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Chapter 1 : Homepage - Health, United States - Products

This update of Key Facts: Race, Ethnicity, and Medical Care, like its predecessors, is intended to serve as a quick reference source on the health, health insurance.

Medicaid and SCHIP provide health coverage for over 30 million low-income children, opening doors to children and their families to affordable preventive, primary, and acute health care services. This is a completely revised and updated version of a report originally issued three years ago Ku and Nimalendran, To avoid duplication with those reports, this chartbook provides relatively little discussion of certain topics. A substantial body of recent medical, health, and economic research, conducted by scholars across the nation, offers detailed information about the needs of low-income children and compelling evidence about the ways that public insurance programs help these children. Even so, it must be acknowledged that the research knowledge base about the effects of Medicaid and SCHIP remains incomplete. Such a randomized study would probably not be considered ethically acceptable in any case. This report is organized into four sections, summarized below. You can click the title of each section to view a PDF document containing the charts in that section or you can download the full version of the chartbook 49pp. The growth in Medicaid and SCHIP enrollment of low-income children more than offset the reduction in employer-sponsored coverage that occurred between and To make substantial headway in further reducing the number of uninsured children, it will be necessary to increase participation in these programs by eligible children and to ensure that sufficient federal and state funds are available to cover their health needs. See Figure 3 Most children covered by Medicaid or SCHIP are in working families that are unable to get or afford private health insurance for their children. Most newly enrolled children were previously uninsured or had recently lost their Medicaid or private health coverage for involuntary reasons, such as parental job loss of a job or divorce. See Figure 6 White children, African American children, and Hispanic children have all experienced substantial reductions in rates of uninsurance in the past decade because of the expansion of the public programs. See Figure 7 Over the past decade, insurance coverage has eroded for immigrant children even as it has grown for children who live in native-born citizen families. Under a law, a large number of legal immigrant children are ineligible for federal coverage under Medicaid or SCHIP. See Figure 8 Children with special health care needs â€" those whose developmental, chronic, or behavioral health problems require specialized care â€" are especially reliant on Medicaid and SCHIP. See Figure 9 One of the most effective ways to bolster enrollment of eligible low-income children is to expand coverage for their parents. They are more likely to be rated as having fair or poor health than privately insured children. While children covered by the public programs are somewhat more likely to be in fair or poor health than those without insurance, substantial numbers of uninsured children with fair or poor health remain uninsured. Medicaid and SCHIP provide access to the medical care that can treat these problems and help children grow, function, and learn more effectively. Like other American children, publicly-insured children are often overweight and Medicaid and SCHIP may be able to do more to address this problem. Moreover, over the past decade the percentage of children who have access to a medical home has grown for children covered by public programs while declining for uninsured children. One year after enrollment, these racial and ethnic disparities had largely been eliminated. See Figure 19 One of the most direct measures of access to medical care is whether a child has seen a doctor or other health professional in the past year. Children covered by Medicaid or SCHIP are much more likely than uninsured children to have preventive health care and to keep up with recommended schedules of well-child visits. See Figures 21 and 22 Because children enrolled in Medicaid or SCHIP are typically in poorer health than other children, it is not surprising that they need to use emergency rooms more often than privately insured children. However, the use of emergency rooms by publicly insured children has declined by about one-quarter over the past decade. See Figure 23 Children insured by Medicaid or SCHIP are less than one-fifth as likely as uninsured children to have unmet medical needs, which means that their families avoided getting medical care because of the costs. See Figures 25 and In addition, low-income children who are continuously covered by public insurance are much more likely to get dental care than children who are uninsured for part or all of a year. This is a stronger

rate of improvement than that of privately insured or uninsured children. Similarly, a Kansas study found that children missed fewer school days due to sickness after they were enrolled in SCHIP. Other research indicates that improved child health may ultimately lead to better health when children grow up to become adults, so there could be more long lasting repercussions Case et al. For example, new federal mandates that state agencies document the citizenship and identity of citizens applying for Medicaid, including children and even newborns, threaten to delay or deny coverage to tens of thousands of eligible low-income citizen children Center on Budget and Policy Priorities, ; deLone, ; Cohen Ross In addition, many states are facing shortfalls in their federal SCHIP funding levels that could begin as soon as mid Park and Broaddus, ; Peterson, If these shortfalls are not filled, enrollment could fall substantially in the coming year. Census data for indicate that about 9 million children 18 or younger are uninsured.

Chapter 2 : Medical care chartbook. (edition) | Open Library

This Rural Health Care chartbook is part of a family of documents and tools that support the National Healthcare Quality and Disparities Report (QDR).The QDR includes annual reports to Congress mandated in the Healthcare Research and Quality Act of (P.L.).

