

12th National Quality Colloquium Boot Camp 1

September 18, 2013

**David B. Nash, MD, MBA
Dean, Jefferson School of Population Health**



Tobacco Smoke Enema (1750s-1810s)

The tobacco enema was used to infuse tobacco smoke into a patient's rectum for various medical purposes, primarily the resuscitation of drowning victims. A rectal tube inserted into the anus was connected to a fumigator and bellows that forced the smoke towards the rectum. The warmth of the smoke was thought to promote respiration, but doubts about the credibility of tobacco enemas led to the popular phrase "blow smoke up one's ass."

**This Old Tool has been reintroduced in Washington D.C. by
the New Administration.
Are you starting to feel it**

INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING

The Economist

JUNE 27TH-JULY 3RD 2009

Economist.com

Iran's agony
The mystery of Mrs Merkel
Asia's consumers to the rescue?
The Greeks and those marbles
Evolution and depression

Reforming health care

This is going to hurt



US\$10.00	UK£5.00	Canada & Mexico	US\$12.00
India	US\$10.00	Japan	US\$15.00
South Africa	US\$10.00	South Korea	US\$12.00
China	US\$10.00	India	US\$10.00
Indonesia	US\$10.00	Malaysia	US\$10.00
Philippines	US\$10.00	Singapore	US\$10.00
Taiwan	US\$10.00	Thailand	US\$10.00
Vietnam	US\$10.00	Other Asia	US\$10.00



Total Hip and Knee Replacements

FISCAL YEAR 2002: JULY 1, 2001 TO JUNE 30, 2002



PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL
JUNE 2005



Regional Variation in Rates of Spine Surgery

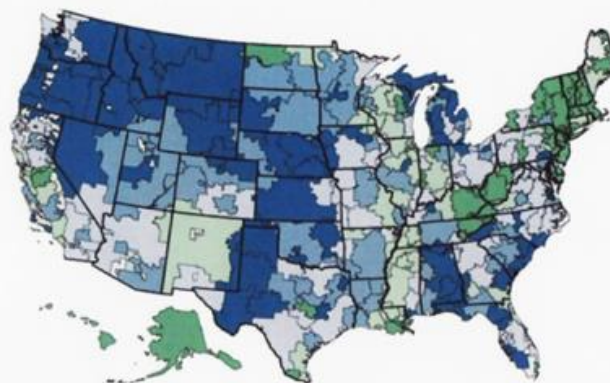
Total Spine Surgery

There was substantial regional variation in overall spine surgery rates among Medicare enrollees in 2002-03 (Figure 3). Rates varied by a factor of almost six, from 1.6 per 1,000 enrollees to 9.4. Among the hospital referral regions where rates of spine surgery were highest were Casper, Wyoming (9.4); Mason City, Iowa (9.0); Bend, Oregon (8.7); Boise, Idaho (8.2); and Billings, Montana (8.0). Regions with rates lower than the national average of 4.0 spine surgery procedures per 1,000 enrollees included Honolulu (1.6); Newark, New Jersey (1.7); Paterson, New Jersey (1.8); Manhattan (1.8); and East Long Island, New York (1.8).



Spine surgery per 1,000 Medicare enrollees (2002-03)
Each point represents the rate in one of the 306 HRRs in the United States.

**Figure 3. Rates of Spine Surgery
Among Hospital Referral Regions, 2002-03**



**Ratio of Total Rates of Spine
Surgery to the U.S. Average
by Hospital Referral Region (2002-03)**

- 1.30 to 2.36 (71)
- 1.10 to < 1.30 (56)
- 0.90 to < 1.10 (80)
- 0.75 to < 0.90 (47)
- 0.40 to < 0.75 (52)
- Not Populated



Map 1. Spine Surgery

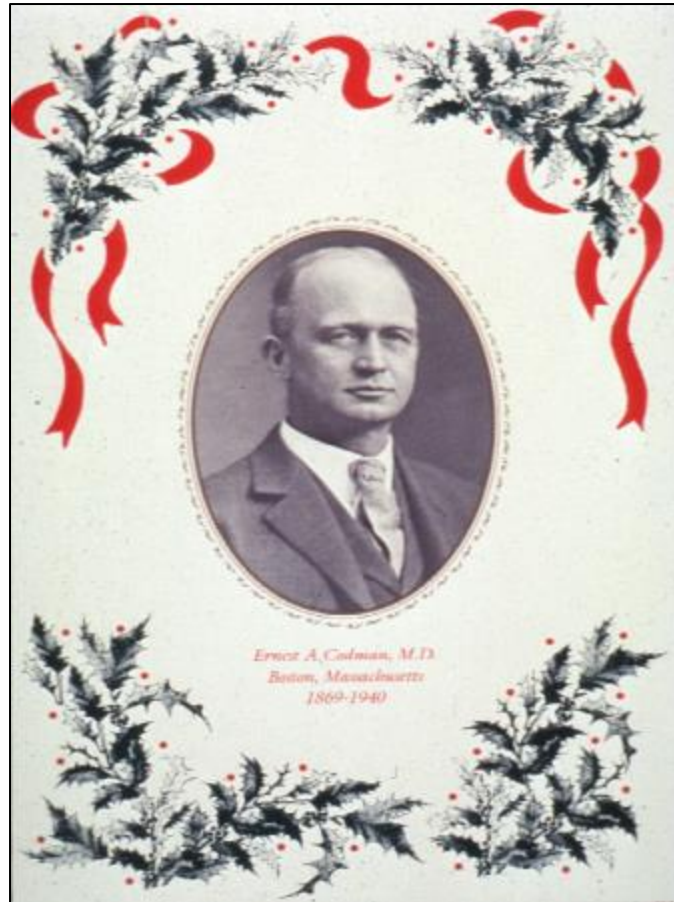
In 71 hospital referral regions, rates of spine surgery were at least 30% higher than the United States average of 4.0 per 1,000 Medicare enrollees. In 52 hospital referral regions, rates were more than 25% lower than the national average.



... all hospitals are accountable to the public for their degree of success...

If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am Coll Surg





Avedis Donabedian

7 January 1919-9 November 2000

The President, Executive Board, Members and Friends of The International Society for Quality in Health Care and the Editors of the Society's Journal, honour the distinguished life and acclaimed contributions of **Avedis Donabedian**, primary architect of the field of quality in health care and a life Member of ISQua, who died peacefully at his home in Ann Arbor, Michigan, USA on 9 November 2000.



ARE DOCTORS JUST PLAYING HUNCHES?

We expect them to use hard data. But that's not always the best kind of medicine

By CHRISTINE GORMAN

NOWHAT PRETENSES MEDICINE IS RIGOR, BUT IF THERE'S ONE thing we ought to be able to rely on, it's that the doctors looking out for us are doing more than playing hunches. We take certain medicines because they work, right? We go into the operating room for certain procedures because they'll make us well, don't we?

Well, maybe. More and more, however, doctors are making the unenviable case that no matter how reliable a drug or other treatment appears to be, too often there's simply little hard evidence that it would make a long-term difference in a person's quality of life or prolonged survival. Obviously, drugs are tested rigorously to show that they are safe and effective before they are approved by the U.S. and other developed countries. But a clinical study is not the real world, and just because a drug leads to a statistically significant improvement in, say, cholesterol levels doesn't guarantee that the desired effect—a healthier or longer life—will follow. Often your doctor is left to make prescription decisions based at least in part on faith, bias or even an educated guess. That ought to be enough to speak even the least fervent patient, but the fact is, recognizing just what a roll of the dice medical care can be may be a good thing.

Interestingly, doctors seeking to provide their patients with the best possible care are exploring what is known as evidence-based



“Some things can't be tested; some things are so obvious, they don't need it.”

—DR. PAUL SLAVATION, director, Center for Evidence-Based Medicine in Oxford, England

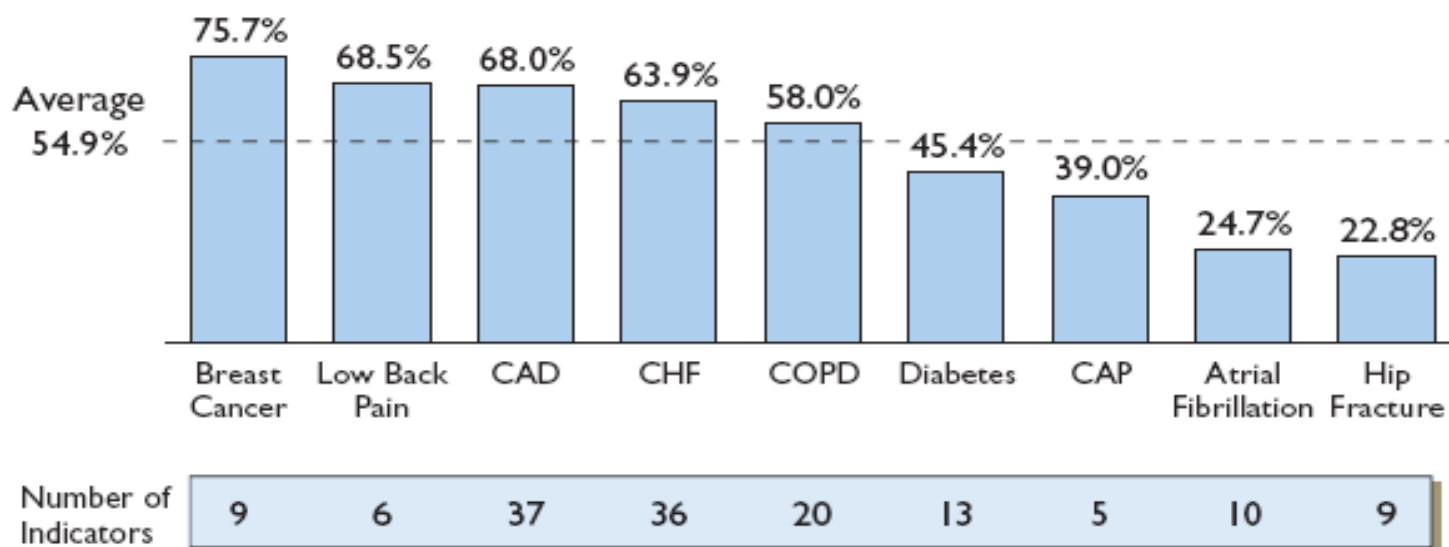
medicine—a hard, cold, empirical look at what works, what doesn't and how to distinguish between the two. It's not enough to prove that a particular blood test or CT scan really spots cancer, for example. You also

