SIX MAJOR TYPES OF DELIVERY SYSTEMS pdf

1: Models of Nursing Care Delivery

5 Types of Health Care Facilities With the increasing complexity of the health care system, patients now have an incredible array of choices when it comes to receiving care. This often includes the option of selecting what type of health care facility they wish to utilize.

Army Retired , and health care consultant; e-mail: Ideally, evidence of the effect of care models on quality and patient safety would also be a major factor in decisionmaking. Historically, four traditional care models have dominated the organization of inpatient nursing care. Functional and team nursing are task-oriented and use a mix of nursing personnel; total patient care and primary nursing are patient-oriented and rely on registered nurses RNs to deliver care. Models have been examined for medical housestaff, 6 pharmacy services, 7 and social workers. Neither the traditional nor the nontraditional inpatient nursing care models have been evaluated rigorously for their effects on patient safety. Of these, some reported pilot data, 6 , 7 , 13 , 24 , 41 , 42 some were quality-improvement projects, 14 , 17 , 43 and others used qualitative methods. However, these qualitative studies illuminate important aspects of care models not evident in quantitative investigations. For example, Ingersoll 32 and Redman and Jones 36 were among the first investigators to assess the effects of patient-centered care models on nurse managers. The data from both of these studies expose the pressure and role confusion experienced by nurse managers. Subsequently, a quantitative investigation found nurse managers experienced a high level of emotional exhaustion, a key component of burnout. The remaining seven studies used Level 3 designs. In two of these studies, large databases were used to examine different care models for home-based long-term care 15 and mental health services. For each of these five investigations, data were reported from only one hospital. Most often, measurements were done at three points in timeâ€”pre-implementation, and at 6 and 12 months after the model was introduced. The first pertains to studies of inpatient nursing care models. Statistically discernible differences were rarely evident, and when they were, there was no clear pattern to guide practice. This is similar to results from the study by Greenberg and colleagues 21 in which most positive effects of change lasted only one year. Despite the growing number of work redesign studies, the findings are too disparate even among those with stronger designs to offer a clear direction about practice changes to improve patient safety. The second cluster of care model studies consists of three investigations that were conducted by other disciplines. The improved ability to detect statistical differences in these models may derive from their large sample sizes, their statistical techniques, or their use of different outcomes. The systematic review and meta-analysis of disease management programs for individuals with depression offers the strongest evidence for guiding care delivery. Research Implications We actually know very little about the relationship between care models and patient safety. Randomized controlled trials RCTs might contribute evidence that would help investigators, administrators, and policy makers sort through the confusion. RCTs would be particularly difficult to conduct, however, given the need to have longitudinal data. The rapidly changing health care environment is not conducive to such endeavors. The most glaring need relates to clarifying the work that needs to be done for patients and then determining which clinicians are best suited to provide it. Looking only at the work of nurses, which has dominated studies of care models in acute care settings, fails to consider nonnursing staff who are critical to the patient care mission. We also know very little about care models that promote patient safety in outpatient settings, home care, or long-term care. These are areas that remain to be explored. Conclusion Care delivery models range from traditional forms, such as team and primary nursing, to emerging models. Even models with the same name may be operationalized in very different ways. The rationale for selecting different care models ranges from economic considerations to the availability of staff. What is glaring in its absence, however, is the limited research related to care models. Even more sparse is research that examines the relationship between models of care and patient safety. Ideally, future studies will not only fill this void, but the models tested will be developed based on a comprehensive view of patient needs, taking the full complement of individuals required to render quality care into account. Search terms were identified with the guidance of a reference librarian. The abstracts for each of the citations were reviewed. From this assessment it was determined that 82 of the articles were sufficiently focused on