The number of equivalent admissions attributed to outpatient services is derived by multiplying admissions by the ratio of outpatient revenue to inpatient revenue. Assisted Livingâ€"Special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who require assistance in activities of daily living. Average Age of Plantâ€"Accumulated depreciation divided by current depreciation expense. Community Hospitalsâ€"Nonfederal, short-term general, and special hospitals whose facilities and services are available to the public e. FTE per Adjusted Admissionâ€"The number of full-time equivalent staff, converted to the number of employees who work full-time divided by the number of adjusted admissions. Group Practice without Wallsâ€"Hospital sponsored physician group. The group shares administrative expenses, although the physicians remain independent practitioners. The system may also own non-health-related facilities. Horizontal Integrationâ€"Merging of two or more firms at the same level of production in some formal, legal relationship. In hospital networks, this may refer to the grouping of several hospitals, outpatient clinics with the hospital, or a geographic network of various health care services. Hospiceâ€"Program providing palliative care, chiefly medical relief of pain and supportive services, addressing the emotional, social, financial, and legal needs of terminally ill patients and their families. This care can be provided in a variety of settings, both inpatient and at home. Hospital Income from Investments and Other Non-operating Gainsâ€"Income not associated with the central operations of the hospital facility. Non-operating gains include income from non-operating activities, including investments, endowments and extraordinary gains, as well as the value of non-realized gains from investments. Hospital Total Net Revenueâ€"Net patient revenue plus all other revenue, including contributions, endowment revenue, governmental grants, and all other payments not made on behalf of individual patients. Hospital Operating Marginâ€"Difference between operating revenue and operating expenses divided by operating revenue; excludes non-operating revenue. Hospital Total Marginâ€"Difference between total net revenue and total expenses divided by total net revenue. Independent Practice Association IPA â€"Legal entity that holds managed care contracts and contracts with physicians to provide care either on a fee-for-service or capitated basis. Inpatient Surgeryâ€"Surgical services provided to patients who remain in the hospital overnight. Long Term Careâ€"Package of services provided to those who are aged, chronically ill, or disabled. Services are delivered for a sustained period to individuals who have a demonstrated need, usually measured by functional dependency. Meals on Wheelsâ€"Hospital sponsored program which delivers meals to people, usually the elderly, who are unable to prepare their own meals. Medicaid Marginâ€"Difference between revenue from Medicaid and expenses associated with treating Medicaid patients, divided by revenue from Medicaid. Medicare Marginâ€"Difference between revenue from Medicare and expenses associated with treating Medicare patients, divided by revenue from Medicare. Niche Providersâ€"Providers that focus on a specific set of medical services, a particular population, or a limited set of medical conditions. Non-patient Hospital Costsâ€"Costs not associated with direct patient care, such as the costs of running cafeterias, parking lots and gift shops. Outpatient Surgeryâ€"Scheduled surgical services provided to patients who do not remain in the hospital overnight. In the AHA Annual Survey, outpatient surgery may be performed in operating suites also used for inpatient surgery, specially designated surgical suites for outpatient surgery or procedure rooms within an outpatient care facility. Outpatient Visitâ€"Visit by a patient not lodged in the hospital while receiving medical, dental, or other services. Total outpatient visits should include all clinic visits, referred visits, observation services, outpatient surgeries and emergency room visits. The PHO can act as a unified agent in managed care contracting, own a managed care plan, own and operate ambulatory care centers or ancillary services projects, or provide administrative services to physician members. Open PHOâ€"Joint venture between a hospital and all members of the medical staff who wish to participate. The open PHO can

act as a unified agent in managed care contracting, own a managed care plan, own and operate ambulatory care centers or ancillary services projects, or provide administrative services to physician members. Private Pay Marginâ€”Difference between revenue from non-government payers and expenses associated with treating private pay patients, divided by revenue from non-government payers. Uncompensated Careâ€”Care provided by hospitals for which hospitals do not receive payment. Underwritingâ€—A health insurer or health plan accepts responsibility for paying the health care services of covered individuals in exchange for dollars, usually referred to as premiums. When a health insurer collects more in premiums than it pays in claim costs and administrative expenses, an underwriting gain is said to occur. If the total expenses exceed the premium dollars collected, an underwriting loss occurs. Underwriting Cycleâ€—Repeating pattern of gains and losses within the insurance industry. Vertical Integrationâ€—Organization of production whereby one business entity controls or owns all stages of the production and distribution of goods or services. In health care, vertical integration can take different forms but most often refers to physicians, hospitals and health plans combining their organizations or processes in some manner to increase efficiencies and competitive strength or to improve quality of care. Integrated delivery systems or healthcare networks are generally vertically integrated.

Chapter 3 : Quality of Health Care in the United States: A Chartbook

In this chartbook, estimates of the primary care physician workforce come from the American Medical Association (AMA) Physician Masterfile. Estimates for other professionals come from a variety of other sources, including the Center for.

Chapter 4 : TrendWatch Chartbook - Glossary | AHA

Medical Home. A number of characteristics of high-quality health care for children can be combined into the concept of the medical home. As defined by the American Academy of Pediatrics, children's medical care should be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. 1 Multiple studies have shown that having a medical home is.

Chapter 5 : Minnesota Health Care Markets Chartbook - Minnesota Dept. of Health

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