need to know whether early detection of that cancer would make a difference in your ability to respond to treatment or it merely means that you would die at the same point but learn about your illness earlier than you would have without the test.

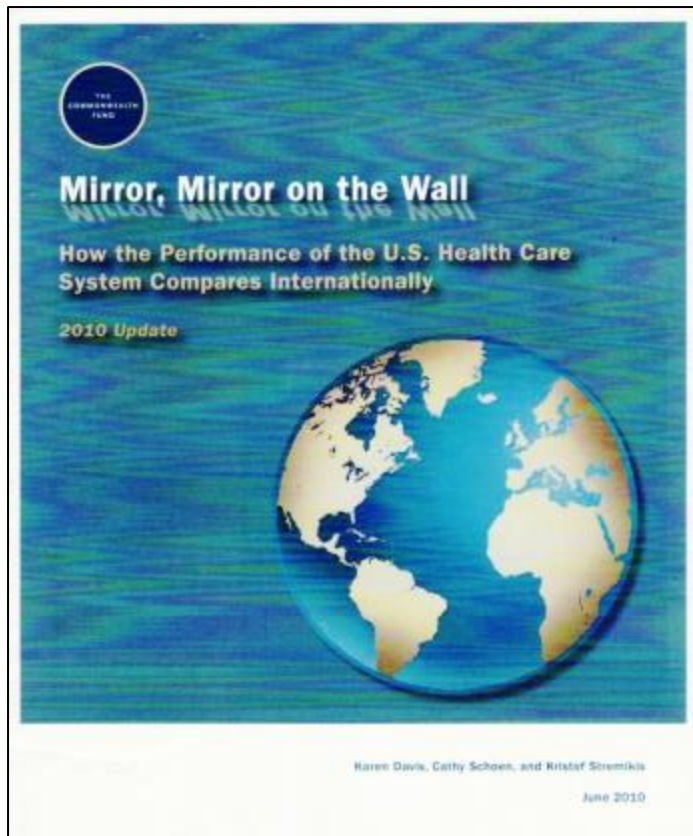
Evidence-based medicine, which uses volumes of studies and answers such questions, is now being

Uneven Adherence to the Evidence

Percentage of Recommended Care Received, by Condition¹



Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*. June 26, 2003: 2635–2645.



A World of Hurt

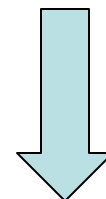



Exhibit ES-1. Overall Ranking

Country Rankings	
Green	1.00–2.33
Yellow	2.34–4.66
Red	4.67–7.00

OVERALL RANKING (2010)

Quality Care
 Effective Care
 Safe Care
 Coordinated Care
 Patient-Centered Care
 Access
 Cost-Related Problem
 Timeliness of Care
 Efficiency
 Equity
 Long, Healthy, Productive Lives
 Health Expenditures/Capita, 2007

							
	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: * Estimate. Expenditures shown in \$US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).



**It is possible to improve care
and dramatically lower costs.**

Berwick Annals 2/98

Getting to 10%

CARE-RELATED COSTS

- Prevent medical errors
- Prevent avoidable hospital admissions
- Prevent avoidable hospital readmissions
- Improve hospital efficiency
- Decrease costs of episodes of care
- Improve targeting of costly services
- Increase shared decision-making

ADMINISTRATIVE COSTS

- Use common billing and claims forms

RELATED REFORMS

- Medical Liability Reform
- Prevent Fraud and Abuse

INSTITUTE OF MEDICINE

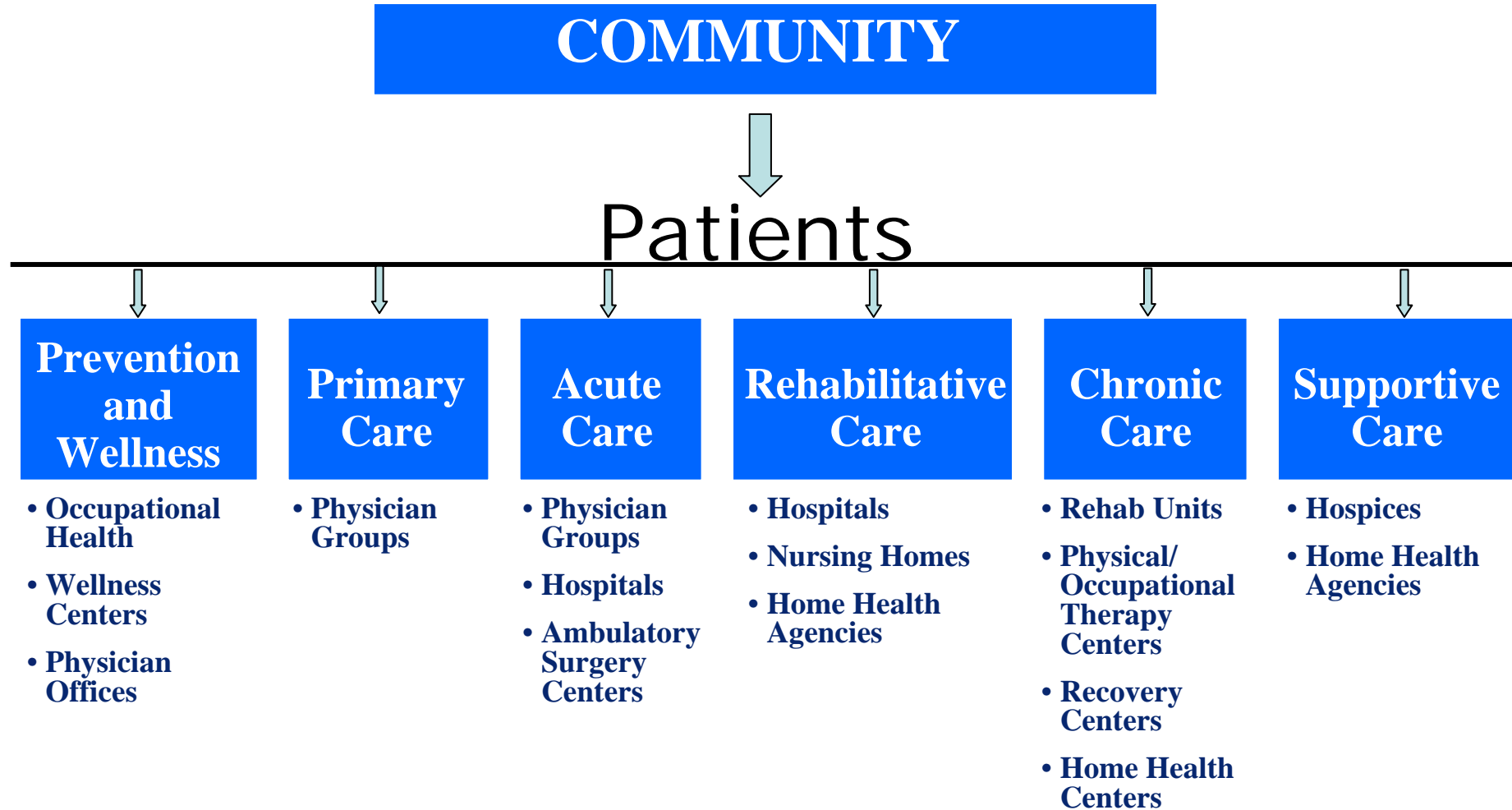
OF THE NATIONAL ACADEMIES

Advising the nation/Improving health

Imperatives of the New Century

- **Accountable for the health status of defined populations**
- **Global Budgets/Targets**
- **Incentives to actively manage clinical care**
- **Incentives to provide a coordinated continuum of care**
- **Incentives for continuous quality improvement**
- **The demand for value**

The Seamless Continuum of Care



Shortell Stages of Integration

- **Functional**
 - bring partners together
- **Physician - System Integration**
 - bring together doctor groups
- **Clinical integration**

What will clinical integration require?