nursing or patient care models and should be considered further. For example, articles about medical management models were not used in this review. Additionally, a number of papers addressed topics with no discernible connection to care models e. The 82 articles were located and carefully read. As a result, 31 additional papers were omitted from the actual analysis. Reasons for these omissions included the lack of sufficient detail about the study, duplicate publications, and studies of advanced practice nurses. This left 51 articles for consideration in this review. Acknowledgments Tremendous gratitude is expressed to the staff of the Armed Forces Medical Library for their considerable support of this work. They conducted the database searches and assisted in acquiring numerous papers considered in this review. Nursing organizational practice and its relationship with other features of ward organization and job satisfaction. Tiedeman ME, Lookinland S. Traditional models of care delivery. What have we learned? Nursing work redesign in response to managed care. Nontraditional models of care delivery. Have they solved the problems? Introduction of a hour work shift model for housestaff in the Medical ICU. Transformation of a pharmacy department: Jt Comm J Qual Improv. Development of the workload analysis scale WAS for the assessment and rehabilitation services of Ballarat Health Services. Soc Work Health Care. Patient care staffing patterns and roles in community-based family practices J Fam Prac http: Dimensions of the staff nurse role in ambulatory care: Prediction costs of Veterans Affairs health care in Gulf War veterans with medically unexplained physical symptoms. The use of unlicensed assistive personnel and selected outcome indications. The design and implementation of a restorative care model for home care. Comparing consumer-directed and agency models for providing supportive services at home. PMC] [PubMed: The quality of nursing home care: Using outcomes and benchmarks for evidence-based practice. Implementation of best practice models. Measuring quality of care with an inpatient elderly population. The geriatric resource nurse model. From profession-based leadership to service line management in the Veterans Health Administration. Disease management programs for depression. A systematic review and meta-analysis of randomized controlled trials. Using continuous quality improvement to improve diabetes care in populations: A randomized trial of telenursing to reduce hospitalization for heart failure: Home Health Care Serv Q. Chapter 39 Nurse staffing, models of care delivery, and interventions. Making health care safer: Agency for Healthcare Research and Quality; Adams A, Bond S. Clinical specialty and organizational features of acute hospital wards. Satisfaction with a new model of professional practice in critical care. Crit Care Nurs Q. Can J Nurs Leadersh. Hall LM, Doran D. Nurse staffing, care delivery model, and patient care quality. J Nurs Care Qual. Differences in professional practice model outcomes: The impact of practice setting. Organizational trust and empowerment in restructured healthcare settings. Effects on staff nurse commitment. Organization of nursing care and stressful work characteristics. Changes related to care delivery patterns. Effects of implementing patient-centered care models on nurse and non-nurse managers. Models of care using unlicensed assistive personnel. Evaluation of a hospital work redesign. Evaluation of a partnership model of care delivery involving registered nurses and unlicensed assistive personnel. An aging population with chronic disease compels new delivery systems focused on new structures and practices.

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2: Delivery (commerce) - Wikipedia

Community wk 6 - major types of dental delivery systems study guide by cherylcearlock includes 57 questions covering vocabulary, terms and more. Quizlet flashcards, activities and games help you improve your grades.

These vehicle bodies were initially built with the traditional GRP sandwich panels but as more damage resistant lightweight materials with better insulation properties have become available companies have been developing Advanced Home Delivery Vehicles. Vehicles are often specialized to deliver different types of goods. On land, semi-trailers are outfitted with various trailers such as box trailers, flatbeds, car carriers, tanks and other specialized trailers, while railroad trains include similarly specialized cars. Armored cars , dump trucks and concrete mixers are examples of vehicles specialized for delivery of specific types of goods. On the sea, merchant ships come in various forms, such as cargo ships , oil tankers and fishing boats. Freight aircraft are used to deliver cargo. Often, passenger vehicles are used for delivery of goods. These include buses , vans , pick-ups , cars e. A significant amount of freight is carried in the cargo holds of passenger ships and aircraft. Everyday travelers, known as a casual courier , can also be used to deliver goods. Delivery to remote, primitive or inhospitable areas may be accomplished using small aircraft , snowmobiles , horse-drawn vehicles , dog sleds , pack animals , on foot, or by a variety of other transport methods. Periodic deliveries[edit] Some products are delivered to consumers on a periodic schedule. At the beginning of the 20th century, perishable farm items such as milk, eggs and ice, were delivered weekly or even daily to customers by local farms. Milkmen delivered milk and other farm produce. With the advent of home refrigeration and better distribution methods, these products are today largely delivered through the same retail distribution systems as other food products. Icemen delivered ice for iceboxes until the popularization of home refrigerator rendered them obsolete in most places. Similarly, laundry was once picked up and washed at a commercial laundry before being delivered to middle-class homes until the appearance of the washing machine and dryer the lower classes washed their own and the upper classes had live-in servants. Likewise deliveries of coal and wood for home heating were more common until they were replaced in many areas by natural gas , oil, or electric heating. Human blood may be delivered to hospitals on a periodic schedule. For example, the last milk delivery by horse-and-wagon in Edmonton was in Related lines of Jeannie C.

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3: Six Key Elements in Organizational Design

Discuss the key elements of the different types of integrated delivery systems. 19 2 tions of the different types of managed care systems that follow provide only.

