experience this situation and their own feelings and thoughts on death and dying. In study V, an intervention to improve communication about prognosis and end-of-life care in HF care was developed and some areas were feasibility tested. Heart failure patients, their families and health care professionals working in HF care or palliative care participated in the development process. Health care professionals (nurses and physicians) participated in the following feasibility testing of the intervention. Conclusions: This thesis shows that prognosis and end-of-life care are seldom discussed with HF patients in Swedish and Dutch heart failure care. and that many heart failure nurses have ambiguous attitudes towards discussing these topics with patients and their families (I+II). The patients described that they receive different messages concerning their heart failure, and that they also have different preferences for discussing the heart failure trajectory with health care professionals. The professionals need to understand the impact of heart failure on each patient and adapt the communication to each individual (III). End-of-life care simulation with skilled supervisors shows great promise for health care professionals to learn good communication skills in end-of-life care conversations (IV). A Question Prompt List and a communication course might be useful for improving communication about the heart failure trajectory in patients, their families, and health

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Introduction: There is an increasing awareness in the field of cardiology regarding the need for improved delivery of palliative care in patients with heart failure (HF). Professional guidelines have drawn attention to the importance of discussing the heart failure trajectory with patients and their families. These discussions can include, for example, talking about the prognosis, expectations for the future, and care at the end-of-life. It seems difficult for health care professionals to choose the right time for initiating these discussions. They often avoid these conversations because they are afraid of taking away hope and make the patients and their families anxious. **Aim:** The overall aim of this thesis was to improve communication about the heart failure trajectory in patients, their families, and health care professionals. **Design and methods:** This thesis includes five studies using different designs and data collection methods. Study I has a cross-sectional design using a questionnaire to collect data to describe heart failure nurses' perceptions of and practice in discussing prognosis and end-of-life care with heart failure patients. Study II has a descriptive and comparative design, where a survey was performed to describe Swedish and Dutch heart failure nurses' reasons for discussing or not discussing prognosis and end-of-life care with patients. Study III has an inductive and exploratory design, where HF patients participated in focus groups or individual interviews. Data was collected based on their perceptions of communication about the heart failure prognosis. Study IV was a small-scale ethnographic study describing and evaluating the delivery of a simulation when teaching third-year nursing students about end-of-life care at a Swedish university. Study V used co-design in which patients with HF from primary care, their family members and health care professionals (physicians and nurses) from palliative and HF care were invited to be constructive participants in the design process of a communication intervention. Health care professionals participated in a first feasibility testing of the intervention. **Results:** Most Swedish HF nurses had discussed prognosis (96%) and end-of-life

clinical practice. The nurses often reported that a physician was to have the main responsibility for such discussions (69%), but that the nurse was also believed to have a role to play (I). Prognosis and end-of-life care were, together with sexual activity, () the three least frequently discussed topics in HF clinics in both Sweden and the Netherlands (II). In conversations with 1,809 Swedish and Dutch HF patients, prognosis was discussed with 38% of the patients and end-of-life care was discussed with 10%. In study III, patients expressed different experiences of and preferences for communication about their HF prognosis. Many patients described that the health care professionals had not provided them with any prognosis information at all. The patients had different understandings of HF as a chronic illness, which had an impact on their preferences for communication about their prognosis (III). The simulation training described in the ethnographic study (IV) was part of an end-of-life care simulation during the last term of the 3- year bachelor degree level nursing education program, where students learn and practice basic palliative care. The students felt that the simulation training was a good opportunity to practice handling end-of- life situations as it gave them a chance to experience this situation and their own feelings and thoughts on death and dying. In study V, an intervention to improve communication about prognosis and end-of-life care in HF care was developed and some areas were feasibility tested. Heart failure patients, their families and health care professionals working in HF care or palliative care participated in the development process. Health care professionals (nurses and physicians) participated in the following feasibility testing of the intervention. **Conclusions:** This thesis shows that prognosis and end-of-life care are seldom discussed with HF patients in Swedish and Dutch heart failure care. and that many heart failure nurses have ambiguous attitudes towards discussing these topics with patients and their families (I+II). The patients described that they receive different messages concerning their heart failure, and that they also have different preferences for discussing the heart failure trajectory with health care professionals. The professionals need to understand the impact of heart failure on each patient and adapt the communication to each individual (III). End-of-life care simulation with skilled supervisors shows

Congress. Senate. Committee on Government learn good communication skills in end-of-life care conversations (IV). A Question Prompt List and a communication course might be useful for improving communication about the heart failure trajectory in patients, their families, and health care professionals

The Birth Control Clinic, Outpatient Abortion and Family Planning Services - Sonia Ruiz Stafko - 1975

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Breaking Point - John P. Geyman - 2011
Our market-based, profit-driven health care system in the United States has put necessary care increasingly beyond the reach of ordinary Americans. Primary health care, the fundamental foundation of all high-performing health care systems in the world, is a critical but ignored casualty of the current system. Unfortunately, primary care is often poorly understood, even within the health professions. This book describes what has become a crisis in primary care, defines its central role, analyzes the reasons for its decline, and assesses its impacts on patients and families. A constructive approach is presented to rebuild and transform U.S. primary care with the urgent goal to address the nation's problems of access, cost, quality and equity of health care for all Americans.