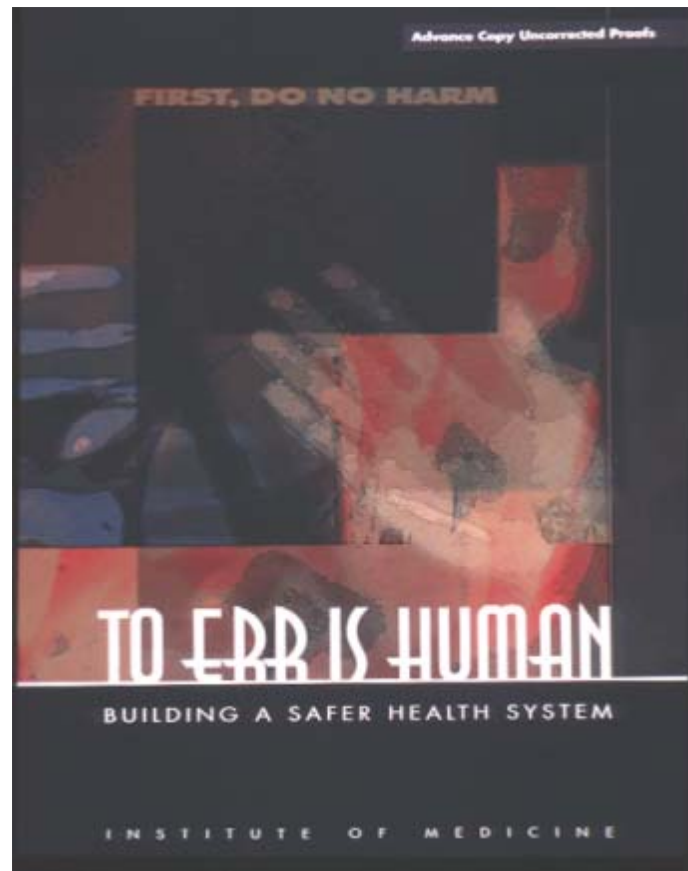
- Centralization of process
- Evidence based medical practice
- Commitment to self evaluation

Cultural Barriers to Integration (*and Industrialization*)

- Autonomous decision making
- Socialization
- Uneven evidence about outcomes
- Fear of performance assessment

Definition of Quality Institute of Medicine

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”



"USA TODAY hopes to serve as a forum for better understanding and unity
to help make the USA truly one nation."

—Allen H. Newbath, Founder, Sept. 15, 1982

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Today's debate: Medical errors

Why do so many still die needlessly in hospitals?

Our view:

Part-voluntary, part-mandatory reporting system can reduce deaths.

When a report came out last week from a private group claiming that nearly 200,000 hospital patients die each year from preventable medical errors, it promptly sparked a fierce controversy.

The estimate was double the number found in a landmark study in 1999 by the Institute of Medicine (IOM), a federal advisory group, and the lead author of that earlier study went on the offensive. He charged that the new report used flawed research methods that inflated the fatalities.

But why argue? The difference alone makes a more telling point: Five years after the IOM report drew front-page headlines and widespread outrage, there still is not even a sure way to measure the problem. And that appalling fact should concern any prospective hospital patient — which is to say everyone.

This year, Congress is finally doing something, though hardly enough.

Before the end of the year, it is expected to install new incentives for medical personnel to report errors. The new system, already approved by both houses, would allow doctors, nurses and other hospital workers to report mistakes anonymously. Independent analysts would then look for patterns and recommend changes. Lawyers and employers would be kept in the dark.

That's an important step.

Suppose, for instance, that a nurse gives a patient the wrong pill because its name and packaging resemble a drug next to it on the hospital pharmacy shelf. Neither she nor the pharmacist will want to reveal the error, for fear of being punished or sued. The error likely will recur.

But if they can confidentially report the problem, experts can devise ways to improve the packaging and placement of med-

Mistakes cost lives

Highlights from a new study of medical errors involving Medicare patients hospitalized from 2000 through 2002:

- Out of 27 million hospitalizations, 1.14 million "safety incidents" occurred.
- 203,664 deaths were directly attributed to the incidents.
- The safety incidents accounted for \$3.54 billion in additional Medicare costs.
- Nearly 60% of safety incidents involved the failure to diagnose and treat conditions that developed in the hospital, bedsores and post-operative infections.

Source: HealthCare Safety in American Hospitals study released July 27

icines to reduce the risk of simple human error. Lives will be saved.

Six states that have set up similar procedures have seen a significant increase in reported mistakes.

That's clearly the right way to handle relatively minor mistakes, even when they result in some harm.

Even so, the picture will still be woefully incomplete — and patients will remain at risk — unless the reporting of errors that kill or cause the most serious injuries is made mandatory.

Only 22 states currently have mandatory error-reporting systems. The others rely on hospital-industry watchdogs or malpractice lawyers to be on the lookout for mistakes.

The argument over numbers is proof that leaving the solution to the courts is not a prescription for eliminating deadly errors.

Five years ago, the IOM recommended a two-tiered approach, part voluntary, part mandatory. It is still the most sensible compromise.

The question is why five years have elapsed with so little being done. With tens of thousands dying needlessly every year, the next life at risk may be your own.



PHYSICAL EXAMINATION

Name: _____ MR # _____ Date: _____

General
Apparent Age
Condition
Appearance
Race, sex, etc.

Weight _____ Blood Pressure _____ Pulse _____ Temp _____ Respirations _____

Head

EENT

Neck

Breasts

Chest & Lungs

Heart and Vascular

Abdomen

Rectal

Pelvic

Musculoskeletal

Neurological

Immunizations

WDMW w 0

NCAH

supple

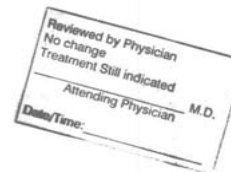
5 mm

clear

AV AF mobile

no masses

- Hspic myomas



Performed by: _____ M.D.
Physician (Intern or Resident)

Section I. Surgical or invasive procedure is scheduled (with right or left specified when laterality is involved), and Pre-Admission Testing sheet is consistent with documentation on current medical record and patient's verbal verification.

Site verified as (circle one): Right Left Bilateral No Laterality

PAT RN Signature

Section II. Surgical or invasive procedure is verified and site has been marked by the physician and is consistent with the patient's current medical record, which must include the H&P and consent.

Site verified as (circle one): Right Left Bilateral No Laterality

Site verified and marked by Surgeon

Staff Nurse Signature

Patient Identification and Site Verification Immediately Prior to the Procedure

(Procedure Physician Signature below indicates that the surgeon identified the patient immediately prior to surgery with the patient on the OR/Procedure table.)

Provider(s) Present	Procedure	Side
Circulating/Assisting Nurse/Personnel	<u>Right heel ulcer</u>	<u>Left</u>
Procedure Physician	<u>dependent with</u>	<u>Bilateral</u>
Anesthesia Provider	<u>QASIS graft & wounds VAO</u>	<u>Right</u>

(Circulating/Assisting Nurse to list name of anesthesia provider, if present. If no anesthesia provider is involved in the procedure, document N/A for Not Applicable. Anesthesia Provider signature, procedure and site will be documented by the Anesthesia Provider on the Anesthesia Record.)

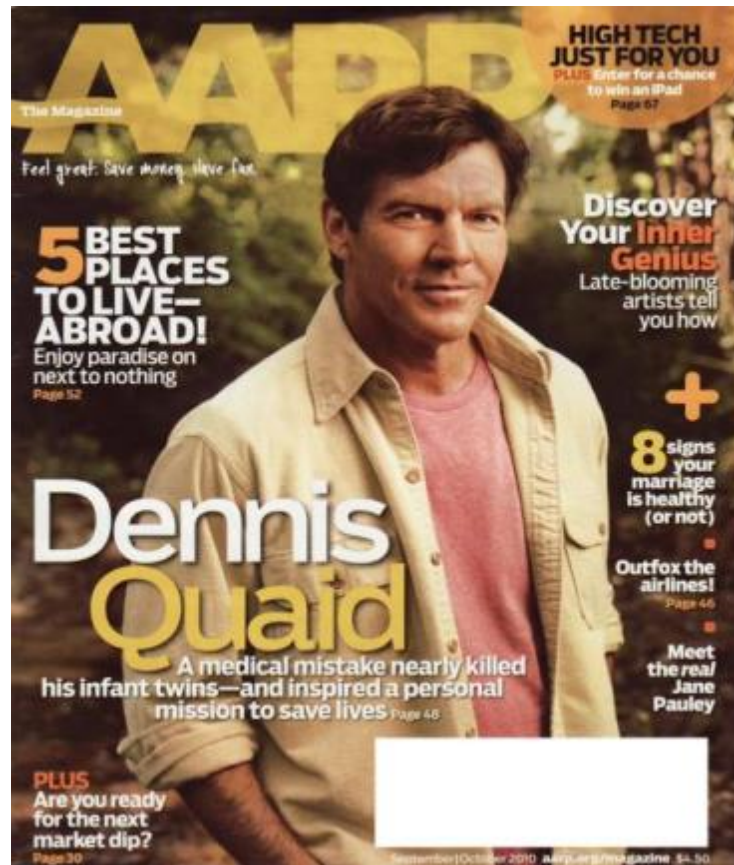
The surgical/procedure team (Surgeon/Procedure Physician, Anesthesiologist, and Circulating/Assisting Nurse/personnel) as listed above has paused to verify the correct patient, procedure and site, and availability of correct implants/special equipment as indicated, by active communication immediately prior to the procedure with the patient on the procedure table. If x-ray films are present, the procedure physician has verified the proper orientation of the films.