References Aim The aim of this guideline is to describe the indications and procedure for the use of oxygen therapy, and its modes of delivery. Introduction The goal of oxygen delivery is to maintain targeted SpO2 levels in children through the provision of supplemental oxygen in a safe and effective way which is tolerated by infants and children to: Give oxygen therapy in a way which prevents excessive CO2 accumulation - i. Reduce the work of breathing. Ensure adequate clearance of secretions and limit the adverse events of hypothermia and insensible water loss by use of optimal humidification dependent on mode of oxygen delivery. Maintain efficient and economical use of oxygen. Definition of terms FiO2: The partial pressure of CO2 in arterial blood. It is used to assess the adequacy of ventilation. The partial pressure of oxygen in arterial blood. It is used to assess the adequacy of oxygenation. Arterial oxygen saturation measured from blood specimen. Arterial oxygen saturation measured via pulse oximetry. Where the total flow delivered to the patient meets or exceeds their Peak Inspiratory Flow Rate the FiO2 delivered to the patient will be accurate. High flow in approved areas only. Consult your NUM if unsure. Humidification is the addition of heat and moisture to a gas. The amount of water vapour that a gas can carry increases with temperature. Increased amounts of carbon dioxide in the blood. Low arterial oxygen tension in the blood. Low oxygen level at the tissues. The total amount of gas moving into and out of the lungs per minute. The minute ventilation volume is calculated by multiplying the tidal volume by the respiration rate, measured in litres per minute. The fastest flow rate of air during inspiration, measured in litres per second. Ventilation - Perfusion VQ mismatch: An imbalance between alveolar ventilation and pulmonary capillary blood flow. The above values are expected target ranges. Any deviation should be documented on the observation chart as MET modifications. Indications for oxygen delivery Where considering the application of oxygen therapy it is essential to perform a thorough clinical assessment of the child. Transient, self-correcting desaturations that have no other physiological correlates eg. Tachycardia, cyanosis may not routinely require oxygen therapy in most cases. There is no physiological basis for the application of low flow oxygen therapy to a child with normal SpO2 and increased work of breathing. Achieving targeted percentage of oxygen saturation as per normal values unless a different target range is specified on the observation chart. The treatment of an acute or emergency situation where hypoxaemia or hypoxia is suspected, and if the child is in respiratory distress manifested by: Short term therapy e. Oxygen treatment should be commenced or increased to avoid hypoxaemia and should be reduced or ceased to avoid hyperoxaemia For children receiving oxygen therapy SpO2 targets will vary according to the age of the child, clinical condition and trajectory of illness. Oxygen therapy concentration and flow may be varied in most circumstances without specific medical orders, but medical orders override these standing orders. Commencement or Increase of Oxygen Therapy: Oxygen therapy should be commenced if: Oxygen therapy should be reduced or ceased if: Check and document oxygen equipment set up at the commencement of each shift and with any change in patient condition. Hourly checks should be made for the following: Ensure the individual MET criteria are observed regardless of oxygen requirements See below nursing guidelines for additional guidance in assessment and monitoring:

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4: Vectors in gene therapy - Wikipedia

6 Different Types of Trucking Jobs March 1, / 0 Comments / in Truck Drivers, Trucking Business, Trucking Operations / by admin Most people believe that a truck driver is simply a guy (or a gal) sitting behind a wheel of a large vehicle and driving hundreds of miles a day.