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Health Care in America - United States.

Operations. Subcommittee on Executive Reorganization - 1969

Health Care in America - United States. Congress. Senate. Committee on Government Operations. Subcommittee on Executive Reorganization - 1969

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Medical Care in Transition: 1962-66 - - 1949

Medical Care in Transition: 1962-66 - - 1949

Departments of Labor and Health, Education, and Welfare Appropriations for 1973 - United States. Congress. House. Committee on Appropriations. Subcommittee on Departments of Labor, and Health, Education, and Welfare, and Related Agencies - 1972

Departments of Labor and Health, Education, and Welfare Appropriations for 1973 - United States. Congress. House. Committee on Appropriations. Subcommittee on Departments of Labor, and Health, Education, and Welfare, and Related Agencies - 1972

Issues in Family Medicine Research and Practice: 2013 Edition - - 2013-05-01
Issues in Family Medicine Research and Practice: 2013 Edition is a ScholarlyEditions™ book that delivers timely, authoritative, and comprehensive information about Internal Medicine. The editors have built Issues in Family Medicine Research and Practice: 2013 Edition on the vast information databases of ScholarlyNews.™ You can expect the information about Internal Medicine in this book to be deeper than what you can access anywhere else, as well as consistently reliable, authoritative, informed, and relevant. The content of Issues in Family Medicine Research and Practice: 2013 Edition has been produced by the world's leading scientists, engineers, analysts, research institutions, and companies. All of the content is from peer-reviewed sources, and all of it is written, assembled, and edited by the editors at ScholarlyEditions™ and available exclusively from us. You now have a source you can cite with

individuals, while hard to pin down exactly, is information is available at <http://www.ScholarlyEditions.com/>.

Issues in Family Medicine Research and Practice: 2013 Edition - - 2013-05-01

Issues in Family Medicine Research and Practice: 2013 Edition is a ScholarlyEditions™ book that delivers timely, authoritative, and comprehensive information about Internal Medicine. The editors have built Issues in Family Medicine Research and Practice: 2013 Edition on the vast information databases of ScholarlyNews.™ You can expect the information about Internal Medicine in this book to be deeper than what you can access anywhere else, as well as consistently reliable, authoritative, informed, and relevant. The content of Issues in Family Medicine Research and Practice: 2013 Edition has been produced by the world's leading scientists, engineers, analysts, research institutions, and companies. All of the content is from peer-reviewed sources, and all of it is written, assembled, and edited by the editors at ScholarlyEditions™ and available exclusively from us. You now have a source you can cite with authority, confidence, and credibility. More information is available at <http://www.ScholarlyEditions.com/>.

Homelessness, Health, and Human Needs - Institute of Medicine - 1988-02-01

There have always been homeless people in the United States, but their plight has only recently stirred widespread public reaction and concern. Part of this new recognition stems from the problem's prevalence: the number of homeless individuals, while hard to pin down exactly, is rising. In light of this, Congress asked the Institute of Medicine to find out whether existing health care programs were ignoring the homeless or delivering care to them inefficiently. This book is the report prepared by a committee of experts who examined these problems through visits to city slums and impoverished rural areas, and through an analysis of papers written by leading scholars in the field.

Homelessness, Health, and Human Needs - Institute of Medicine - 1988-02-01

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National Medical Care Utilization and Expenditure Survey - - 1988

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National Medical Care Utilization and Expenditure Survey - - 1983

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Procedures and Questionnaires of the National Medical Care Utilization and Expenditure Survey - Gordon Scott Bonham - 1983

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Quality By Design - Eugene C. Nelson - 2007-03-22

Quality by Design reflects the research and applied training conducted at Dartmouth Medical School under the leadership of Gene Nelson, Paul Batalden, and Marjorie Godfrey. The book includes the research results of high-performing clinical microsystems, illustrative case studies that highlight individual clinical programs, guiding principles that are easily applied, and tools, techniques, and methods that can be adapted by clinical practices and interdisciplinary clinical teams. The authors describe how to develop microsystems that can attain peak performance through active engagement of interdisciplinary teams in learning and applying improvement science and measurement; explore the essence of leadership for clinical Microsystems; show what mid-level leaders can do to enable peak performance at the front lines of care; outline the design and redesign of services and planning care to match

information you'll need right at your finger tips. issue of safety; describe the vital role of data in creating a rich and useful information environment; provide a core curriculum that can build microsystems' capability, provide excellent care, promote a positive work environment, and contribute to the larger organization. Ancillary materials for use in classroom teaching, training, or coaching are available at <http://clinicalmicrosystem.org/materials/>

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My Personal Medical Log Book / a Health Record Keeper and Journal - RealMe Journals - 2019-11-09