Signature - Circulating/Assisting Nurse/Personnel

Date

Time

2/23/07 1526





 Joint Commission
Resources

How Medical Errors Affect Physicians

Features

Reporting Systems

- The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

5 Million Lives Campaign

- Miles to Go: An Introduction to the 5 Million Lives Campaign

Teamwork and Communication

- The Continuing Problem of Mixed Test Results in an Integrated Health System with an Advanced Electronic Medical Record

Health Professions Education

- Honesty and Medical Student Attitudes Toward Medical Errors and Adverse Events

Methods, Tools, and Strategies

- Awareness and Use of a Cognitive Aid for Anesthesiology

Department

Rapid Response Systems: The Stories

- Improving Rapid Response Systems: Progress, Issues, and Future Directions

www.jcoqs.com

Only 77% wash hands after using the toilet

Advocates are pushing for more frequent scrubbing in health care and non-health care settings.

VICTORIA STAGG ELLIOTT
AMNEWS STAFF

How clean are your hands? How about the person who just shook yours?

Several presentations at last month's Interscience Conference on Antimicrobial Agents and Chemotherapy in Chicago suggested that people not only wash their hands less often than they say they do, but the number who really do appears to be decreasing. Also, improving hand hygiene in the health care setting saves money.

"Hands are great distributors of disease, but hand washing is a great intervention," said Judy Daly, PhD, spokeswoman for the American Society for Microbiology, which organizes this meeting. She is also director of the microbiology laboratory at Primary Children's Medical Center in Salt Lake City.

According to data from observational and telephone surveys by Harris Interactive, which were commissioned by the society as well as the Soap and Detergent Assn. and released at the meeting, 93% of adults say they always wash their hands after using a public restroom. When ob-

served in places such as train stations and sports stadiums, only 77% actually do. This represented a decline from the 83% observed in the 2005 version of this survey.

Significant gender differences also were seen, with only 66% of men soaping up compared with 88% of women. Similar gaps between men and women also were found by other studies that examined the behavior of doctors and health care professionals.

"Very clearly, guys need to step up to the sink," said Brian Sansoni, vice president of communication for the soap association.

This issue has long concerned medical societies, patient safety organizations and public health agencies. The American Medical Association urges everyone to view hand washing as important. Experts suggest, however, that while this activity is important across the board, more payoff may be gained from programs that focus on health care settings.

"The message about improving hand hygiene is a good message to support, but we will naturally see the greatest result in the places where the

sickest people are," said Dr. M. Lindsay Grayson, vice chair of Austin Hospital/Austin Health in Melbourne, Australia.

In these venues, the benefit of hand hygiene is increasingly being quantified. For instance, a paper presented by Dr. Grayson found that hand hygiene education for health care professionals along with ensuring that alcohol hand rubs were available significantly reduced the number of methicillin-resistant *Staphylococcus aureus* infections. In turn, this result saved his state's health system more than a million dollars.

"We need a culture change," Dr. Grayson said. "Those who provide care should feel funny walking up to a patient having not used an alcohol-based hand rub. And the patient should feel pretty funny, too."

An Argentinean study also found that upping compliance with hand hygiene recommendations in the intensive care unit reduced the device-associated infection rate from nearly 20% to just shy of 5%. But although researchers say these efforts can pay for themselves, improving hand hygiene



PHOTO BY TED GRUDZINSKI
Judy Daly, PhD, presented the hygiene findings at the Chicago conference.

comes with significant challenges. In Dr. Grayson's study, the urban institutions did not do as well as the rural ones because of high staff turnover.

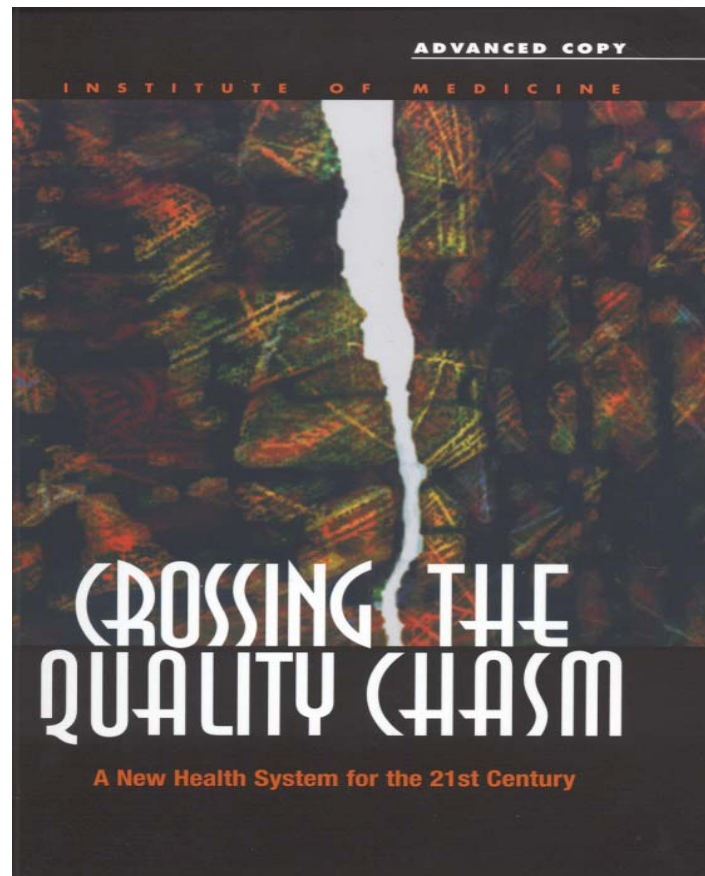
The factors that motivate health care professionals to wash more often also might not be the most obvious ones. A study out of the University of Geneva Hospitals in Switzerland found that the opportunity to reduce nosocomial infections did not increase hand washing, but peer pressure and easy access to hand-washing facilities did. ♦

OCTOBER 8, 2007

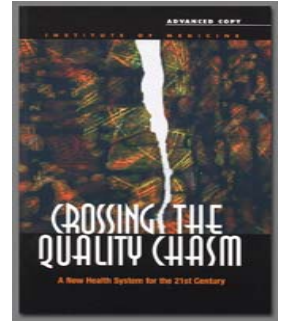
AMERICAN MEDICAL ASSOCIATION

AMERICAN MEDICAL NEWS





Institute of Medicine Report 2001



Outlines Key Dimensions of the Healthcare Delivery System:

Safe: avoiding injuries to patients from the care that is intended to help them.

Effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding **underuse** and **overuse**, respectively).

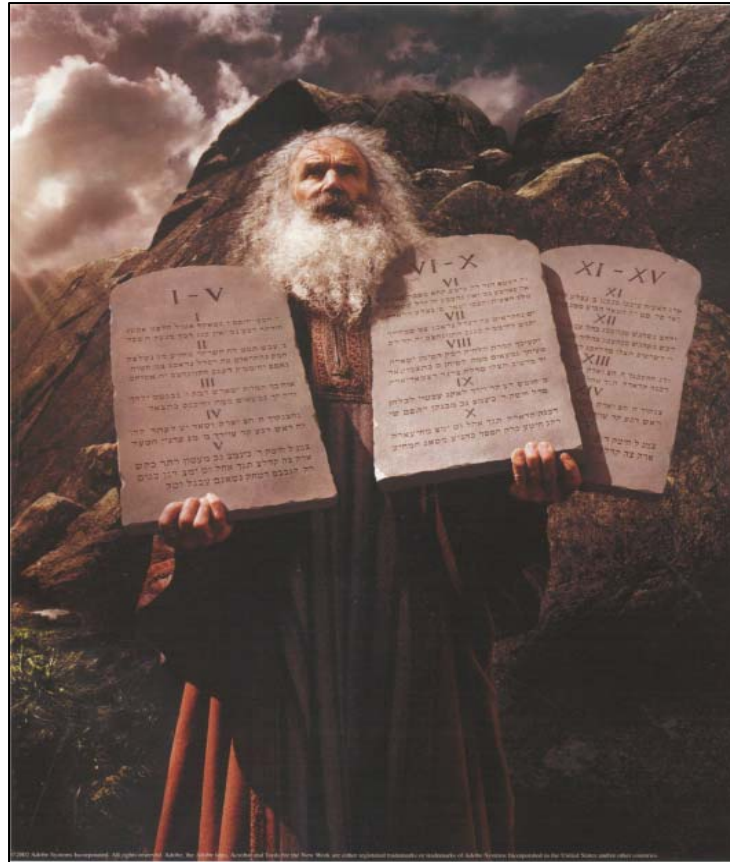
Patient-centered: providing care that is **respectful** of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely: **reducing waits** and sometimes harmful **delays** for both those who receive and those who give care.