Outpatient care can be provided by primary care physicians and various types of medical specialists. For care from a primary care physician, it is usually necessary for the person seeking care to have previously registered been enrolled with that physician. A doctor may refuse to accept a patient for treatment in any of the following situations: If the doctor already has a full roster of registered persons â€" such that the doctor would not have the ability to properly care for their existing registered persons if additional persons were registered. If the patient is not insured by a health insurance company with which the provider of medical services has a contract; this does not apply to persons with insurance who are insured in another Member State of the European Union, a state that is part of the European Economic Area or the Swiss Confederation, or persons from a country with which the Czech Republic has entered into a social security agreement, which includes within its scope a substantive right to healthcare. Should a primary care physician refuse to register or accept an individual as a patient, the refused person is entitled to have the refusal provided to them in writing. In the case of an emergency i. Individuals always have the right to visit a specialist without first seeing their primary care physician. The following types of outpatient care are provided: It also includes the coordination of the continuity of healthcare services being provided by other providers specialists, medical facilities. Primary outpatient care also includes any necessary home visits to a patient. This is care that requires the services of a medical specialist for example, an internist, surgeon, cardiologist, etc. This care is provided to patients whose medical condition requires repeated daily outpatient type treatments. There are the following types of inpatient health care facilities: Inpatient care must be provided in a medical facility of a healthcare provider with hour operating hours. In the Czech Republic there are four types of inpatient care: This is intended for any of the following: Patients with a sudden illness or the sudden deterioration of a chronic condition, which seriously threatens their health, but does not lead directly to a failure of vital bodily functions. The performance of a medical procedure that cannot be done on the outpatient basis. To give an early start to some type of medical rehabilitation program. This level of care is provided to patients in situations in which there is a sudden bodily malfunction or a sudden threat to basic bodily functions or situations in which such a malfunction can be reasonably expected to occur. This level of care is provided to the following: Patients who were given a baseline diagnosis and whose health condition has been stabilized. Patients who are dealing with a sudden illness or a sudden worsening of a chronic condition. Patients whose medical condition requires follow-up care or some type of therapeutic rehabilitative care. Patients who are partially or totally dependent on some type of care for the support of vital bodily functions. This level of care is provided to patients whose medical condition cannot be significantly improved by medical treatment or intervention. It is also provided to patients requiring the ongoing provision of some type of nursing care to prevent their condition from worsening. This level of care is also provided to patients with some type of impaired basic bodily function. Medical Rescue Service and Emergency Service The Medical Rescue Service is a healthcare service, which is contacted using the below-listed emergency phone number. It is primarily designed to provide pre-hospitalization emergency care to an individual with a severe health impairment or to someone facing a life-threatening situation. It is used in the case of a sudden severe illness or injury, when the patient cannot be expected to get to the hospital by themselves. This service is also used in the event of an accident, when someone needs to receive immediate care. The following phone numbers are to be used in an emergency situation: An Emergency Service paid for by the health insurance provider is also available for use by those with a less severe sudden illness including injury, a dental problem outside of normal business hours and in the absence of an attending physician. Based on the arrangements made in different local areas and with different medical facilities, doctors either cover for one other in their own offices or the care is provided in special offices of the emergency medical services or dental emergency services. These emergency services are usually provided by inpatient medical care service

providers i. More information can be obtained from the Department of Health or from the offices of the local Regional Authorities on the manner in which emergency medical services are dispatched and provided. These occupation-related medical services include preventative examinations and health condition assessments, which are used to evaluate the fitness of an individual to perform the tasks required of them by their respective job. Also included here are consultations on occupational health and safety issues, occupationally-related diseases and work-related illnesses. As part of these occupational medical services, the employer pays for employee training in first aid and the regular supervision of workplaces and working conditions. Through the active and long-term monitoring of the condition of such patients, it is possible to get a timely diagnosis of when there is the need for additional therapeutic intervention. Providing of Medicines and Medical Devices In the Czech Republic there is an extensive network of pharmaceutical dispensing facilities pharmacies , which are used for the distribution of medicinal products drugs and medical devices, both on the basis of a doctor-provided prescription and without it i. Medical prescriptions have the following types of validity:

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5: Viral and nonviral delivery systems for gene delivery

This chapter has outlined the main areas in which the health care delivery system and the governmental public health agencies interface. These areas include the regulatory and quality monitoring functions performed by governmental agencies, disease surveillance and reporting by health care providers, and the provision of safety-net services.

The model of nursing care used varies greatly from one facility to another and from one set of patient circumstances to another.. Involves use of a team leader and team members to provide various aspects of nursing care to a group of patients. In team nursing, medications might be given by one nurse while baths and physical care are given by a nursing assistant under the supervision of a nurse team leader. Skill mixes include experienced and specially qualified nurses to nursing orderlies. The quality of patient care with this system is questionable, and fragmentation of care is of concern. This type of nursing care allows the nurse to give direct patient care. Nursing care is directed toward meeting all of the individualized patient needs. This care method is rejected by many institutions as too costly. Organization of medical and nursing care according to the degree of illness and care requirements in the hospital. Progressive patient care is the systematic grouping of patients according to their degree of illness and dependency on the nurse rather than by classification of disease and sex. It is a method of planning the hospital facilities, both staff and equipment, to meet the individual requirements of the patient. Elements of PPC are Raven RW, Intensive care units for critically ill patient Self-care units for convalescent patients or those requiring investigation. Beds attached to out-patient departments for " one day" patients. The elements can also be named as intensive care, intermediate care, self-care, long-term care, and organized home care. Major concepts of PPC PPC is defined as better patient care through the organization of hospital facilities, services and staff around the changing medical and nursing needs of the patient PPC is tailoring of hospital services to meet patients needs PPC is caring for the right patient in the right bed with the right services at the right time PPC is systematic classification of patients based on their medical needs References Smeltzer SC, Bare BG. Lippincott Williams and Wilkins. British Medical Journal, Public Health Reports, Vol. Elements of progressive patient care. In Progressive patient care-an anthology, edited by L. University of Michigan Press, Ann Arbor,