This is the perfect personal health record book to track all your important healthcare information in one convenient place. It's designed for ease of use and completeness, making it ideal for every member of the family, from mom & dad, children, aging parents and caregivers. Take it with you to each medical appointment, ER/urgent care visit, and hospital stay, and you'll have all the

As a bonus, you'll get wallet sized medication and emergency contact cards to cut out/fill out and carry with you (4 of each). This Medical Health Record Keeper Features: Large 8 x 10 size for ample space to write in Personal Information page including emergency contacts Insurance & Pharmacy Information Family Medical History with 2 - 2 page spreads to include up to 14 family members My Medical Quick View page Immunizations Notes Pages - on a 2 page spread between each new section Medication Log - with name, condition, dose, frequency, start & end dates, prescribing physician and notes sections My Physicians Pages - with contact information including patient portal login & password information Preferred Hospitals & Imaging Center - location, contact and patient portal information Surgical History - procedure, date, hospital, physician, (right, left, both n/a) and ample room for notes! Emergency Room/Urgent Care - everything you need including discharge instructions Doctor Visits - 2 page spread including date, appointment time, physician & specialty, ample room for questions/concerns you don't want to forget to address with your doctor, vitals, medication updates, doctor diagnosis/discussion notes section, and tests being ordered (exam, date, facility, appointment time, prep and results) Bonus pages! Wallet sized medication cards (4) and wallet sized emergency information cards (4) to cut out (not perforated) fill out and carry with you. They're great to share with family too! Simple. Comprehensive. Organized. Perfect for the whole family! Thank you for your interest in our Medical Health Record Book. We wish you good health & happiness!!

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Compendium of HHS Evaluations and Relevant Other Studies - HHS Policy Information Center (U.S.) - 1990

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Advance Data from Vital & Health Statistics of the National Center for Health Statistics - 1976

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Family Practice in the Eastern Mediterranean Region - Hassan Salah - 2019-04-08

This joint publication from the World Health

of Family Doctors (WONCA) provides a concise analysis of the state of family practice in the 22 countries spread over North Africa, the Middle East and Western Asia, i.e. the Eastern Mediterranean Region (EMR) in both English and Arabic. It shares perspectives and advice from global and regional leaders on how family practice can be introduced and strengthened in high-, middle- and low-income countries.

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Population Health Management for Poly Chronic Conditions - Thomas T.H. Wan - 2017-10-24

This book is dedicated to population health management and how it can be used to improve the health care and outcomes for patients with poly chronic conditions. The book uses an integrated approach guided by a transdisciplinary orientation that incorporates both a macro and a micro-theoretical framework for promoting population health management. Thus, policy decision makers can prioritize how limited resources can be used to optimize health service needs of the chronically ill and disabled in the nation as well as in the globe. The book also identifies appropriate applications of health information technology that can facilitate interoperability, data sharing and effective communication to ensure that applicable knowledge is derived from the available information. Multiple implications of population health management for poly chronic conditions suggest that concerted efforts in promoting preventive strategies can yield numerous benefits. Continuous improvement efforts through impact evaluation and a commitment to the adoption of the health information technology resources needed are also critical aspects of this process. Patients with poly chronic conditions

opinions on innovative care management of health services. Great potential exists to improve the health and health care of these individuals through improved coordination integrating multiple domains of the population health management approach. Population Health Management is needed now more than ever due to the current challenges facing the health care system that were not present in previous decades. This book points out strategic directions suggested by empirical evidence and experts' opinions on innovative care management solutions observed in many advanced countries.

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Encyclopedia of Family Health - Martha Craft-Rosenberg - 2011-01-20

Request a FREE 30-day online trial to this title at www.sagepub.com/freetrial What is unique about the process in the discussion of healthcare and interventions to use when working with families? What assessment tools provide guidance for healthcare providers as they determine interventions for families in their care? What are the changing dimensions of contemporary family life, and what impact do those dimensions have on health promotion for families? How is family healthcare changing in terms of practices, delivery systems, costs and insurance coverage? Students are able to explore these questions and more in the Encyclopedia of Family Health. Approximately 350 signed articles written by experts from such varied fields as health and nursing, social and behavioral sciences, and policy provide authoritative, cross-disciplinary coverage. Entries examine theory, research and policy as they relate to family practice in a manner that is accessible and jargon-free. From 'Adolescent Suicide' and 'Alternative Therapies' to 'Visitation during Hospitalization' and 'Weight Problems and Genetics', this work provides coverage of a variety of issues within a family context. The Encyclopedia of Family Health provides a comprehensive summary of theory, research, practice, and policy on family health and wellness promotion for students and researchers.

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Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2011 - United States. Congress. House. Committee on Appropriations. Subcommittee on the Departments of Labor, Health and Human Services, Education, and

Related Agencies - 2010

Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2011 - United States. Congress. House. Committee on Appropriations. Subcommittee on the Departments of Labor, Health and Human Services, Education, and Related Agencies - 2010

Rural Health Care for the Elderly - United States. Congress. Senate. Special Committee on Aging - 1982

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