Equitable: providing care that does **not vary** in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Efficient: **avoiding waste, including waste of equipment, supplies, ideas, and energy.**

Source: Institute of Medicine 2001; 5-6



Ten Commandments

Crossing the Quality Chasm

Current Rules

1. Care is based primarily on visits
2. Professional autonomy drives variability
3. Professionals control care
4. Information is a record
5. Decision making is based on training and experience

New Rules

1. Care is based on continuous healing relationships
2. Care is customized according to patient needs and values
3. The patient is the source of control
4. Knowledge is shared freely
5. Decision making is evidence-based

Don Berwick 2002

Ten Commandments (*cont.d*)

Current Rules

6. “Do no harm” is an individual responsibility
7. Secrecy is necessary
8. The system reacts to needs
9. Cost reduction is sought
10. Preference is given to professional roles over the system

New Rules

6. Safety is a system property
7. Transparency is necessary
8. Needs are anticipated
9. Waste is continuously decreased
10. Cooperation among clinicians is a priority

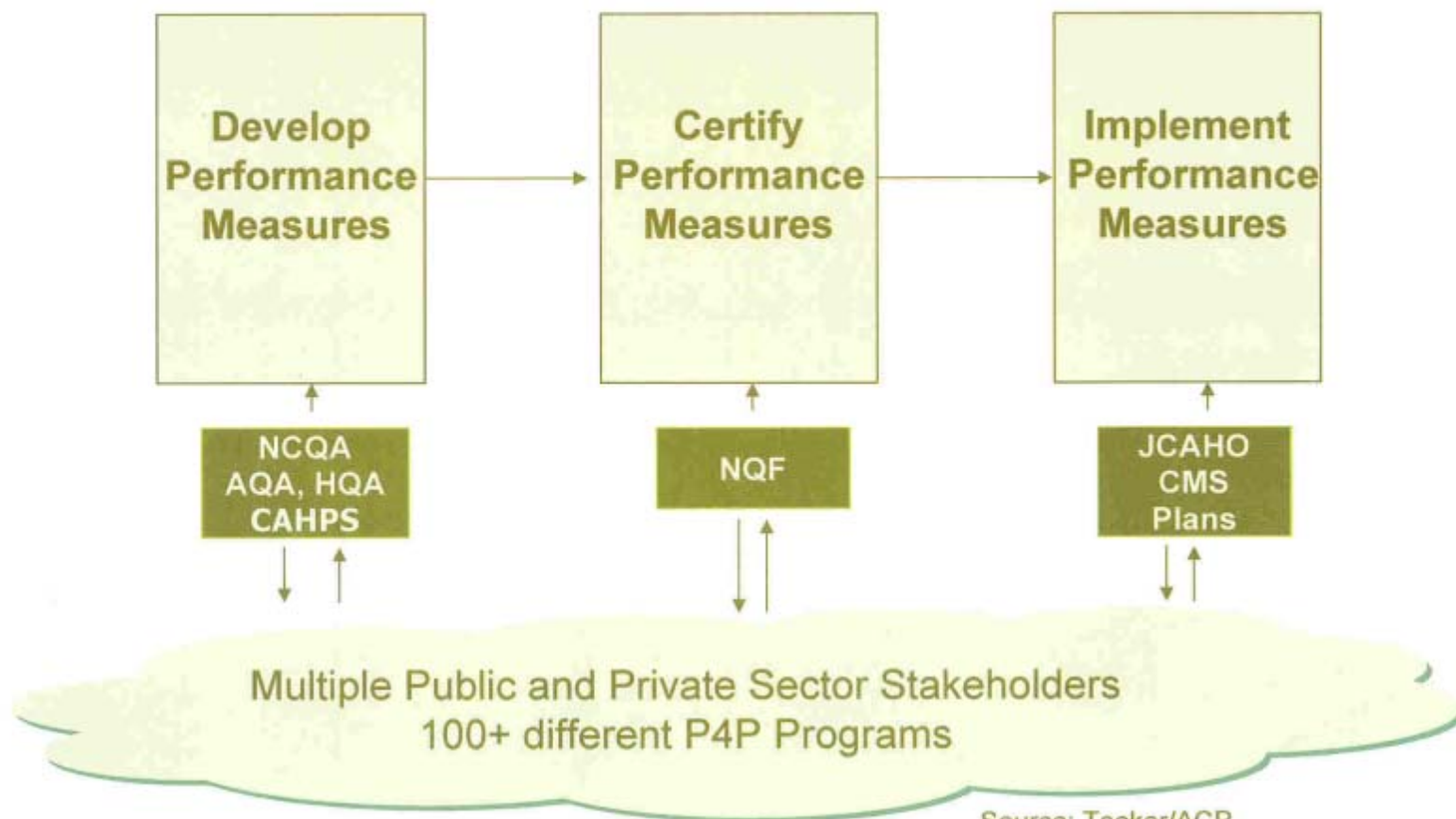
Don Berwick 2002



Figure 1 Attributes of the Institute of Medicine quality objectives with related curriculum areas.

A need for unified governance

No American Quality Improvement Community



Source: Tooker/ACP

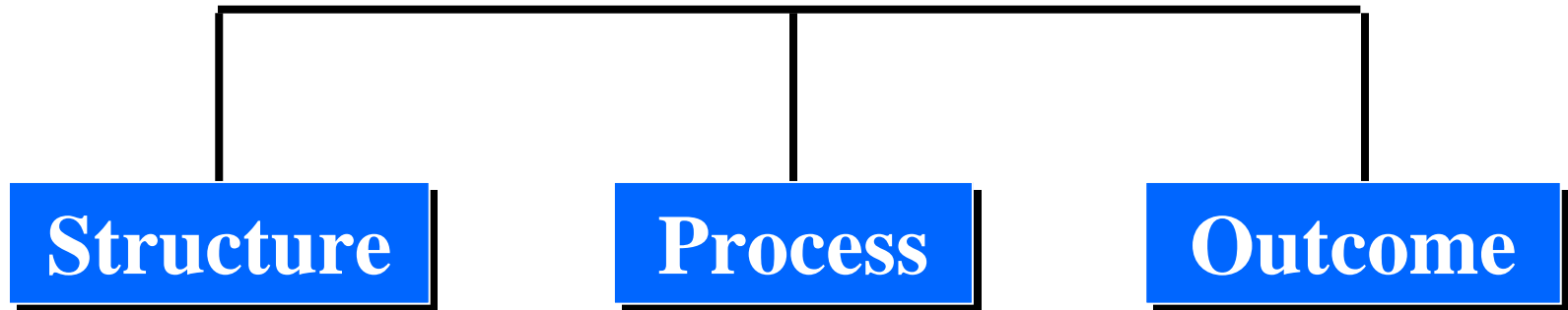
“Unexplained Clinical Variation”

- **Major roadblock to:**
 - **Lowering costs**
 - **Improving quality**
 - **Establishing accountability**

The Assumption of Financial Risk

- Creates need for accountability.
- Makes me care what my partners order!
- Most importantly, it obviates need for external control.
 - *Yes, but now we have to do it ourselves!*

Old Quality Tripod



What is Outcomes Management?

- **Three tiered definition**

Tier One *Outcomes (Traditional)*

- **Morbidity**
- **Mortality**
- **Return to the O.R.**
- **Nosocomial Infections**

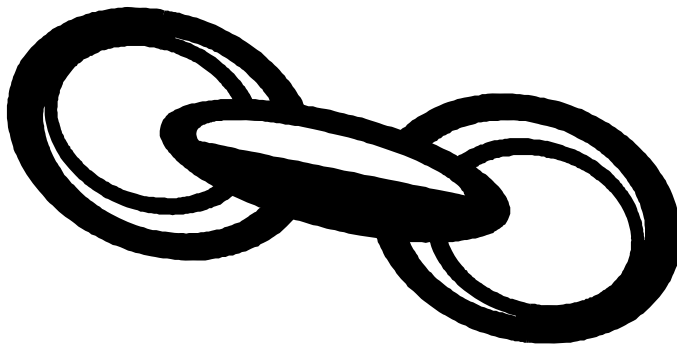
Tier Two *Outcomes (Modern)*

- **Patient satisfaction**
- **Functional status**
- **Return to work**

Tier Three *Outcomes* (Ellwood)

- Linking tiers one and two to payment

Tier 1



Tier 2

=

Tier 3



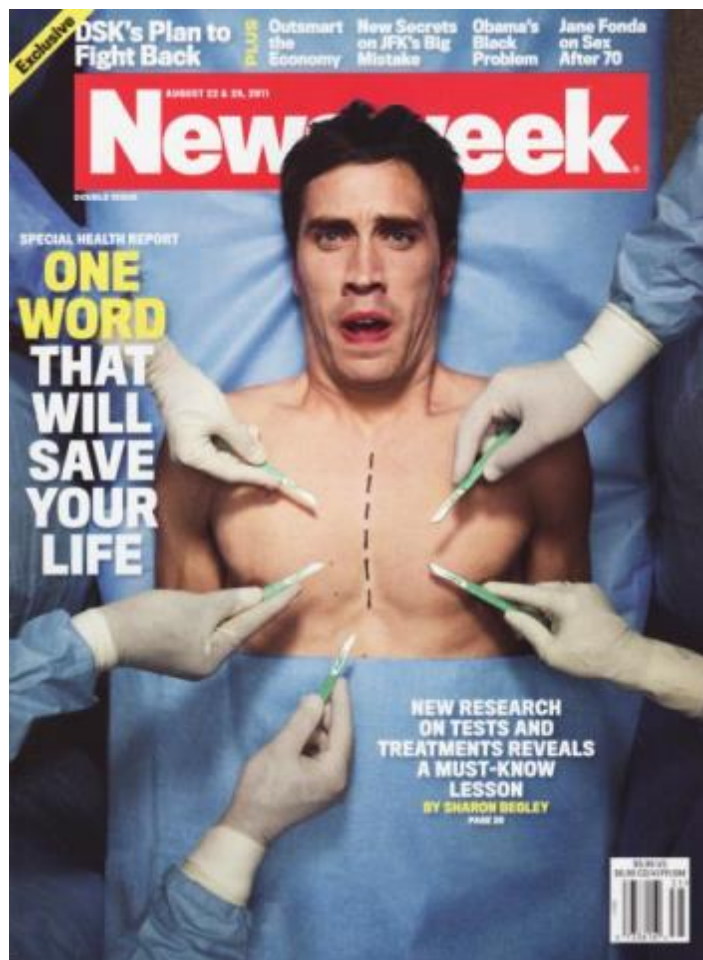
Autonomy and Accountability

A Zero Sum Game?