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6: WHO | Health systems service delivery

*Project Delivery System *- The process selected to execute a construction project for the purpose of assigning responsibilities and risk to the project team.*

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,

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7: Care Models - Patient Safety and Quality - NCBI Bookshelf

Delivery is the process of transporting goods from a source location to a predefined destination. There are different delivery types. Cargo (physical goods) are primarily delivered via roads and railroads on land, shipping lanes on the sea and airline networks in the air.

Organizational Design is a process that involves decisions about the following six key elements: This section is presented by: Work Specialization Describes the degree to which tasks in an organization are divided into separate jobs. The main idea of this organizational design is that an entire job is not done by one individual. It is broken down into steps, and a different person completes each step. Individual employees specialize in doing part of an activity rather than the entire activity. Departmentalization It is the basis by which jobs are grouped together. For instance every organization has its own specific way of classifying and grouping work activities. There are five common forms of departmentalization: As shown in the Figure , it groups jobs by functions performed. It can be used in all kinds of organizations; it depends on the goals each of them wants to achieve. Figure Functional Departmentalization example Different aspects on this type of departmentalization: Positive Aspects Efficiencies from putting together similar specialties and people with common skills, knowledge, and orientations Coordination within functional area Poor communication across functional areas Limited view of organizational goals Product Departmentalization. It groups jobs by product line. Product Departmentalization example Source: Bombardier Annual Report Different aspects on this type of departmentalization: Positive Aspects Allows specialization in particular products and services Managers can become experts in their industry Closer to customers Limited view of organizational goals Geographical Departmentalization. It groups jobs on the basis of territory or geography. Geographical Departmentalization example Different aspects on this type of departmentalization: Positive Aspects More effective and efficient handling of specific regional issues that arise Serve needs of unique geographic markets better Duplication of functions Can feel isolated from other organizational areas Process Departmentalization. It groups on the basis of product or customer flow. Process Departmentalization example Different aspects on this type of departmentalization: Positive Aspects More efficient flow of work activities Can only be used with certain types of products Customer Departmentalization. It groups jobs on the basis of common customers Figure Customer Departmentalization example Different aspects on this type of departmentalization: Chain of command It is defined as a continuous line of authority that extends from upper organizational levels to the lowest levels and clarifies who reports to whom. There are three important concepts attached to this theory: Refers to the rights inherent in a managerial position to tell people what to do and to expect them to do it. The obligation to perform any assigned duties. The management principle that each person should report to only one manager. Span of Control It is important to a large degree because it determines the number of levels and managers an organization has. Also, determines the number of employees a manager can efficiently and effectively manage.

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8: Oxygen Administration: What is the Best Choice? | RT

Generally speaking, when we think of e-commerce, we think of an online commercial transaction between a supplier and a client. However, and although this idea is right, we can be more specific and actually divide e-commerce into six major types, all with different characteristics.

Essentially, this is true. However, not all trucking jobs are created equal. They vary in intensity and pay as well as benefits. Whether you are just starting out on your way to becoming a trucker or getting ready to change professions, you might want to get a better idea of the various types of trucking jobs. Long-Haul Trucker These truckers work with heavy trucks carrying various loads. They usually drive for long periods of time, be it within the state or interstate. The work schedule of long-haul truckers can vary greatly. Some come back home the same night, others travel for days or weeks at a time. Long-haul drivers often work in teams in order to avoid layovers. Pick up and Delivery Trucker These truckers work with all types of trucks from heavy to light. They usually have regular routes for pickup and delivery of various goods. Such truck drivers can earn more money if they also have sales skills. Specialized Truck Drivers These truckers transport unusual loads, including oversized or sensitive materials. They work both within the states and between them. Such drivers often need extra training to learn how to operate the equipment that handles the specialized loads. Depending on the type of the load, various permits might be required. Hazardous Load Truck Drivers These drivers require training to learn how to handle hazardous loads. They need to know the characteristics of the materials they are carrying and how to handle them safely, as well as how to act in an emergency. Hazardous load truck drivers must pass an extra test when applying for CDL. One of the highest paid hazardous load truck drivers are tanker drivers. They have to deal with liquefied or gaseous loads. The high wages come from the danger such truckers face if the load is not handled properly. The containers these drivers carry can be either pressurized or non-pressurized. Such containers make the driving harder. Meanwhile, tank truck drivers risk their lives. Refrigerated Truck Drivers These truck drivers deal with refrigerated containers. They haul them to different destinations, both within the state and out of it. Temperature sensitive loads need special attention since they can spoil if carried too slowly. Flat Bed Truck Drivers These drivers operate flatbed trucks that are usually used to load construction materials, such as pipes, wood, timber, and more. Improperly fastened cargo is one of the main reasons for accidents caused by the truckers. Before choosing a trucking job, make sure you have the proper permits and ask yourself whether you are ready to execute dangerous tasks.