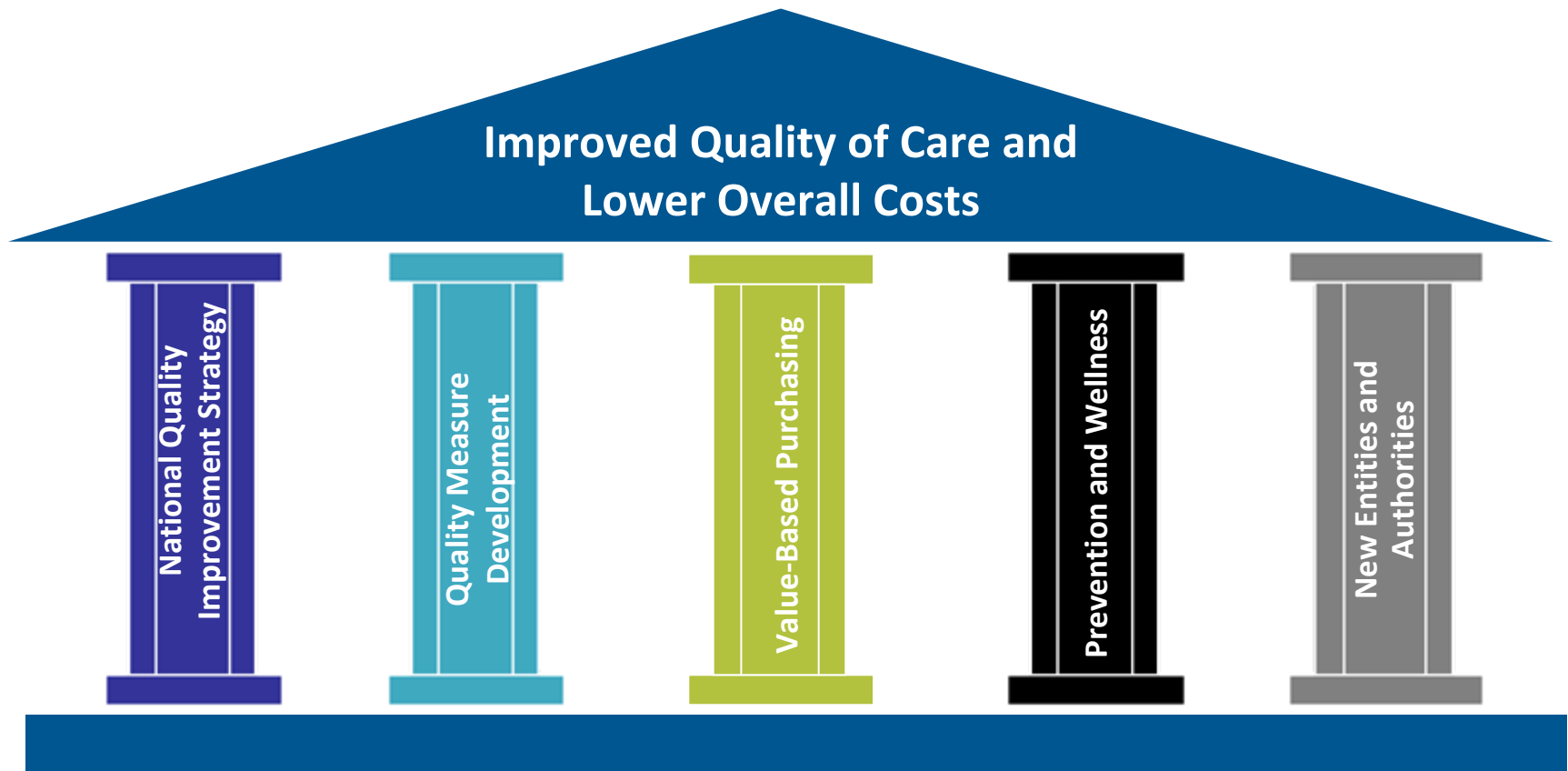
A Real Integrated System

- **Performs no scientifically groundless treatments**
- **Formally searches for effective, proven care practices**
- **Is the safest health care organization**
- **Involves patients and families fully in their own care**
- **Is an open health care organization**

ACT



Health Reform Builds on the Current Quality Infrastructure



Report to Congress

**National Strategy for Quality
Improvement in Health Care**

March 2011



HealthCare.gov

Take health care into your own hands



PARTNERSHIP FOR PATIENTS
BETTER CARE, LOWER COSTS

The Four Underlying Concepts of Cost Containment Through Payment Reform.....

Tying payment to **evidence and outcomes** rather than per unit of service

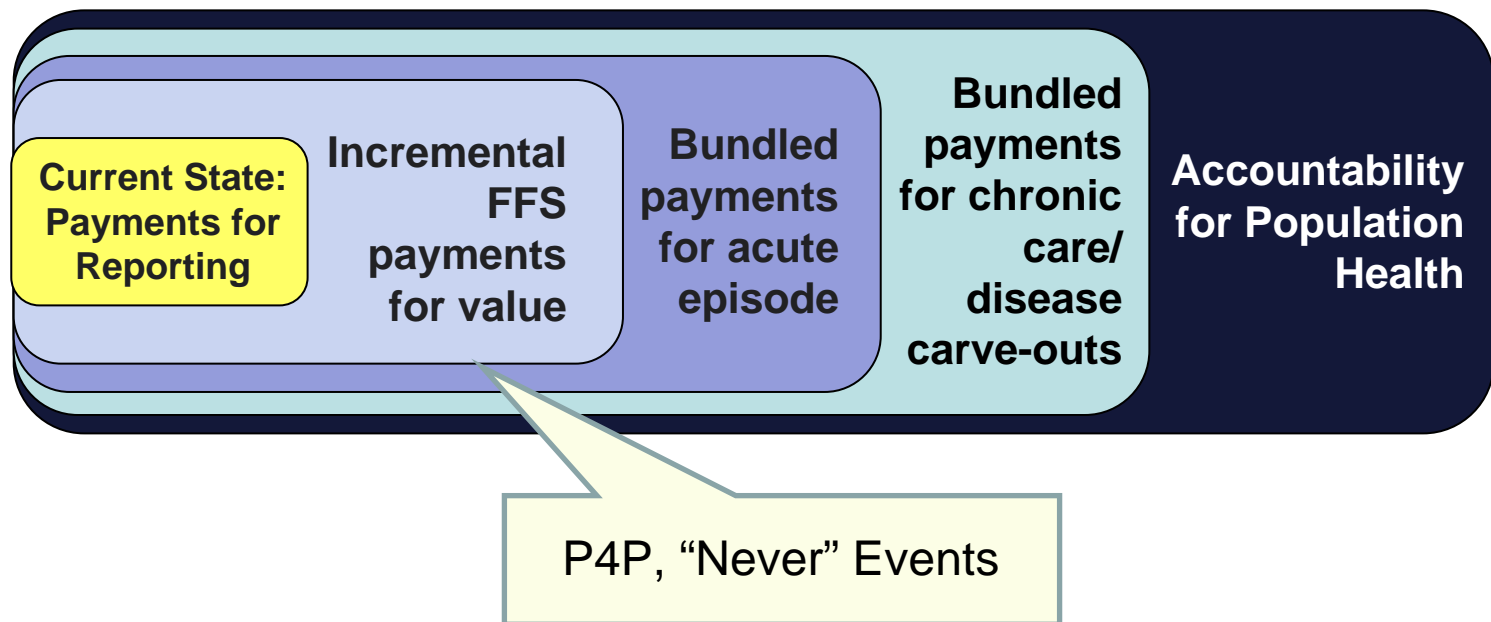
“Bundling” payments for physician and hospital services by episode or condition