SIX MAJOR TYPES OF DELIVERY SYSTEMS pdf

9: Types of healthcare delivery services

A review of the different oxygen delivery devices, clinical indications, and utilization will present below. Low-Flow Delivery Typical low-flow oxygen systems provide supplemental oxygen often less than the patient's total minute ventilation.

This part describes types of contracts that may be used in acquisitions. It prescribes policies and procedures and provides guidance for selecting a contract type appropriate to the circumstances of the acquisition. Contract types vary according to -- 1 The degree and timing of the responsibility assumed by the contractor for the costs of performance; and 2 The amount and nature of the profit incentive offered to the contractor for achieving or exceeding specified standards or goals. The specific contract types range from firm-fixed-price, in which the contractor has full responsibility for the performance costs and resulting profit or loss , to cost-plus-fixed-fee, in which the contractor has minimal responsibility for the performance costs and the negotiated fee profit is fixed. In between are the various incentive contracts see Subpart Contract types not described in this regulation shall not be used, except as a deviation under Subpart 1. Prime contracts including letter contracts other than firm-fixed-price contracts shall, by an appropriate clause, prohibit cost-plus-a-percentage-of-cost subcontracts see clauses prescribed in Subpart Negotiating the contract type and negotiating prices are closely related and should be considered together. The objective is to negotiate a contract type and price or estimated cost and fee that will result in reasonable contractor risk and provide the contractor with the greatest incentive for efficient and economical performance. However, when a reasonable basis for firm pricing does not exist, other contract types should be considered, and negotiations should be directed toward selecting a contract type or combination of types that will appropriately tie profit to contractor performance. In particular, contracting officers should avoid protracted use of a cost-reimbursement or time-and-materials contract after experience provides a basis for firmer pricing. This shall be documented in the acquisition plan, or in the contract file if a written acquisition plan is not required by agency procedures. For such instances, acquisition personnel shall discussâ€” A How the Government identified the additional risks e. There are many factors that the contracting officer should consider in selecting and negotiating the contract type. They include the following: Price analysis, with or without competition, may provide a basis for selecting the contract type. The degree to which price analysis can provide a realistic pricing standard should be carefully considered. In the absence of effective price competition and if price analysis is not sufficient, the cost estimates of the offeror and the Government provide the bases for negotiating contract pricing arrangements. It is essential that the uncertainties involved in performance and their possible impact upon costs be identified and evaluated, so that a contract type that places a reasonable degree of cost responsibility upon the contractor can be negotiated. Complex requirements, particularly those unique to the Government, usually result in greater risk assumption by the Government. This is especially true for complex research and development contracts, when performance uncertainties or the likelihood of changes makes it difficult to estimate performance costs in advance. As a requirement recurs or as quantity production begins, the cost risk should shift to the contractor, and a fixed-price contract should be considered. If the entire contract cannot be firm-fixed-price, the contracting officer shall consider whether or not a portion of the contract can be established on a firm-fixed-price basis. If urgency is a primary factor, the Government may choose to assume a greater proportion of risk or it may offer incentives tailored to performance outcomes to ensure timely contract performance. In times of economic uncertainty, contracts extending over a relatively long period may require economic price adjustment or price redetermination clauses. This factor may be criticalâ€” 1 When the contract type requires price revision while performance is in progress; or 2 When a cost- reimbursement contract is being considered and all current or past experience with the contractor has been on a fixed-price basis. If performance under the proposed contract involves concurrent operations under other contracts, the impact of those contracts, including their pricing arrangements, should be considered. If the contractor proposes extensive subcontracting, a contract type reflecting the actual risks to the prime contractor should be selected. Contractor risk usually decreases as the requirement is repetitively acquired. Also, product