Reimbursement for the **coordination of care** in a medical home

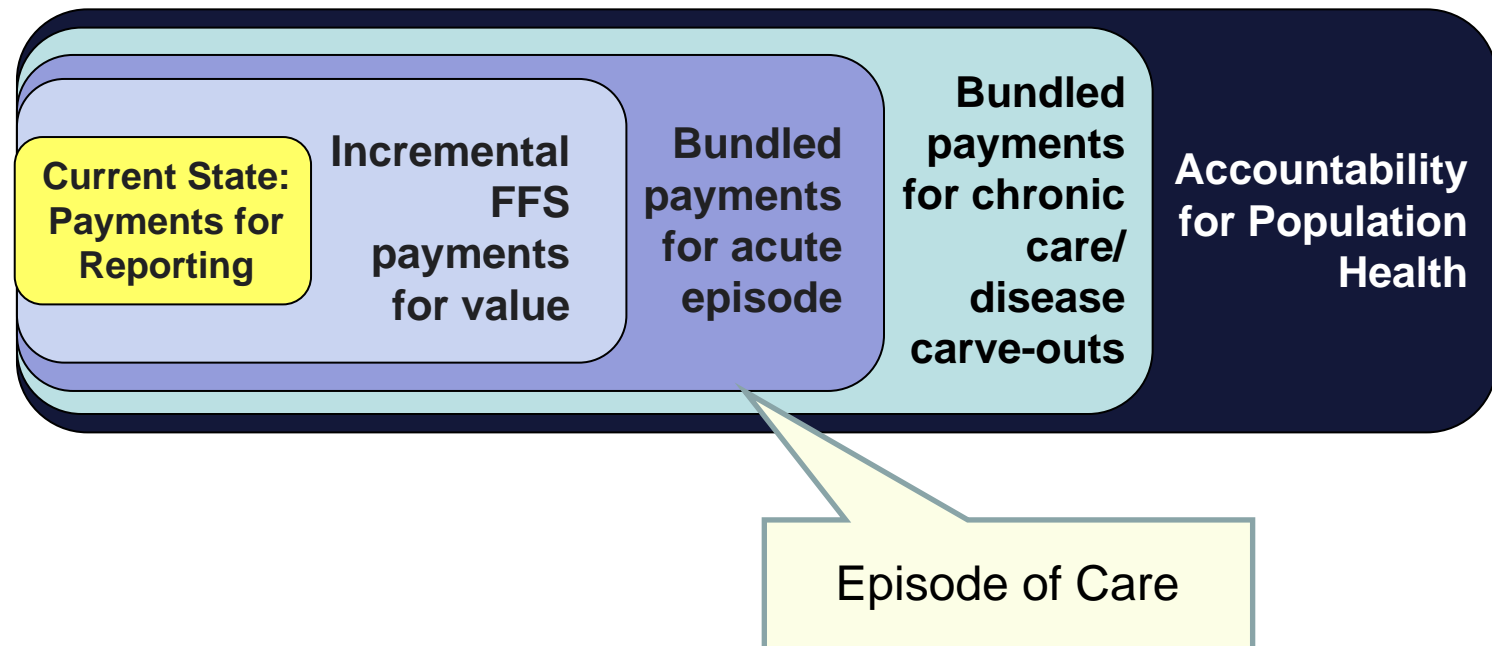
Accountability for results - patient management across care settings

Range of Models in Existence or Development

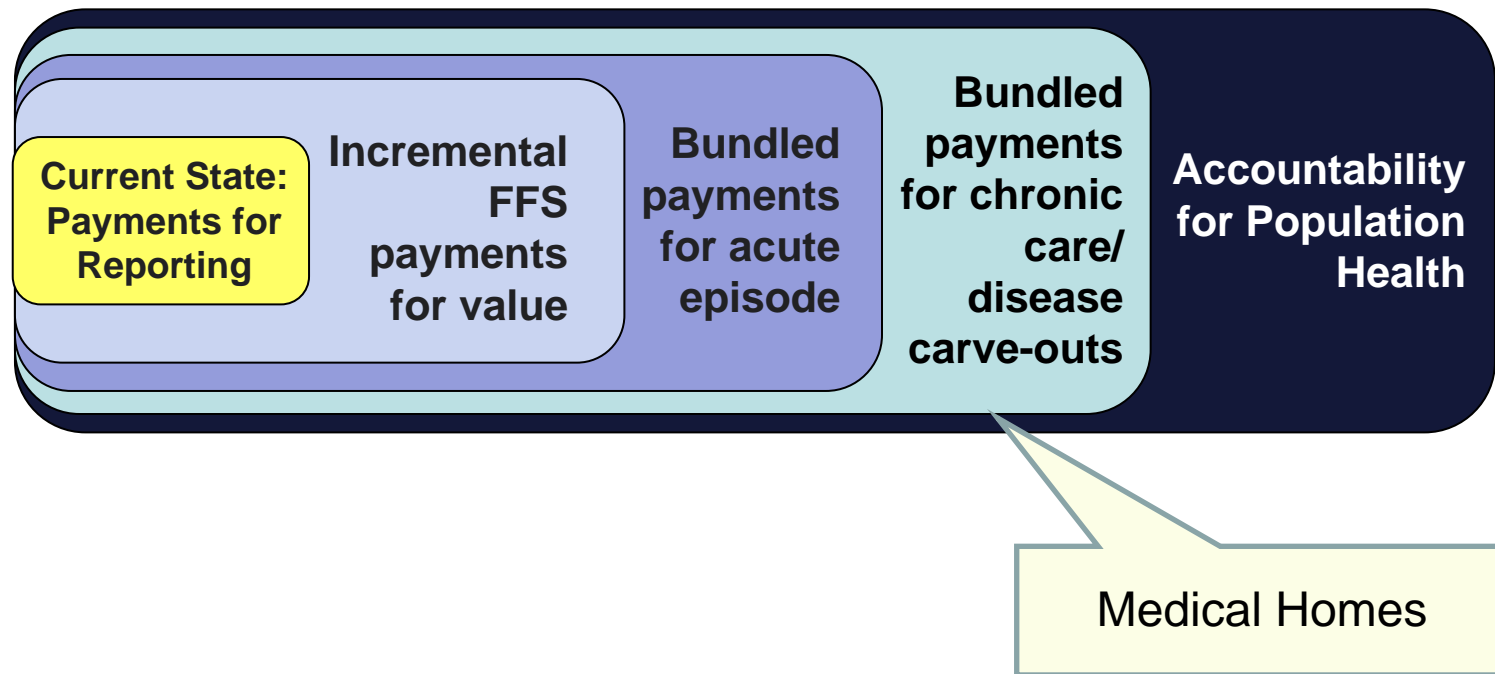
Increasing assumed risk by provider
→
Increasing coordination/integration required



Range of Models in Existence or Development



Range of Models in Existence or Development



What is a Medical Home?

- A Medical Home is “a community-based primary care setting which provides and coordinates high-quality, planned, patient and family-centered health promotion, acute illness care, and chronic condition management”

Care that is:

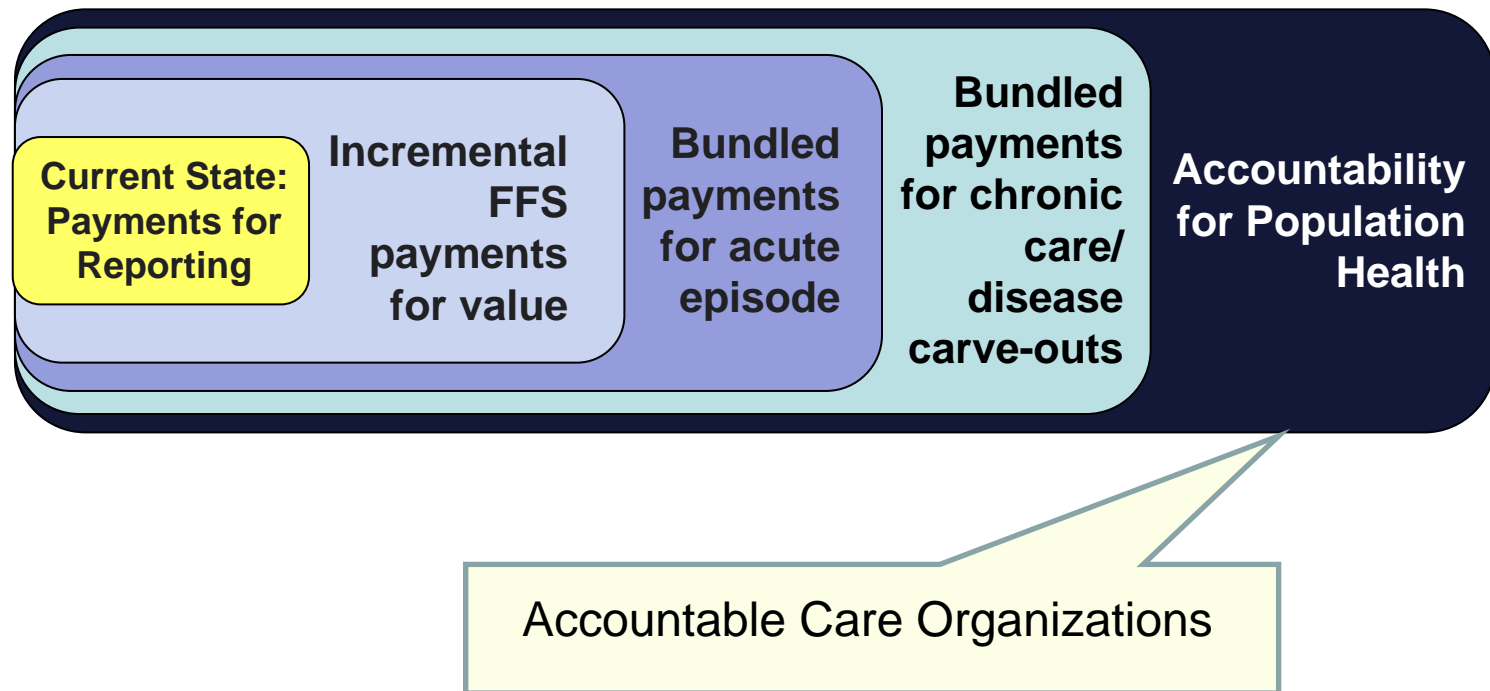
- Accessible
- Family-centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally effective



and for which the PCP:

Shares Responsibility with
Patient/Family

Range of Models in Existence or Development



By Susan DeVore and R. Wesley Champion

Driving Population Health Through Accountable Care Organizations

DOI: 10.1377/hlthaff.2010.0935
HEALTH AFFAIRS 30,
NO. 1 (2011): 41-50
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The People-to-People Health
Foundation, Inc.