descriptions or descriptions of services to be performed can be defined more clearly. The contracting officer shall complete and insert the provision at Fixed-price contracts providing for an adjustable price may include a ceiling price, a target price including target cost , or both. Unless otherwise specified in the contract, the ceiling price or target price is subject to adjustment only by operation of contract clauses providing for equitable adjustment or other revision of the contract price under stated circumstances. The contracting officer shall use firm-fixed-price or fixed-price with economic price adjustment contracts when acquiring commercial items, except as provided in This contract type places upon the contractor maximum risk and full responsibility for all costs and resulting profit or loss. It provides maximum incentive for the contractor to control costs and perform effectively and imposes a minimum administrative burden upon the contracting parties. The contracting officer may use a firm-fixed-price contract in conjunction with an award-fee incentive see The contract type remains firm-fixed-price when used with these incentives. A firm-fixed-price contract is suitable for acquiring commercial items see Parts 2 and 12 or for acquiring other supplies or services on the basis of reasonably definite functional or detailed specifications see Part 11 when the contracting officer can establish fair and reasonable prices at the outset, such as when -- a There is adequate price competition; b There are reasonable price comparisons with prior purchases of the same or similar supplies or services made on a competitive basis or supported by valid certified cost or pricing data; c Available cost or pricing information permits realistic estimates of the probable costs of performance; or d Performance uncertainties can be identified and reasonable estimates of their cost impact can be made, and the contractor is willing to accept a firm fixed price representing assumption of the risks involved. Economic price adjustments are of three general types: These price adjustments are based on increases or decreases from an agreed-upon level in published or otherwise established prices of specific items or the contract end items. These price adjustments are based on increases or decreases in specified costs of labor or material that the contractor actually experiences during contract performance. These price adjustments are based on increases or decreases in labor or material cost standards or indexes that are specifically identified in the contract. The contract type remains fixed-price with economic price adjustment when used with these incentives. A fixed-price contract with economic price adjustment may be used when i there is serious doubt concerning the stability of market or labor conditions that will exist during an extended period of contract performance, and ii contingencies that would otherwise be included in the contract price can be identified and covered separately in the contract. Price adjustments based on established prices should normally be restricted to industry-wide contingencies. For use of economic price adjustment in sealed bid contracts, see This does not apply to prompt payment or cash discounts. The contracting officer should consider using an economic price adjustment clause based on cost indexes of labor or material under the circumstances and subject to approval as described in paragraphs d 1 and d 2 of this section. Because of the variations in circumstances and clause wording that may arise, no standard clause is prescribed. A fixed-price incentive contract is a fixed-price contract that provides for adjusting profit and establishing the final contract price by a formula based on the relationship of final negotiated total cost to total target cost. Fixed-price incentive contracts are covered in Subpart Prescribed clauses are found at A fixed-price contract with prospective price redetermination provides for -- a A firm fixed price for an initial period of contract deliveries or performance and b Prospective redetermination, at a stated time or times during performance, of the price for subsequent periods of performance. A fixed-price contract with prospective price redetermination may be used in acquisitions of quantity production or services for which it is possible to negotiate a fair and reasonable firm fixed price for an initial period, but not for subsequent periods of contract performance. Each subsequent pricing period should be at least 12 months. This ceiling price should provide for assumption of a reasonable proportion of the risk by the contractor and, once established, may be adjusted only by operation of contract clauses providing for equitable adjustment or other revision of the contract price under stated circumstances. This contract type shall not be used unless -- a Negotiations have established that -- 1 The conditions for use of a firm-fixed-price contract are not present see The contracting officer shall, when contracting by negotiation, insert the clause at A fixed-ceiling-price contract with retroactive price redetermination provides for -- a A fixed ceiling price; and b Retroactive price redetermination within the ceiling after completion of the contract. The established ceiling price may be

adjusted only if required by the operation of contract clauses providing for equitable adjustment or other revision of the contract price under stated circumstances. A firm-fixed-price, level-of-effort term contract requires -- a The contractor to provide a specified level of effort, over a stated period of time, on work that can be stated only in general terms; and b The Government to pay the contractor a fixed dollar amount. A firm-fixed-price, level-of-effort term contract is suitable for investigation or study in a specific research and development area. The product of the contract is usually a report showing the results achieved through application of the required level of effort. However, payment is based on the effort expended rather than on the results achieved. Cost-reimbursement types of contracts provide for payment of allowable incurred costs, to the extent prescribed in the contract. These contracts establish an estimate of total cost for the purpose of obligating funds and establishing a ceiling that the contractor may not exceed except at its own risk without the approval of the contracting officer. This includes appropriate Government surveillance during performance in accordance with 1. A cost contract is a cost-reimbursement contract in which the contractor receives no fee. A cost contract may be appropriate for research and development work, particularly with nonprofit educational institutions or other nonprofit organizations. A cost-sharing contract is a cost-reimbursement contract in which the contractor receives no fee and is reimbursed only for an agreed-upon portion of its allowable costs. A cost-sharing contract may be used when the contractor agrees to absorb a portion of the costs, in the expectation of substantial compensating benefits. A cost-plus-incentive-fee contract is a cost-reimbursement contract that provides for an initially negotiated fee to be adjusted later by a formula based on the relationship of total allowable costs to total target costs. Cost-plus-incentive-fee contracts are covered in Subpart A cost-plus-award-fee contract is a cost-reimbursement contract that provides for a fee consisting of a a base amount which may be zero fixed at inception of the contract and b an award amount, based upon a judgmental evaluation by the Government, sufficient to provide motivation for excellence in contract performance. Cost-plus-award-fee contracts are covered in Subpart A cost-plus-fixed-fee contract is a cost-reimbursement contract that provides for payment to the contractor of a negotiated fee that is fixed at the inception of the contract. The fixed fee does not vary with actual cost, but may be adjusted as a result of changes in the work to be performed under the contract. This contract type permits contracting for efforts that might otherwise present too great a risk to contractors, but it provides the contractor only a minimum incentive to control costs. No cost-plus-fixed-fee contract shall be awarded unless the contracting officer complies with all limitations in A cost-plus-fixed-fee contract may take one of two basic forms -- completion or term. This form of contract normally requires the contractor to complete and deliver the specified end product e. However, in the event the work cannot be completed within the estimated cost, the Government may require more effort without increase in fee, provided the Government increases the estimated cost. Under this form, if the performance is considered satisfactory by the Government, the fixed fee is payable at the expiration of the agreed-upon period, upon contractor statement that the level of effort specified in the contract has been expended in performing the contract work. Renewal for further periods of performance is a new acquisition that involves new cost and fee arrangements. If the contract is a time-and-materials contract, the clause at Further, the clause at Incentive contracts are designed to obtain specific acquisition objectives by-- 1 Establishing reasonable and attainable targets that are clearly communicated to the contractor; and 2 Including appropriate incentive arrangements designed to -- i motivate contractor efforts that might not otherwise be emphasized and ii discourage contractor inefficiency and waste. The incentive increases or decreases are applied to performance targets rather than minimum performance requirements. Cost-reimbursement incentive contracts are subject to the overall limitations in This determination shall be documented in the contract file and, for award-fee contracts, shall address all of the suitability items in An award-fee contract is suitable for use when-- i The work to be performed is such that it is neither feasible nor effective to devise predetermined objective incentive targets applicable to cost, schedule, and technical performance; ii The likelihood of meeting acquisition objectives will be enhanced by using a contract that effectively motivates the contractor toward exceptional performance and provides the Government with the flexibility to evaluate both actual performance and the conditions under which it was achieved; and iii Any additional administrative effort and cost required to monitor and evaluate performance are justified by the expected benefits as documented by a

risk and cost benefit analysis to be included in the Determination and Findings referenced in The basis for all award-fee determinations shall be documented in the contract file to include, at a minimum, a determination that overall cost, schedule and technical performance in the aggregate is or is not at a satisfactory level. This determination and the methodology for determining the award fee are unilateral decisions made solely at the discretion of the Government. All contracts providing for award fees shall be supported by an award-fee plan that establishes the procedures for evaluating award fee and an Award-Fee Board for conducting the award-fee evaluation. Award-fee plans shall-- i Be approved by the FDO unless otherwise authorized by agency procedures; ii Identify the award-fee evaluation criteria and how they are linked to acquisition objectives which shall be defined in terms of contract cost, schedule, and technical performance. Contracting officers may supplement the adjectival rating description. Contractor has met overall cost, schedule, and technical performance requirements of the contract in the aggregate as defined and measured against the criteria in the award-fee plan for the award-fee evaluation period. The use of rollover of unearned award fee is prohibited.

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