ABSTRACT Accountable care organizations, scheduled to become part of the Medicare program under the Affordable Care Act, have been promoted as a way to improve health care quality, reduce growth in costs, and increase patients' satisfaction. It is unclear how these organizations will develop. Yet in principle they will have to meet quality metrics, adopt improved care processes, assume risk, and provide incentives for population health and wellness. These capabilities represent a radical departure from today's health delivery system. In May 2010 the Premier healthcare alliance formed the Accountable Care Implementation Collaborative, which consists of health systems that seek to pursue accountability by forming partnerships with private payers to evolve from fee-for-service payment models to new, value-driven models. This article describes how participants in the collaborative are building models and developing best practices that can inform the implementation of accountable care organizations as well as public policies.

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Humana's Accountable Care Organization pilot

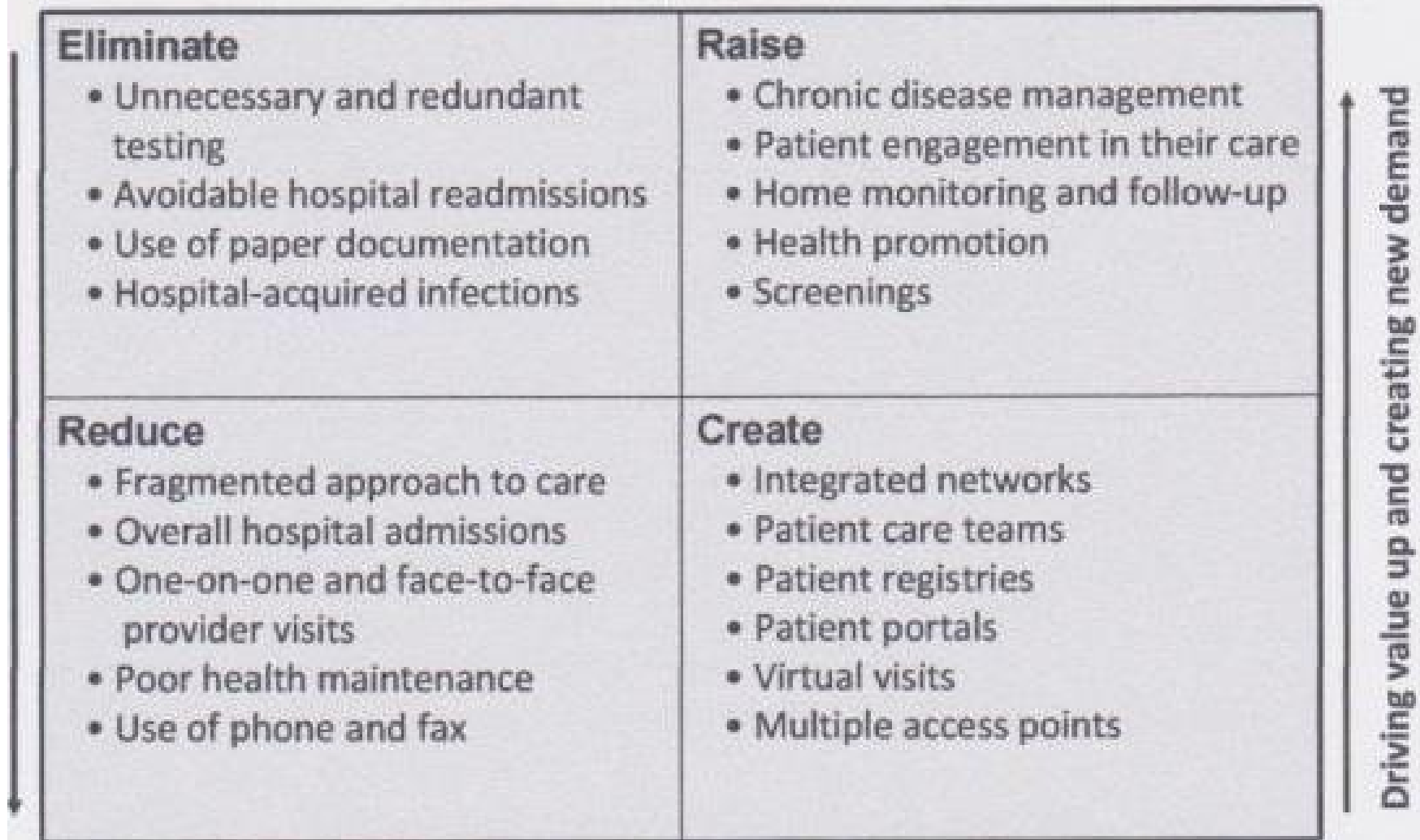
- Unites expertise of Humana and Norton Healthcare of Louisville
- One of only five pilots in the U.S. authorized by Dartmouth and Brookings
- Accountability of measured outcomes, cost, and patient delivery
- Industry-standard performance measures including financial, quality, regulatory
- Core principles:
 - Integrated care delivery among provider teams
 - Defined patient population to measure
 - Pay-for-results based on improved outcomes and cost



BROOKINGS



The Four Actions Framework Builds the Foundation for Accountable Care



Source: W. Chan Kim and Renee Mauborgne, *Blue Ocean Strategy: How to Create Uncontested Market Space and Make the Competition Irrelevant*. Harvard Business School Press, Boston, 2005.

What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income

How Might We Get There?

Change the Culture

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care

Population Health Management

CONTENTS

- Lifestyle Behavior and Emotional Health
- Strategic Response by Providers
- Tobacco Dependence Treatment Guideline Implementation
- Theory-Based Telehealth and Patient Empowerment
- Health-Related Productivity Loss
- Quality of Care for Veterans with Chronic Diseases

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POPULATION HEALTH

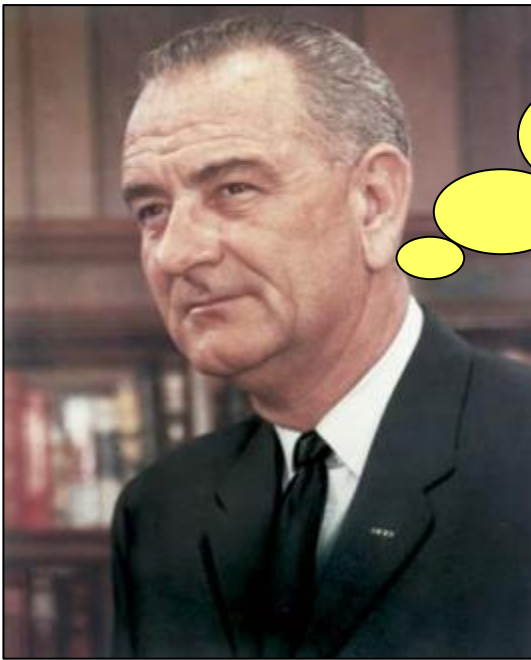
CREATING A CULTURE
OF WELLNESS



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<p>Master of Science in Healthcare Quality and Safety</p> <h2>MS-HQS</h2>  <p>Online Program</p> <p>Jefferson. School of Population Health</p> <p>THOMAS JEFFERSON UNIVERSITY</p>	<p>Master of Public Health</p> <h2>MPH</h2>  <p>CEPH</p> <p>Jefferson. School of Population Health</p> <p>THOMAS JEFFERSON UNIVERSITY</p>	<p>Master of Science in Applied Health Economics and Outcomes Research</p> <h2>MS-AHEOR</h2>  <p>Online Program</p> <p>Jefferson. School of Population Health</p> <p>THOMAS JEFFERSON UNIVERSITY</p>	<p>Master of Science in Health Policy</p> <h2>MS-HP</h2>  <p>Online Program</p> <p>Jefferson. School of Population Health</p> <p>THOMAS JEFFERSON UNIVERSITY</p>
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**"It's always better to
have them in the tent
pissing out, than outside
the tent pissing in."**



President, L.B. Johnson

Nash's Immutable Rule



High Quality
care
costs less!

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